ARTICLE 2

HEALTH INSURANCE

Section 1. Minnesota Statutes 2022, section 62A.02, subdivision 1, is amended to read:

Subdivision 1. **Filing.** (a) For purposes of this section, "health plan" means a health plan as defined in section 62A.011 or a policy of accident and sickness insurance as defined in section 62A.01. No health plan shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner. The filing for nongroup health plan forms shall include a statement of actuarial reasons and data to support the rate. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

(b) The filing must include the health plan's prescription drug formulary. Proposed revisions to the health plan's prescription drug formulary must be filed with the commissioner no later than August 1 of the application year.

(c) The provisions of paragraph (b) shall not be severable from section 62Q.83. If any provision of paragraph (b) or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 2. **[62A.0412] COVERAGE OF INFERTILITY TREATMENT.**

Subdivision 1. **Scope.** This section applies to all large group health plans that provide maternity benefits to Minnesota residents. This section only applies to large group health plans.

Subd. 2. **Required coverage.** (a) Every health plan under subdivision 1 must provide comprehensive coverage for the diagnosis of infertility, treatment for infertility, and standard fertility preservation services that are:

(1) considered medically necessary by the enrollee's treating health care provider; and

(2) recognized by either the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecologists, or the American Society of Clinical Oncology.

(b) Coverage under this section must include but is not limited to ovulation induction, procedures and devices to monitor ovulation, artificial insemination, oocyte retrieval

procedures, in vitro fertilization, gamete intrafallopian transfer, oocyte replacement, cryopreservation techniques, micromanipulation of gametes, and standard fertility preservation services.

(c) Coverage under this section must include unlimited embryo transfers, but may impose a limit of four completed oocyte retrievals. Single embryo transfer must be used when medically appropriate and recommended by the treating health care provider.

(d) Coverage for surgical reversal of elective sterilization is not required under this section.

(e) Cost-sharing requirements, including co-payments, deductibles, and coinsurance for infertility coverage, must not be greater than the cost-sharing requirements for maternity coverage under the enrollee's health plan.

(f) Health plans under subdivision 1 may not include in the coverage under this section:

(1) any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on other prescription medications;

(2) any exclusions, limitations, or other restrictions on coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party; or

(3) any benefit maximums, waiting periods, or any other limitations on coverage for the diagnosis of infertility, treatment of infertility, and standard fertility preservation services, except as provided in paragraphs (c) and (d), that are different from those imposed upon benefits for services not related to infertility.

Subd. 3. **Definitions.** (a) For the purposes of this section, the definitions in this subdivision have the meanings given them.

(b) "Infertility" means a disease, condition, or status characterized by:

(1) the failure of a person with a uterus to establish a pregnancy or to carry a pregnancy to live birth after 12 months of unprotected sexual intercourse for a person under the age of 35 or six months for a person 35 years of age or older, regardless of whether a pregnancy resulting in miscarriage occurred during such time;

(2) a person's inability to reproduce either as a single individual or with the person's partner without medical intervention; or

(3) a licensed health care provider's findings based on a patient's medical, sexual, and reproductive history; age; physical findings; or diagnostic testing.

(c) "Diagnosis of and treatment for infertility" means the recommended procedures and medications from the direction of a licensed health care provider that are consistent with established, published, or approved medical practices or professional guidelines from the

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American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

(d) "Standard fertility preservation services" means procedures that are consistent with the established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

EFFECTIVE DATE. This section is effective August 1, 2023, and applies to all large group health plans issued or renewed on or after that date.

Sec. 3. Minnesota Statutes 2022, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements ~~of~~ for health insurers under the federal Deficit Reduction Act of 2005, Public Law 109-171 and the federal Consolidated Appropriations Act of 2022, Public Law 117-103, including any federal regulations adopted under ~~that act~~ those acts, to the extent that ~~it imposes~~ they impose a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal ~~act~~ acts prior to the effective ~~date~~ dates provided for ~~that provision~~ those provisions in the federal ~~act~~ acts. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a health-care item or service for an individual receiving benefits under paragraph (b).

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B; or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability

THE FOLLOWING SECTION IS FROM ARTICLE 1

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Section 1. Minnesota Statutes 2022, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements ~~of~~ for health insurers under the federal Deficit Reduction Act of 2005, Public Law 109-171 and the federal Consolidated Appropriations Act of 2022, Public Law 117-103, including any federal regulations adopted under ~~that act~~ those acts, to the extent that ~~it imposes~~ they impose a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal ~~act~~ acts prior to the effective ~~date~~ dates provided for ~~that provision~~ those provisions in the federal ~~act~~ acts. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a health-care item or service for an individual receiving benefits under paragraph (b).

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B; or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability

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to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health insurer for those services. If the commissioner of human services notifies the health insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health insurer must be issued directly to the commissioner. Submission by the department to the health insurer of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health insurer, the health insurer shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(f) A health insurer must process a clean claim made by a state agency for covered expenses paid under state medical programs within 90 business days of the claim's submission. A health insurer must process all other claims made by a state agency for covered expenses paid under a state medical program within the timeline set forth in Code of Federal Regulations, title 42, section 447.45(d)(4).

(g) A health insurer may request a refund of a claim paid in error to the Department of Human Services within two years of the date the payment was made to the department. A request for a refund shall not be honored by the department if the health insurer makes the request after the time period has lapsed.

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to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health insurer for those services. If the commissioner of human services notifies the health insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health insurer must be issued directly to the commissioner. Submission by the department to the health insurer of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health insurer, the health insurer shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(f) A health insurer must process a clean claim made by a state agency for covered expenses paid under state medical programs within 90 business days of the claim's submission. A health insurer must process all other claims made by a state agency for covered expenses paid under a state medical program within the timeline set forth in Code of Federal Regulations, title 42, section 447.45(d)(4).

(g) A health insurer may request a refund of a claim paid in error to the Department of Human Services within two years of the date the payment was made to the department. A request for a refund shall not be honored by the department if the health insurer makes the request after the time period has lapsed.

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Sec. 4. Minnesota Statutes 2022, section 62A.15, is amended by adding a subdivision to read:

Subd. 3d. **Pharmacist.** All policies or contracts referred to in subdivision 1 must provide benefits relating to expenses incurred for medical treatment or services provided by a licensed pharmacist, according to the requirements of section 151.01, to the extent the medical treatment or services are within the pharmacist's scope of practice, if such a policy or contract provides the benefits relating to expenses incurred for the same medical treatment or services provided by a licensed physician.

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

Sec. 5. Minnesota Statutes 2022, section 62A.15, subdivision 4, is amended to read:

Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor, a licensed optometrist, a registered nurse meeting the requirements of subdivision 3a, a licensed physician assistant, ~~or~~ a licensed acupuncture practitioner, or a licensed pharmacist.

(b) When carriers referred to in subdivision 1 make claim determinations concerning the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any of these determinations that are made by health care professionals must be made by, or under the direction of, or subject to the review of licensed doctors of chiropractic.

(c) When a carrier referred to in subdivision 1 makes a denial of payment claim determination concerning the appropriateness, quality, or utilization of acupuncture services for individuals in this state performed by a licensed acupuncture practitioner, a denial of payment claim determination that is made by a health professional must be made by, under the direction of, or subject to the review of a licensed acupuncture practitioner.

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

Sec. 6. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to read:

Subd. 5. **Mammogram; diagnostic services and testing.** If a health care provider determines an enrollee requires additional diagnostic services or testing after a mammogram, a health plan must provide coverage for the additional diagnostic services or testing with no cost sharing, including co-pay, deductible, or coinsurance.

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

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THE FOLLOWING SECTIONS ARE FROM ARTICLE 13

Section 1. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to read:

Subd. 5. **Mammogram; diagnostic services and testing.** If a health care provider determines an enrollee requires additional diagnostic services or testing after a mammogram, a health plan must provide coverage for the additional diagnostic services or testing with no cost-sharing, including co-pay, deductible, or coinsurance.

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

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Sec. 7. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to read:

Subd. 6. **Application.** If the application of subdivision 5 before an enrollee has met their health plan's deducible would result 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), then subdivision 5 shall apply to diagnostic services or testing only after the enrollee has met their health plan's deductible.

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

Sec. 8. Minnesota Statutes 2022, section 62A.673, subdivision 2, is amended to read:

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

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

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

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support

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Sec. 2. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to read:

Subd. 6. **Application.** If the application of subdivision 5 before an enrollee has met their health plan's deductible would result 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), then subdivision 5 shall apply to diagnostic services or testing only after the enrollee has met their health plan's deductible.

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

THE FOLLOWING SECTION IS FROM ARTICLE 1

Sec. 2. Minnesota Statutes 2022, section 62A.673, subdivision 2, is amended to read:

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

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

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

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support

health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, ~~2023~~ 2025, telehealth also includes audio-only communication between a health care provider and a patient in accordance with subdivision 6, paragraph (b). Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

Sec. 9. **[62D.1071] COVERAGE OF LICENSED PHARMACIST SERVICES.**

Subdivision 1. **Pharmacist.** All health maintenance contracts must provide benefits relating to expenses incurred for medical treatment or services provided by a licensed pharmacist, to the extent the medical treatment or services are within the pharmacist's scope of practice, if the health maintenance contract provides benefits relating to expenses incurred for the same medical treatment or services provided by a licensed physician.

Subd. 2. **Denial of benefits.** When paying claims for enrollees in Minnesota, a health maintenance organization must not deny payment for medical services covered by an enrollee's health maintenance contract if the services are lawfully performed by a licensed pharmacist.

Subd. 3. **Medication therapy management.** This section does not apply to or affect the coverage or reimbursement for medication therapy management services under section 62Q.676 or 256B.0625, subdivisions 5, 13h, and 28a.

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

Sec. 10. Minnesota Statutes 2022, section 62J.497, subdivision 1, is amended to read:

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

(b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(f) "Electronic prescription drug program" means a program that provides for e-prescribing.

(g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(k) "NCPDP Formulary and Benefits Standard" means the most recent version of the National Council for Prescription Drug Programs Formulary and Benefits Standard or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

(l) "NCPDP Real-Time Prescription Benefit Standard" means the most recent National Council for Prescription Drug Programs Real-Time Prescription Benefit Standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(2) of the Social Security Act, and regulations adopted pursuant to that section.

~~(l)~~ (m) "NCPDP SCRIPT Standard" means the most recent version of the National Council for Prescription Drug Programs SCRIPT Standard, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

~~(m)~~ (n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(o) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision 15.

~~(n)~~ (p) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

~~(o)~~ (q) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

~~(p)~~ (r) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

(s) "Real-time prescription benefit tool" means a tool that is capable of being integrated into a prescriber's e-prescribing system and that provides a prescriber with up-to-date and patient-specific formulary and benefit information at the time the prescriber submits a prescription.

Sec. 11. Minnesota Statutes 2022, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

(f) Group purchasers and pharmacy benefit managers must use a real-time prescription benefit tool that complies with the NCPDP Real-Time Prescription Benefit Standard and that, at a minimum, notifies a prescriber:

(1) if a prescribed drug is covered by the patient's group purchaser or pharmacy benefit manager;

(2) if a prescribed drug is included on the formulary or preferred drug list of the patient's group purchaser or pharmacy benefit manager;

(3) of any patient cost-sharing for the prescribed drug;

(4) if prior authorization is required for the prescribed drug; and

(5) of a list of any available alternative drugs that are in the same class as the drug originally prescribed and for which prior authorization is not required.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 12. **[62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

Subdivision 1. **Billing requirements.** (a) Each health care provider and health facility shall comply with the federal Consolidated Appropriations Act, 2021, Division BB also known as the "No Surprises Act," including any federal regulations adopted under that act.

(b) For the purposes of this section, "provider" or "facility" means any health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to relevant provisions of the No Surprises Act.

Subd. 2. **Investigations and compliance.** (a) The commissioner shall, to the extent practicable, seek the cooperation of health care providers and facilities, and may provide any support and assistance as available, in obtaining compliance with this section.

(b) The commissioner shall determine the manner and processes for fulfilling any responsibilities and taking any of the actions in paragraphs (c) to (f).

(c) A person who believes a health care provider or facility has not complied with the requirements of the No Surprises Act or this section may file a complaint with the commissioner in the manner determined by the commissioner.

(d) The commissioner shall conduct compliance reviews and investigate complaints filed under this section in the manner determined by the commissioner to ascertain whether health care providers and facilities are complying with this section.

(e) The commissioner may report violations under this section to other relevant federal and state departments and jurisdictions as appropriate, including the attorney general and relevant licensing boards, and may also coordinate on investigations and enforcement of this section with other relevant federal and state departments and jurisdictions as appropriate, including the attorney general and relevant licensing boards.

(f) A health care provider or facility may contest whether the finding of facts constitute a violation of this section according to the contested case proceeding in sections 14.57 to 14.62, subject to appeal according to sections 14.63 to 14.68.

(g) Any data collected by the commissioner as part of an active investigation or active compliance review under this section are classified (1) if the data is not on individuals, it is classified as protected nonpublic data pursuant to section 13.02 subdivision 13; or (2) if

THE FOLLOWING SECTIONS ARE FROM ARTICLE 3

Sec. 5. **[62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

Subdivision 1. **Billing requirements.** (a) Each health care provider and health facility shall comply with Consolidated Appropriations Act, 2021, Division BB also known as the "No Surprises Act," including any federal regulations adopted under that act.

(b) For the purposes of this section, "provider" or "facility" means any health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to relevant provisions of the No Surprises Act.

Subd. 2. **Compliance.** The commissioner shall, to the extent practicable, seek the cooperation of health care providers and facilities and may provide any support and assistance as available, in obtaining compliance with this section.

the data is on individuals, it is classified as confidential pursuant to sections 13.02, subdivision 3. Data describing the final disposition of an investigative or compliance review are classified as public.

Subd. 3. **Civil penalty.** (a) The commissioner, in monitoring and enforcing this section, may levy a civil monetary penalty against each health care provider or facility found to be in violation of up to $100 for each violation, but may not exceed $25,000 for identical violations during a calendar year.

(b) No civil monetary penalty shall be imposed under this section for violations that occur prior to January 1, 2024.

Sec. 13. Minnesota Statutes 2022, section 62J.824, is amended to read:

62J.824 FACILITY FEE DISCLOSURE.

(a) Prior to the delivery of nonemergency services, a provider-based clinic that charges a facility fee shall provide notice to any patient, including patients served by telehealth as defined in section 62A.673, subdivision 2, paragraph (h), stating that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense.

(b) Each health care facility must post prominently in locations easily accessible to and visible by patients, including on its website, a statement that the provider-based clinic is part of a hospital and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense.

(c) This section does not apply to laboratory services, imaging services, or other ancillary health services that are provided by staff who are not employed by the health care facility or clinic.

(d) For purposes of this section:

(1) "facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses; and

(2) "provider-based clinic" means the site of an off-campus clinic or provider office, located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144, and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

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Sec. 14. **[62J.826] MEDICAL AND DENTAL PRACTICES; CURRENT STANDARD CHARGES; COMPARISON TOOL.**

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

(b) "CDT code" means a code value drawn from the Code on Dental Procedures and Nomenclature published by the American Dental Association.

(c) "Chargemaster" means the list of all individual items and services maintained by a medical or dental practice for which the medical or dental practice has established a charge.

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

(e) "CPT code" means a code value drawn from the Current Procedural Terminology published by the American Medical Association.

(f) "Dental service" means a service charged using a CDT code.

(g) "Diagnostic laboratory testing" means a service charged using a CPT code within the CPT code range of 80047 to 89398.

(h) "Diagnostic radiology service" means a service charged using a CPT code within the CPT code range of 70010 to 79999 and includes the provision of x-rays, computed tomography scans, positron emission tomography scans, magnetic resonance imaging scans, and mammographies.

(i) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58, but does not include a health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

(j) "Medical or dental practice" means a business that:

(1) earns revenue by providing medical care or dental services to the public;

(2) issues payment claims to health plan companies and other payers; and

(3) may be identified by its federal tax identification number.

(k) "Outpatient surgical center" means a health care facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.

(l) "Standard charge" means the regular rate established by the medical or dental practice for an item or service provided to a specific group of paying patients. This includes all of the following:

(1) the charge for an individual item or service that is reflected on a medical or dental practice's chargemaster, absent any discounts;

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Sec. 6. **[62J.826] MEDICAL AND DENTAL PRACTICES; CURRENT STANDARD CHARGES.**

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

(b) "CDT code" means a code value drawn from the Code on Dental Procedures and Nomenclature published by the American Dental Association.

(c) "Chargemaster" means the list of all individual items and services maintained by a medical or dental practice for which the medical or dental practice has established a charge.

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

(e) "CPT code" means a code value drawn from the Current Procedural Terminology published by the American Medical Association.

(f) "Dental service" means a service charged using a CDT code.

(g) "Diagnostic laboratory testing" means a service charged using a CPT code within the CPT code range of 80047 to 89398.

(h) "Diagnostic radiology service" means a service charged using a CPT code within the CPT code range of 70010 to 79999 and includes the provision of x-rays, computed tomography scans, positron emission tomography scans, magnetic resonance imaging scans, and mammographies.

(i) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58, but does not include a health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

(j) "Medical or dental practice" means a business that:

(1) earns revenue by providing medical care or dental services to the public;

(2) issues payment claims to health plan companies and other payers; and

(3) may be identified by its federal tax identification number.

(k) "Outpatient surgical center" means a health care facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.

(l) "Standard charge" means the regular rate established by the medical or dental practice for an item or service provided to a specific group of paying patients. This includes all of the following:

(1) the charge for an individual item or service that is reflected on a medical or dental practice's chargemaster, absent any discounts;

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(2) the charge that a medical or dental practice has negotiated with a third-party payer for an item or service;

(3) the lowest charge that a medical or dental practice has negotiated with all third-party payers for an item or service;

(4) the highest charge that a medical or dental practice has negotiated with all third-party payers for an item or service; and

(5) the charge that applies to an individual who pays cash, or cash equivalent, for an item or service.

Subd. 2. **Requirement; current standard charges.** The following medical or dental practices must make available to the public a list of their current standard charges for all items and services, as reflected in the medical or dental practice's chargemaster, provided by the medical or dental practice:

(1) hospitals;

(2) outpatient surgical centers; and

(3) any other medical or dental practice that has revenue of greater than $50,000,000 per year and that derives the majority of its revenue by providing one or more of the following services:

(i) diagnostic radiology services;

(ii) diagnostic laboratory testing;

(iii) orthopedic surgical procedures, including joint arthroplasty procedures within the CPT code range of 26990 to 27899;

(iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT code 66982 or 66984, or refractive correction surgery to improve visual acuity;

(v) anesthesia services commonly provided as an ancillary to services provided at a hospital, outpatient surgical center, or medical practice that provides orthopedic surgical procedures or ophthalmologic surgical procedures;

(vi) oncology services, including radiation oncology treatments within the CPT code range of 77261 to 77799 and drug infusions; or

(vii) dental services.

Subd. 3. **Required file format and content.** (a) A medical or dental practice that is subject to this section must make available to the public, and must report to the commissioner, current standard charges using the format and data elements specified in the currently effective version of the Hospital Price Transparency Sample Format (Tall) (CSV) and related data dictionary recommended for hospitals by the Centers for Medicare and Medicaid Services (CMS). If CMS modifies or replaces the specifications for this format, the form

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(2) the charge that a medical or dental practice has negotiated with a third-party payer for an item or service;

(3) the lowest charge that a medical or dental practice has negotiated with all third-party payers for an item or service;

(4) the highest charge that a medical or dental practice has negotiated with all third-party payers for an item or service; and

(5) the charge that applies to an individual who pays cash, or cash equivalent, for an item or service.

Subd. 2. **Requirement; current standard charges.** The following medical or dental practices must make available to the public a list of their current standard charges, as reflected in the medical or dental practice's chargemaster, for all items and services provided by the medical or dental practice:

(1) hospitals;

(2) outpatient surgical centers; and

(3) any other medical or dental practice that has revenue of greater than $50,000,000 per year and that derives the majority of its revenue by providing one or more of the following services:

(i) diagnostic radiology services;

(ii) diagnostic laboratory testing;

(iii) orthopedic surgical procedures, including joint arthroplasty procedures within the CPT code range of 26990 to 27899;

(iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT code 66982 or 66984, or refractive correction surgery to improve visual acuity;

(v) anesthesia services commonly provided as an ancillary to services provided at a hospital, outpatient surgical center, or medical practice that provides orthopedic surgical procedures or ophthalmologic surgical procedures;

(vi) oncology services, including radiation oncology treatments within the CPT code range of 77261 to 77799 and drug infusions; or

(vii) dental services.

Subd. 3. **Required file format and content.** (a) A medical or dental practice that is subject to this section must make available to the public, and must report to the commissioner, current standard charges using the format and data elements specified in the currently effective version of the Hospital Price Transparency Sample Format (Tall) (CSV) and related data dictionary recommended for hospitals by the Centers for Medicare and Medicaid Services (CMS). If CMS modifies or replaces the specifications for this format, the form

of this file must be modified or replaced to conform with the new CMS specifications by the date specified by CMS for compliance with its new specifications. All prices included in the file must be expressed as dollar amounts. The data must be in the form of a comma separated values file which can be directly imported, without further editing or remediation, into a relational database table which has been designed to receive these files. The medical or dental practice must make the file available to the public in a manner specified by the commissioner and must report the file to the commissioner in a manner and frequency specified by the commissioner.

(b) A medical or dental practice must test its file for compliance with paragraph (a) before making the file available to the public and reporting the file to the commissioner.

(c) A hospital must comply with this section no later than January 1, 2024. A medical or dental practice that meets the requirements in subdivision 2, clause (3), or an outpatient surgical center must comply with this section no later than January 1, 2025.

Sec. 15. Minnesota Statutes 2022, section 62J.84, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section and section 62J.841, the terms defined in this subdivision have the meanings given.

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

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

(1) ~~an original,~~ 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~~ 42, section 262(a)(c).

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

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

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

(2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42, section 447.502; or

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

(f) "Manufacturer" means a drug manufacturer licensed under section 151.252, but does not include an entity required to be licensed under that section solely because the entity repackages or relabels drugs. The provisions of this paragraph shall not be severable from

of this file must be modified or replaced to conform with the new CMS specifications by the date specified by CMS for compliance with its new specifications. All prices included in the file must be expressed as dollar amounts. The data must be in the form of a comma-separated-values file that can be directly imported without further editing or remediation into a relational database table that has been designed to receive these files. The medical or dental practice must make the file available to the public in a manner specified by the commissioner and must report the file to the commissioner in a manner and frequency specified by the commissioner.

(b) A medical or dental practice must test its file for compliance with paragraph (a) before making the file available to the public and reporting the file to the commissioner.

(c) A hospital must comply with this section no later than January 1, 2024. A medical or dental practice that meets the requirements in subdivision 2, clause (3), or an outpatient surgical center must comply with this section no later than January 1, 2025.

Sec. 7. Minnesota Statutes 2022, section 62J.84, subdivision 2, is amended to read:

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

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

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

(1) ~~an original,~~ 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~~ 42, section 262(a)(c).

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

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

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

(2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42, section 447.502; or

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

(f) "Manufacturer" means a drug manufacturer licensed under section 151.252.

section 62Q.83. If this paragraph or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

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

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

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

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

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

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

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

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

(o) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded, or dispensed under the supervision of a pharmacist.

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

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

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

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

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

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

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

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

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

(o) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded, or dispensed under the supervision of a pharmacist.

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

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(q) "Pricing unit" means the smallest dispensable amount of a prescription drug product that could be dispensed.

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

(s) "Wholesale drug distributor" or "wholesaler" means an entity that:

(1) is licensed to act as a wholesale drug distributor under section 151.47; and

(2) distributes prescription drugs, for which it is not the manufacturer, to persons or entities, or both, other than a consumer or patient in the state.

Sec. 16. Minnesota Statutes 2022, section 62J.84, subdivision 3, is amended to read:

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

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

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

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

(4) the introductory price of the prescription drug when it was ~~approved for marketing by the Food and Drug Administration and the net yearly increase, by calendar year, in the price of the prescription drug during the previous five years~~ introduced for sale in the United

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(q) "Pricing unit" means the smallest dispensable amount of a prescription drug product that could be dispensed.

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

(s) "Wholesale drug distributor" or "wholesaler" means an entity that:

(1) is licensed to act as a wholesale drug distributor under section 151.47; and

(2) distributes prescription drugs, of which it is not the manufacturer, to persons or entities, or both, other than a consumer or patient in the state.

Sec. 8. Minnesota Statutes 2022, section 62J.84, subdivision 3, is amended to read:

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

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

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

(4) the introductory price of the prescription drug when it was ~~approved for marketing by the Food and Drug Administration and the net yearly increase, by calendar year, in the price of the prescription drug during the previous five years~~ introduced for sale in the United

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States and the price of the drug on the last day of each of the five calendar years preceding the price increase;

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

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug;

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

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

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

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

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

(11) the name and location of the company that manufactured the drug; ~~and~~

(12) if a brand name prescription drug, the ~~ten~~ highest ~~prices~~ price paid for the prescription drug during the previous calendar year in ~~any country other than~~ the ten countries, excluding the United States~~.~~, that charged the highest single price for the prescription drug; and

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

(i) price at acquisition;

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

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

(iv) date of acquisition; and

(v) acquisition price.

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

Sec. 17. Minnesota Statutes 2022, section 62J.84, subdivision 4, is amended to read:

Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no later than 60 days after a manufacturer introduces a new prescription drug for sale in the

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States and the price of the drug on the last day of each of the five calendar years preceding the price increase;

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

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug;

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

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

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

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

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

(11) the name and location of the company that manufactured the drug; ~~and~~

(12) if a brand name prescription drug, the ~~ten~~ highest ~~prices~~ price paid for the prescription drug during the previous calendar year in ~~any country other than~~ the ten countries, excluding the United States~~.~~, that charged the highest single price for the prescription drug; and

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

(i) price at acquisition;

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

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

(iv) date of acquisition; and

(v) acquisition price.

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

Sec. 9. Minnesota Statutes 2022, section 62J.84, subdivision 4, is amended to read:

Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no later than 60 days after a manufacturer introduces a new prescription drug for sale in the

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United States that is a new brand name drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting less than 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting less than 30 days and is not at least 15 percent lower than the referenced brand name drug when the generic or biosimilar drug is launched, the manufacturer must submit to the commissioner, in the form and manner prescribed by the commissioner, the following information, if applicable:

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

~~(1)~~ (2) the price of the prescription drug;

~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a breakthrough therapy designation or a priority review;

~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug; and

~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

(b) The manufacturer may submit documentation necessary to support the information reported under this subdivision.

Sec. 18. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

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United States that is a new brand name drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than 30 days and is not at least 15 percent lower than the referenced brand name drug when the generic or biosimilar drug is launched, the manufacturer must submit to the commissioner, in the form and manner prescribed by the commissioner, the following information, if applicable:

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

~~(1)~~ (2) the price of the prescription drug;

~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a breakthrough therapy designation or a priority review;

~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug; and

~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

(b) The manufacturer may submit documentation necessary to support the information reported under this subdivision.

Sec. 10. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3~~, 4, and 5~~ to 6 and 9 to 14, and the manufacturers of those prescription drugs; ~~and~~

(2) information reported to the commissioner under subdivisions 3~~, 4, and 5~~ to 6 and 9 to 14~~.~~; and

(3) information reported to the commissioner under section 62J.841, subdivision 2.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or, subject to section 62J.841, subdivision 2, paragraph (e), is trade secret information under section 13.37, subdivision 1, paragraph (b); or, subject to section 62J.841, subdivision 2, paragraph (e), is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

(f) The provisions in this subdivision referencing 62J.841 shall not be severable from section 62Q.83. If any reference to section 62J.841 or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 19. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format

(1) a list of the prescription drugs reported under subdivisions 3, 4, and ~~5,~~ 11 to 14 and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 3, 4, and ~~5~~ 11 to 14.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

Sec. 11. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format

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of the information reported under this section and section 62J.841; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section and section 62J.841.

(b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting entities to establish a standard format for reporting information under this section and section 62J.841 and may use existing reporting methodologies to establish a standard format to minimize administrative burdens to the state and ~~manufacturers~~ reporting entities.

(c) The provisions in this subdivision referencing 62J.841 shall not be severable from section 62Q.83. If any reference to section 62J.841 or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 20. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

Subd. 8. **Enforcement and penalties.** (a) A ~~manufacturer~~ reporting entity may be subject to a civil penalty, as provided in paragraph (b), for:

(1) failing to register under subdivision 15;

~~(1)~~ (2) failing to submit timely reports or notices as required by this section and section 62J.841;

~~(2)~~ (3) failing to provide information required under this section and section 62J.841; ~~or~~

~~(3)~~ (4) providing inaccurate or incomplete information under this section and section 62J.841; or

(5) failing to comply with section 62J.841, subdivisions 2, paragraph (e), and 4.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section and section 62J.841 as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section and section 62J.841 upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section and section 62J.841 shall be deposited in the health care access fund.

(f) The provisions in this subdivision referencing 62J.841 shall not be severable from section 62Q.83. If any reference to section 62J.841 or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

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of the information reported under this section; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section.

(b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting entities to establish a standard format for reporting information under this section and may use existing reporting methodologies to establish a standard format to minimize administrative burdens to the state and ~~manufacturers~~ reporting entities.

Sec. 12. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

Subd. 8. **Enforcement and penalties.** (a) A ~~manufacturer~~ reporting entity may be subject to a civil penalty, as provided in paragraph (b), for:

(1) failing to register under subdivision 15;

~~(1)~~ (2) failing to submit timely reports or notices as required by this section;

~~(2)~~ (3) failing to provide information required under this section; or

~~(3)~~ (4) providing inaccurate or incomplete information under this section.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section shall be deposited in the health care access fund.

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Sec. 21. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

Subd. 9. **Legislative report.** (a) No later than May 15, ~~2022~~ 2024, and by January 15 of each year thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section and section 62J.841, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state, health carriers, and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state, health carriers, and other payers in the management of pharmaceutical costs and limiting formulary changes due to prescription drug cost increases during a coverage year.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3~~, 4, and 5~~ to 6 and 9 to 14, and section 62J.841.

(c) The provisions in this subdivision shall not be severable from section 62Q.83. If this subdivision or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 22. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the department's website a list of prescription drugs that the commissioner determines to represent a substantial public interest and for which the department intends to request data under subdivisions 9 to 14, subject to paragraph (c). The commissioner shall base its inclusion of prescription drugs on any information the commissioner determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state, and the department shall consider drug product families that include prescription drugs:

(1) that triggered reporting under subdivisions 3, 4, or 6 during the previous calendar quarter;

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

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

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Sec. 13. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each year thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state and other payers in the management of pharmaceutical costs.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3, 4, and ~~5~~ 11 to 14.

Sec. 14. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the department's website a list of prescription drugs that the department determines to represent a substantial public interest and for which the department intends to request data under subdivisions 11 to 14, subject to paragraph (c). The department shall base its inclusion of prescription drugs on any information the department determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state, and the department shall consider drug product families that include prescription drugs:

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

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

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

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(b) Not sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via email, reporting entities registered with the department of the requirement to report under subdivisions 9 to 14.

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

Sec. 23. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

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

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

(2) which the manufacturer manufactures or repackages;

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

(4) for which the manufacturer has not submitted data under subdivision 3 or 6 during the 120-day period prior to the date of the notification to report.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

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

(ii) the introduced to market date; or

(iii) the acquisition date;

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

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(b) Not sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via email, reporting entities registered with the department of the requirement to report under subdivisions 11 to 14.

(c) No more than 500 prescription drugs may be designated as having a substantial public interest in any one notice.

Sec. 15. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

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

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

(2) which the manufacturer manufactures or repackages;

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

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

(ii) the introduced to market date; or

(iii) the acquisition date;

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

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

(5) the direct costs incurred during the 12-month period prior to the date of the notification to report by the manufacturers that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug;

(6) the number of units of the prescription drug sold during the 12-month period prior to the date of the notification to report;

(7) the total sales revenue for the prescription drug during the 12-month period prior to the date of the notification to report;

(8) the total rebate payable amount accrued for the prescription drug during the 12-month period prior to the date of the notification to report;

(9) the manufacturer's net profit attributable to the prescription drug during the 12-month period prior to the date of the notification to report;

(10) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the 12-month period prior to the date of the notification to report, if applicable;

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

(12) the patent expiration date of the prescription drug if the prescription drug is under patent;

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

(14) if the prescription drug is a brand name prescription drug, the ten countries other than the United States that paid the highest prices for the prescription drug during the previous calendar year and their prices; and

(15) if the prescription drug was acquired by the manufacturer within a 12-month period prior to the date of the notification to report, all of the following information:

(i) the price at acquisition;

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

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

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

(5) the direct costs incurred during the 12-month period prior to the date of the notification to report by the manufacturers that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug;

(6) the number of units of the prescription drug sold during the 12-month period prior to the date of the notification to report;

(7) the total sales revenue for the prescription drug during the 12-month period prior to the date of the notification to report;

(8) the total rebate payable amount accrued for the prescription drug during the 12-month period prior to the date of the notification to report;

(9) the manufacturer's net profit attributable to the prescription drug during the 12-month period prior to the date of the notification to report;

(10) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the 12-month period prior to the date of the notification to report, if applicable;

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

(12) the patent expiration date of the prescription drug if the prescription drug is under patent;

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

(14) if the prescription drug is a brand name prescription drug, the ten countries other than the United States that paid the highest prices for the prescription drug during the previous calendar year and their prices; and

(15) if the prescription drug was acquired by the manufacturer within a 12-month period prior to the date of the notification to report, all of the following information:

(i) the price at acquisition;

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

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

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(iv) the date of acquisition; and

(v) the acquisition price.

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

Sec. 24. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the pharmacy by the department under subdivision 9.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug acquired during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the 12-month period prior to the date of the notification to report;

(6) the total payment receivable by the pharmacy for dispensing the drug including ingredient cost, dispensing fee, and administrative fees during the 12-month period prior to the date of the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report; and

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(iv) the date of acquisition; and

(v) the acquisition price.

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

Sec. 16. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the pharmacy by the department under subdivision 10.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug acquired during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the 12-month period prior to the date of the notification to report;

(6) the total payment receivable by the pharmacy for dispensing the drug including ingredient cost, dispensing fee, and administrative fees during the 12-month period prior to the date of the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report; and

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(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the 12-month period prior to the date of the notification to report.

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

Sec. 25. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a PBM must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the PBM by the department under subdivision 9.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(3) the total reimbursement amount accrued and payable to pharmacies for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(4) the total reimbursement or administrative fee amount, or both, accrued and receivable from payers for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(5) the total rebate receivable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report; and

(6) the total rebate payable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report.

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(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the 12-month period prior to the date of the notification to report.

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

Sec. 17. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a PBM must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the PBM by the department under subdivision 10.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(3) the total reimbursement amount accrued and payable to pharmacies for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(4) the total reimbursement or administrative fee amount, or both, accrued and receivable from payers for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(5) the total rebate receivable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report; and

(6) the total rebate payable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report.

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

Sec. 26. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 14. **Wholesaler prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a wholesaler must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the wholesaler by the department under subdivision 10.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug product acquired by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the wholesale drug distributor to acquire the drug product during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report;

(5) the number of units of the drug product sold by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(6) gross revenue from sales in the United States generated by the wholesale drug distributor for this drug product during the 12-month period prior to the date of the notification to report; and

(7) total rebate payable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report.

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

Sec. 18. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 14. **Wholesale drug distributor prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a wholesale drug distributor must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the wholesale drug distributor by the department under subdivision 10.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug product acquired by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the wholesale drug distributor to acquire the drug product during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report;

(5) the number of units of the drug product sold by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(6) gross revenue from sales in the United States generated by the wholesale drug distributor for this drug product during the 12-month period prior to the date of the notification to report; and

(7) total rebate payable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report.

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

Sec. 27. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 15. **Registration requirements.** Beginning January 1, 2024, a reporting entity subject to this chapter shall register with the department in a form and manner prescribed by the commissioner.

Sec. 28. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the expedited rulemaking process under section 14.389.

Sec. 29. **[62J.841] REPORTING PRESCRIPTION DRUG PRICES; FORMULARY DEVELOPMENT AND PRICE STABILITY.**

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

(b) "Average wholesale price" means the customary reference price for sales by a drug wholesaler to a retail pharmacy, as established and published by the manufacturer.

(c) "National drug code" means the numerical code maintained by the United States Food and Drug Administration and includes the label code, product code, and package code.

(d) "Wholesale acquisition cost" has the meaning given in United States Code, title 42, section 1395w-3a(c)(6)(B).

(e) "Unit" has the meaning given in United States Code, title 42, section 1395w-3a(b)(2).

Subd. 2. **Price reporting.** (a) Beginning July 31, 2024, and by July 31 of each year thereafter, a manufacturer must report to the commissioner the information in paragraph (b) for every drug with a wholesale acquisition cost of $100 or more for a 30-day supply or for a course of treatment lasting less than 30 days, as applicable to the next calendar year.

(b) A manufacturer shall report a drug's:

(1) national drug code, labeler code, and the manufacturer name associated with the labeler code;

(2) brand name, if applicable;

(3) generic name, if applicable;

(4) wholesale acquisition cost for one unit;

(5) measure that constitutes a wholesale acquisition cost unit;

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(c) The wholesale drug distributor may submit any documentation necessary to support the information reported under this subdivision.

Sec. 19. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 15. **Registration requirements.** Beginning January 1, 2024, a reporting entity subject to this chapter shall register with the department in a form and manner prescribed by the commissioner.

Sec. 20. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the expedited rulemaking process under section 14.389.

(6) average wholesale price; and

(7) status as brand name or generic.

(c) The effective date of the information described in paragraph (b) must be included in the report to the commissioner.

(d) A manufacturer must report the information described in this subdivision in the form and manner specified by the commissioner.

(e) Information reported under this subdivision is classified as public data not on individuals, as defined in section 13.02, subdivision 14, and must not be classified by the manufacturer as trade secret information, as defined in section 13.37, subdivision 1, paragraph (b).

(f) A manufacturer's failure to report the information required by this subdivision is grounds for disciplinary action under section 151.071, subdivision 2.

Subd. 3. **Public posting of prescription drug price information.** By October 1 of each year, beginning October 1, 2024, the commissioner must post the information reported under subdivision 2 on the department's website, as required by section 62J.84, subdivision 6.

Subd. 4. **Price change.** (a) If a drug subject to price reporting under subdivision 2 is included in the formulary of a health plan submitted to and approved by the commissioner of commerce for the next calendar year under section 62A.02, subdivision 1, the manufacturer may increase the wholesale acquisition cost of the drug for the next calendar year only after providing the commissioner with at least 90 days written notice.

(b) A manufacturer's failure to meet the requirements of paragraph (a) is grounds for disciplinary action under section 151.071, subdivision 2.

Subd. 5. **Not severable.** The provisions of this section shall not be severable from section 62Q.83. If any provision of this section or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 30. 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:

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

THE FOLLOWING SECTION IS FROM ARTICLE 13

Sec. 3. 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:

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

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(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 may establish sufficiency by referencing any reasonable criteria, which include but are not limited to:

(1) ratios of providers to enrollees by specialty;

(2) ratios of primary care professionals to enrollees;

(3) geographic accessibility of providers;

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

(5) hours of operation;

(6) the ability of the network to meet the needs of enrollees that are:

(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;

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

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

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

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

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

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

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

(1) provider to covered person ratios by specialty;

(2) primary care provider to covered person ratios;

(3) geographic accessibility of providers;

(4) geographic variation and population dispersion;

(5) waiting times for an appointment with a participating provider;

(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 telehealth, mobile clinics, and centers of excellence; and

(9) the availability of technological and specialty care services to meet the needs of covered persons requiring technologically advanced or specialty care services.

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

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

THE FOLLOWING SECTIONS ARE FROM ARTICLE 3

Sec. 21. Minnesota Statutes 2022, section 62Q.01, is amended by adding a subdivision to read:

Subd. 6b. **No Surprises Act.** "No Surprises Act" means Division BB of the Consolidated Appropriations Act, 2021, which amended Title XXVII of the Public Health Service Act, Public Law 116-260, and any amendments to and any federal guidance or regulations issued under this act.

Sec. 22. Minnesota Statutes 2022, section 62Q.021, is amended by adding a subdivision to read:

Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider, and health facility shall comply with the No Surprises Act, including any federal regulations adopted under the act, to the extent that the act imposes requirements that apply in this state but are not required under the laws of this state. This subdivision does not require compliance with any provision of the No Surprises Act before the effective date provided for that provision in the No Surprises Act. The commissioner shall enforce this subdivision.

THE FOLLOWING SECTIONS ARE FROM ARTICLE 13

Sec. 4. 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:

Senate Language S2995-3

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Sec. 31. **[62Q.451] UNRESTRICTED ACCESS TO SERVICES FOR THE DIAGNOSIS, MONITORING, AND TREATMENT OF RARE DISEASES.**

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

(b) "Rare disease or condition" means any disease or condition:

(1) that affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;

(2) that affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb;

(3) that is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or

(4) for which an enrollee:

(i) has received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint;

(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 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:

(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.

(ii) has documentation in the enrollee's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and

(iii) had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

Subd. 2. **Unrestricted access.** (a) No health plan company may restrict the choice of an enrollee as to where the enrollee receives services from a licensed health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition, including but not limited to additional restrictions through any prior authorization, preauthorization, prior approval, precertification process, increased fees, or other methods.

(b) Any services provided by, referred for, or ordered by an out-of-network provider for an enrollee who, before receiving and being notified of a definitive diagnosis, satisfied the requirements in subdivision 1, paragraph (b), clause (4), are governed by paragraph (c), even if the subsequent definitive diagnosis does not meet the definition of rare disease or condition in subdivision 1, paragraph (b), clause (1), (2), or (3). Once the enrollee is definitively diagnosed with a disease or condition that does not meet the definition of rare disease or condition in subdivision 1, paragraph (b), clause (1), (2), or (3), and the enrollee or a parent or guardian of a minor enrollee has been notified of the diagnosis, any services provided by, referred for, or ordered by an out-of-network provider related to the diagnosis are governed by paragraph (c) for up to 60 days, providing time for care to be transferred to a qualified in-network provider and to schedule needed in-network appointments. After this 60-day period, subsequent services provided by, referred for, or ordered by an out-of-network provider related to the diagnosis are no longer governed by paragraph (c).

(c) Cost-sharing requirements and benefit or services limitations for the diagnosis and treatment of a rare disease or condition must not place a greater financial burden on the enrollee or be more restrictive than those requirements for in-network medical treatment.

(d) A health plan company must provide enrollees with written information on the content and application of this section and must train customer service representatives on the content and application of this section.

Subd. 3. **Coverage; prior authorization.** (a) Nothing in this section requires a health plan company to provide coverage for a medication, procedure or treatment, or laboratory or clinical testing, that is not covered under the enrollee's health plan.

(b) Coverage for a service must not be denied solely on the basis that it was provided by, referred for, or ordered by an out-of-network provider.

(c) Any prior authorization requirements for a service that is provided by, referred for, or ordered by an out-of-network provider must be the same as any prior authorization requirements for a service that is provided by, referred for, or ordered by an in-network provider.

Subd. 4. **Payments to out-of-network providers for services provided in this state.** (a) If a health plan company has an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks, then the provider shall accept the established contractual payment for that service as payment in full.

(b) If a health plan company does not have an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks, then the provider shall accept:

(1) the provider's established rate for uninsured patients for that service as payment in full; or

(2) if the provider does not have an established rate for uninsured patients for that service, then the average commercial insurance rate the health plan company has paid for that service in this state over the past 12 months as payment in full.

(d) If the payment amount is determined under paragraph (b), clause (2), and the health plan company has not paid for that service in this state within the past 12 months, then the health plan company shall pay the lesser of the following:

(1) the average rate in the commercial insurance market the health plan company paid for that service across all states over the past 12 months; or

(2) the provider's standard charge.

(e) This subdivision does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapters 256B or 256L.

Subd. 5. **Payments to out-of-network providers when services are provided outside of the state.** (a) If a health plan company has an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in another state related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks in the state where the service is provided, then the health plan company shall pay the established contractual payment for that service.

(b) If a health plan company does not have an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in another state related to the diagnosis, monitoring, and treatment of a rare disease

or condition, across any of the health plan's networks in the state where the service is provided, then the health plan company shall pay:

(1) the provider's established rate for uninsured patients for that service; or

(2) if the provider does not have an established rate for uninsured patients for that service, then the average commercial insurance rate the health plan company has paid for that service in the state where the service is provided over the past 12 months.

(c) If the payment amount is determined under paragraph (b), clause (2), and the health plan company has not paid for that service in the state where the service is provided within the past 12 months, then the health plan company shall pay the lesser of the following:

(1) the average commercial insurance rate the health plan company has paid for that service across all states over the last 12 months; or

(2) the provider's standard charge.

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

Subd. 6. **Exclusions.** (a) This section does not apply to health care coverage offered by the State Employee Group Insurance Program.

(b) This section does not apply to medications obtained from a retail pharmacy as defined in section 62W.02, subdivision 18.

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

Sec. 32. **[62Q.473] BIOMARKER TESTING.**

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

(b) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.

(c) "Biomarker testing" means the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyst tests; multiplex panel tests; protein expression; and whole exome, whole genome, and whole transcriptome sequencing.

(d) "Clinical utility" means a test provides information that is used to formulate a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision.

(e) "Consensus statement" means a statement that: (1) describes optimal clinical care outcomes, based on the best available evidence, for a specific clinical circumstance; and (2) is developed by an independent, multidisciplinary panel of experts that: (i) uses a rigorous and validated development process that includes a transparent methodology and reporting structure; and (ii) strictly adheres to the panel's conflict of interest policy.

(f) "Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline that: (1) establishes a standard of care informed by (i) a systematic review of evidence, and (ii) an assessment of the risks and benefits of alternative care options; and (2) is developed by an independent organization or medical professional society that: (i) uses a transparent methodology and reporting structure; and (ii) adheres to a conflict of interest policy. Nationally recognized clinical practice guideline includes recommendations to optimize patient care.

Subd. 2. **Biomarker testing; coverage required.** (a) A health plan must provide coverage for biomarker testing to diagnose, treat, manage, and monitor illness or disease if the test provides clinical utility. For purposes of this section, a test's clinical utility may be demonstrated by medical and scientific evidence, including but not limited to:

(1) nationally recognized clinical practice guidelines as defined in this section;

(2) consensus statements as defined in this section;

(3) labeled indications for a United States Food and Drug Administration (FDA) approved or FDA-cleared test, indicated tests for an FDA-approved drug, or adherence to warnings and precautions on FDA-approved drug labels; or

(4) Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.

(b) Coverage under this section must be provided in a manner that limits disruption of care, including the need for multiple biopsies or biospecimen samples.

(c) Nothing in this section prohibits a health plan company from requiring a prior authorization or imposing other utilization controls when approving coverage for biomarker testing.

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

Senate Language S2995-3

House Language UES2995-2

Sec. 33. **[62Q.522] COVERAGE OF CONTRACEPTIVE METHODS AND SERVICES.**

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

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

(1) is not a nonprofit entity;

(2) has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer owners; and

(3) has no publicly traded ownership interest.

For purposes of this paragraph:

(i) ownership interests owned by a corporation, partnership, limited liability company, estate, trust, or similar entity are considered owned by that entity's shareholders, partners,

Sec. 5. **[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 $25 per one-month supply for each prescription drug regardless of the amount or type of medication required to fill the prescription and to no more than $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 their plan's deductible would result 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), then this section shall apply to that specific prescription drug or related medical supply only after the enrollee has met their plan's 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.

members, or beneficiaries in proportion to their interest held in the corporation, partnership, limited liability company, estate, trust, or similar entity;

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

(iii) ownership interests owned by all individuals in a family are considered held by a single owner. For purposes of this item, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

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

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

(d) "Contraceptive service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy, excluding vasectomies. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptive methods or services, management of side effects, counseling for continued adherence, and device insertion or removal.

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

(1) organized as a nonprofit entity and holds itself out to be religious; or

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

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

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

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

(1) is approved as safe and effective;

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

(3) is bioequivalent in that:

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

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

(4) is adequately labeled; and

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

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

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

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

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

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

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

Subd. 3. **Exemption.** (a) An exempt organization is not required to cover contraceptives or contraceptive services if the exempt organization has religious objections to the coverage. An exempt organization that chooses to not provide coverage for some or all contraceptives and contraceptive services must notify employees as part of the hiring process and to all employees at least 30 days before:

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

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

(b) If the exempt organization provides coverage for some contraceptive methods or services, the notice required under paragraph (a) must provide a list of the contraceptive methods or services the organization refuses to cover.

Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the requirements of subdivision 2 to provide coverage of contraceptive methods and services, with respect to the contraceptive methods or services identified in the notice under this paragraph, if the eligible organization provides notice to any health plan company the eligible organization contracts with that it is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of contraceptive methods or services.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to coverage for some or all of contraceptive methods or services, including a list of the contraceptive methods or services the eligible organization objects to, if applicable; and (3) the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

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

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

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

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

(1) expressly exclude coverage for those contraceptive methods or services identified in the notice under paragraph (a) from the health plan; and

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

Senate Language S2995-3

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

(f) On January 1, 2024, and every year thereafter a health plan company must notify the commissioner, in a manner determined by the commissioner, of the number of eligible organizations granted an accommodation under this subdivision.

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

Sec. 34. **[62Q.523] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS.**

Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.522, subdivisions 3 and 4, all health plans that provide prescription coverage must comply with the requirements of this section.

Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact.

Subd. 3. **Required coverage.** Health plan coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration to prescribe the prescription contraceptives for up to 12 months.

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

House Language UES2995-2

THE FOLLOWING SECTIONS ARE FROM ARTICLE 3

Sec. 23. Minnesota Statutes 2022, section 62Q.55, subdivision 5, is amended to read:

Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by a nonparticipating provider, with or without prior authorization, the health plan company shall not impose coverage restrictions or limitations that are more restrictive than apply to emergency services received from a participating provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network and shall count toward the in-network deductible. All coverage and charges for emergency services must comply with the No Surprises Act.

Sec. 24. Minnesota Statutes 2022, section 62Q.556, is amended to read:

62Q.556 ~~UNAUTHORIZED PROVIDER SERVICES~~ CONSUMER PROTECTIONS AGAINST BALANCE BILLING.

Subdivision 1. **~~Unauthorized provider services~~ Nonparticipating provider balance billing prohibition.** (a) Except as provided in paragraph ~~(c), unauthorized provider services occur~~ (b), balance billing is prohibited when an enrollee receives services from:

(1) ~~from~~ a nonparticipating provider at a participating hospital or ambulatory surgical center, ~~when the services are rendered:~~ as described by the No Surprises Act, including any federal regulations adopted under that act;

~~(i) due to the unavailability of a participating provider;~~

~~(ii) by a nonparticipating provider without the enrollee's knowledge; or~~

~~(iii) due to the need for unforeseen services arising at the time the services are being rendered; or~~

(2) ~~from~~ a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility~~.~~; or

(3) a nonparticipating provider or facility providing emergency services as defined in section 62Q.55, subdivision 3, and other services as described in the requirements of the No Surprises Act.

~~(b) Unauthorized provider services do not include emergency services as defined in section 62Q.55, subdivision 3.~~

~~(c)~~ (b) The services described in paragraph (a), ~~clause (2)~~ clauses (1), (2), and (3), as defined in the No Surprises Act, and any federal regulations adopted under that act, are ~~not unauthorized provider services~~ subject to balance billing if the enrollee ~~gives advance written~~ provides informed consent ~~to~~ prior to receiving services from the nonparticipating provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan. The informed consent must comply with all requirements of the No Surprises Act, including any federal regulations adopted under that act.

Subd. 2. **~~Prohibition~~ Cost-sharing requirements and independent dispute resolution.** (a) An enrollee's financial responsibility for the ~~unauthorized~~ nonparticipating provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for ~~unauthorized~~ nonparticipating provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the ~~unauthorized~~ nonparticipating provider services with the nonparticipating provider. If ~~a health plan company's and nonparticipating provider's attempts~~ the attempt to negotiate reimbursement for the ~~health care~~ nonparticipating provider services ~~do~~ does not result in a resolution, ~~the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties.~~ either party may initiate the federal independent dispute resolution process pursuant to the No Surprises Act, including any federal regulations adopted under that act.

~~(c) The commissioner of health, in consultation with the commissioner of the Bureau of Mediation Services, must develop a list of professionals qualified in arbitration, for the purpose of resolving disputes between a health plan company and nonparticipating provider arising from the payment for unauthorized provider services. The commissioner of health shall publish the list on the Department of Health website, and update the list as appropriate.~~

~~(d) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.~~

Subd. 3. **Annual data reporting.** (a) Beginning April 1, 2024, a health plan company must report annually to the commissioner of health:

(1) the total number of claims and total billed and paid amounts for nonparticipating provider services, by service and provider type, submitted to the health plan in the prior calendar year; and

(2) the total number of enrollee complaints received regarding the rights and protections established by the No Surprises Act in the prior calendar year.

(b) The commissioners of commerce and health shall develop the form and manner for health plan companies to comply with paragraph (a).

Subd. 4. **Enforcement.** (a) Any provider or facility, including a health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to the relevant provisions of the No Surprises Act is subject to the requirements of this section and section 62J.811.

(b) The commissioner of commerce or health shall enforce this section.

(c) If a health-related licensing board has cause to believe that a provider has violated this section, it may further investigate and enforce the provisions of this section pursuant to chapter 214.

Sec. 25. Minnesota Statutes 2022, section 62Q.56, subdivision 2, is amended to read:

Subd. 2. **Change in health plans.** (a) If an enrollee is subject to a change in health plans, the enrollee's new health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the new health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy ~~beyond the first trimester of pregnancy~~;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization under this paragraph, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria provided in this paragraph.

(b) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for new enrollees who request continuity of care with their former provider, if the new enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

(c) This subdivision applies only to group coverage and continuation and conversion coverage, and applies only to changes in health plans made by the employer.

Sec. 26. Minnesota Statutes 2022, section 62Q.73, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

(1) for individual health plans, a complaint decision relating to a health care service or claim that is partially or wholly adverse to the complainant;

(2) an individual health plan that is grandfathered plan coverage may instead apply the definition of adverse determination for group coverage in clause (3);

(3) for group health plans, a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant;

(4) any adverse determination, as defined in section 62M.02, subdivision 1a, that has been appealed in accordance with section 62M.06 and the appeal did not reverse the adverse determination;

(5) a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary; ~~or~~

(6) the enrollee has met the requirements of subdivision 6, paragraph (e)~~.~~<u>; or</u>

<u>(7) a decision relating to a health plan's coverage of nonparticipating provider services as described in and subject to section 62Q.556, subdivision 1, paragraph (a).</u>

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Sec. 27. Minnesota Statutes 2022, section 62Q.73, subdivision 7, is amended to read:

Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan <u>or section 62Q.556, subdivision 1, paragraph (a)</u>.

(b) For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

(c) For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse

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Sec. 35. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

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

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract term" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, it means a single calendar year.

(d) "Formulary" means a list of prescription drugs that has been developed by clinical and pharmacy experts and that represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company. For purposes of this definition, "pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of the plan's enrollees and may include but is not limited to procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make the plan's formulary

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determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.

(d) For an external review of an adverse determination involving experimental or investigational treatment, the external review entity must base its decision on all documents submitted by the health plan company and enrollee, including:

(1) medical records;

(2) the recommendation of the attending physician, advanced practice registered nurse, physician assistant, or health care professional;

(3) consulting reports from health care professionals;

(4) the terms of coverage;

(5) federal Food and Drug Administration approval; and

(6) medical or scientific evidence or evidence-based standards.

and related benefit information available by electronic means and, upon request, in writing, at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract term:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from the plan's formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book at a lower cost to the enrollee, or a biosimilar as defined by United States Code, title 42, section 262(i)(2), and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract term upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract term.

(d) A health plan company may remove any drugs from the plan's formulary that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either the Food and Drug Administration or the product manufacturer, or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

(e) Health plan companies, managed care plans, and county-based purchasing plans under section 256B.69 and chapter 256L may update their formulary or preferred drug list quarterly, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the calendar year.

Subd. 4. **Exclusion.** This section does not apply to health plans offered under the state employee group insurance program.

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

Sec. 36. Minnesota Statutes 2022, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) All health plan companies, dental organizations, and third-party administrators shall submit encounter data on a monthly basis to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home, data on contractual value-based payments, and~~, for claims incurred on or after January 1, 2019,~~ data deemed necessary by the commissioner to uniquely identify claims in the individual health insurance market; ~~and~~

(3) the data must include enrollee race and ethnicity, to the extent available, for claims incurred on or after January 1, 2023; and

(4) except for the ~~identifier~~ data described in ~~clause~~ clauses (2) and (3), the data must not include information that is not included in a health care claim, dental care claim, or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out the commissioner's responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the

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Sec. 28. Minnesota Statutes 2022, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) All health plan companies, dental plan companies, and third-party administrators shall submit encounter data on a monthly basis to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home, data on contractual value-based payments, and~~, for claims incurred on or after January 1, 2019,~~ data deemed necessary by the commissioner to uniquely identify claims in the individual health insurance market; ~~and~~

(3) the data must include enrollee race and ethnicity, to the extent available; and

~~(3)~~ (4) except for the ~~identifier~~ data described in ~~clause~~ clauses (2) and (3), the data must not include information that is not included in a health care claim, dental care claim, or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out the commissioner's responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. ~~Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data.~~ Notwithstanding the data classifications in this paragraph, data on providers collected under this subdivision may be released or published as authorized in subdivision 11. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the

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commissioner and with established and emerging data quality standards to ensure data quality.

Sec. 37. Minnesota Statutes 2022, section 62U.04, subdivision 5, is amended to read:

Subd. 5. **Pricing data.** (a) All health plan companies, dental organizations, and third-party administrators shall submit, on a monthly basis, data on their contracted prices with health care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. Data on contracted prices submitted under this paragraph must include data on supplemental contractual value-based payments paid to health care providers. The data shall be submitted in the form and manner specified by the commissioner of health.

(b) The commissioner or the commissioner's designee shall only use the data submitted under this subdivision to carry out the commissioner's responsibilities under this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data collected under this subdivision are private data on individuals or nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Sec. 38. Minnesota Statutes 2022, section 62U.04, subdivision 5a, is amended to read:

Subd. 5a. **Self-insurers.** (a) The commissioner shall not require a self-insurer governed by the federal Employee Retirement Income Security Act of 1974 (ERISA) to comply with this section.

(b) A third-party administrator must annually notify the self-insurers whose health plans are administered by the third-party administrator that the self-insurer may elect to have the third-party administrator submit encounter data, data on contracted prices, and data on nonclaims-based payments under subdivisions 4, 5, and 5b, from the self-insurer's health plan for the upcoming plan year. This notice must be provided in a form and manner specified by the commissioner. After receiving responses from self-insurers, a third-party administrator must, in a form and manner specified by the commissioner, report to the commissioner:

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commissioner and with established and emerging data quality standards to ensure data quality.

EFFECTIVE DATE. Paragraph (a), clause (3), is effective retroactively from January 1, 2023, and applies to claims incurred on or after that date.

Sec. 29. Minnesota Statutes 2022, section 62U.04, subdivision 5, is amended to read:

Subd. 5. **Pricing data.** (a) All health plan companies, dental plan companies, and third-party administrators shall submit, on a monthly basis, data on their contracted prices with health care providers and dental care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. Data on contracted prices submitted under this paragraph must include data on supplemental contractual value-based payments paid to health care providers. The data shall be submitted in the form and manner specified by the commissioner of health.

(b) The commissioner or the commissioner's designee shall only use the data submitted under this subdivision to carry out the commissioner's responsibilities under this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. Notwithstanding the data classifications in this paragraph, data on providers collected under this subdivision may be released or published as authorized in subdivision 11. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Sec. 30. Minnesota Statutes 2022, section 62U.04, subdivision 5a, is amended to read:

Subd. 5a. **Self-insurers.** (a) The commissioner shall not require a self-insurer governed by the federal Employee Retirement Income Security Act of 1974 (ERISA) to comply with this section.

(b) A third-party administrator must annually notify the self-insurers whose health plans are administered by the third-party administrator that the self-insurer may elect to have the third-party administrator submit encounter data and data on contracted prices under subdivisions 4 and 5 from the self-insurer's health plan for the upcoming plan year. This notice must be provided in a form and manner specified by the commissioner. After receiving responses from self-insurers, a third-party administrator must, in a form and manner specified by the commissioner, report to the commissioner:

(1) the self-insurers that elected to have the third-party administrator submit encounter data and data on contracted prices from the self-insurer's health plan for the upcoming plan year;

(2) the self-insurers that declined to have the third-party administrator submit encounter data and data on contracted prices from the self-insurer's health plan for the upcoming plan year; and

(3) data deemed necessary by the commissioner to identify and track the status of reporting of data from self-insured health plans.

(c) Data collected under this subdivision are private data on individuals or nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

Sec. 39. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to read:

Subd. 5b. **Nonclaims-based payments.** (a) Beginning January 1, 2025, all health plan companies and third-party administrators shall submit to a private entity designated by the commissioner of health all nonclaims-based payments made to health care providers. The data shall be submitted in a form, manner, and frequency specified by the commissioner. Nonclaims-based payments are payments to health care providers designed to pay for value of health care services over volume of health care services and include alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments. Nonclaims-based payments submitted under this subdivision must, to the extent possible, be attributed to a health care provider in the same manner in which claims-based data are attributed to a health care provider and, where appropriate, must be combined with data collected under subdivisions 4 to 5a in analyses of health care spending.

(b) Data collected under this subdivision are private data on individuals or nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

(c) The commissioner shall consult with health plan companies, hospitals, and health care providers in developing the data reported under this subdivision and standardized reporting forms.

Sec. 40. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's

(1) the self-insurers that elected to have the third-party administrator submit encounter data and data on contracted prices from the self-insurer's health plan for the upcoming plan year;

(2) the self-insurers that declined to have the third-party administrator submit encounter data and data on contracted prices from the self-insurer's health plan for the upcoming plan year; and

(3) data deemed necessary by the commissioner to identify and track the status of reporting of data from self-insured health plans.

Sec. 31. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to read:

Subd. 5b. **Nonclaims-based payments.** (a) Beginning January 1, 2025, all health plan companies and third-party administrators shall submit to a private entity designated by the commissioner of health all nonclaims-based payments made to health care providers. The data shall be submitted in a form, manner, and frequency specified by the commissioner. Nonclaims-based payments are payments to health care providers designed to pay for value of health care services over volume of health care services and include alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments. Nonclaims-based payments submitted under this subdivision must, to the extent possible, be attributed to a health care provider in the same manner in which claims-based data are attributed to a health care provider and, where appropriate, must be combined with data collected under subdivisions 4 and 5 in analyses of health care spending.

(b) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

(c) The commissioner shall consult with health plan companies, hospitals, health care providers, and the commissioner of human services in developing the data reported under this subdivision and standardized reporting forms.

Sec. 32. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's

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designee shall only use the data submitted under subdivisions 4 ~~and 5~~ to 5b for the following purposes:

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

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

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

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

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

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

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

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

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

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

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

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designee shall only use the data submitted under subdivisions 4 ~~and~~, 5, 5a, and 5b for the ~~following~~ purposes authorized in this subdivision and in subdivision 13:

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

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

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

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

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

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

(ii) not identify individual patients~~, payers, or providers~~ but that may identify the rendering or billing hospital, clinic, or medical practice so long as no individual health professionals are identified and the commissioner finds the data to be accurate, valid, and suitable for publication for such use;

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

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

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

(6) to conduct analyses of the impact of health care transactions on health care costs, market consolidation, and quality under section 144.593, subdivision 6.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) ~~so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned~~. The data published under this paragraph may identify hospitals, clinics, and medical practices so long as no individual health professionals are identified and the commissioner finds the data to be accurate, valid, and suitable for publication for such use.

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

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

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

Sec. 41. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to read:

Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The commissioner may make any data submitted under this section, including data classified as private or nonpublic, available to individuals and organizations engaged in efforts to research or affect transformation in health care outcomes, access, quality, disparities, or spending, provided use of the data serves a public benefit and is not employed to:

(1) create an unfair market advantage for any participant in the health care market in the state of Minnesota, health plan companies, payers, and providers;

(2) reidentify or attempt to reidentify an individual in the data; and

(3) publicly report details derived from the data regarding any contract between a health plan company and a provider.

(b) To implement the provisions in paragraph (a), the commissioner must:

(1) establish detailed requirements for data access; a process for data users to apply for access to and use of the data; legally enforceable data use agreements to which data users must consent; a clear and robust oversight process for data access and use, including a data management plan, that ensures compliance with state and federal data privacy laws; agreements for state agencies and the University of Minnesota to ensure proper and efficient use and security of data; and technical assistance for users of the data and stakeholders;

(2) develop a fee schedule to support the cost of expanded use of the data, provided the fees charged under the schedule do not create a barrier to access for those most affected by disparities; and

(3) create a research advisory group to advise the commissioner on applications for data use under this subdivision, including an examination of the rigor of the research approach, the technical capabilities of the proposed users, and the ability of the proposed user to successfully safeguard the data.

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

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

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

Sec. 33. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to read:

Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The commissioner or the commissioner's designee shall make the data submitted under subdivisions 4, 5, 5a, and 5b available to individuals and organizations engaged in research on, or efforts to effect transformation in, health care outcomes, access, quality, disparities, or spending, provided the use of the data serves a public benefit. Data made available under this subdivision may not be used to:

(1) create an unfair market advantage for any participant in the health care market in Minnesota, including health plan companies, payers, and providers;

(2) reidentify or attempt to reidentify an individual in the data; or

(3) publicly report contract details between a health plan company and provider and derived from the data.

(b) To implement paragraph (a), the commissioner shall:

(1) establish detailed requirements for data access; a process for data users to apply to access and use the data; legally enforceable data use agreements to which data users must consent; a clear and robust oversight process for data access and use, including a data management plan, that ensures compliance with state and federal data privacy laws; agreements for state agencies and the University of Minnesota to ensure proper and efficient use and security of data; and technical assistance for users of the data and for stakeholders;

(2) develop a fee schedule to support the cost of expanded access to and use of the data, provided the fees charged under the schedule do not create a barrier to access or use for those most affected by disparities; and

(3) create a research advisory group to advise the commissioner on applications for data use under this subdivision, including an examination of the rigor of the research approach, the technical capabilities of the proposed user, and the ability of the proposed user to successfully safeguard the data.

Sec. 42. Minnesota Statutes 2022, section 62U.10, subdivision 7, is amended to read:

Subd. 7. **Outcomes reporting; savings determination.** (a) ~~Beginning November 1, 2016, and~~ Each November 1 ~~thereafter~~, the commissioner of health shall determine the actual total private and public health care and long-term care spending for Minnesota residents related to each health indicator projected in subdivision 6 for the most recent calendar year available. The commissioner shall determine the difference between the projected and actual spending for each health indicator and for each year, and determine the savings attributable to changes in these health indicators. The assumptions and research methods used to calculate actual spending must be determined to be appropriate by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner, in consultation with the commissioners of human services and management and budget, shall use the proportion of spending for state-administered health care programs to total private and public health care spending for each health indicator for the calendar year two years before the current calendar year to determine the percentage of the calculated aggregate savings amount accruing to state-administered health care programs.

(b) The commissioner may use the data submitted under section 62U.04, subdivisions 4 ~~and 5,~~ to 5b, to complete the activities required under this section, but may only report publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

Sec. 43. Minnesota Statutes 2022, section 151.071, subdivision 2, is amended to read:

Subd. 2. **Grounds for disciplinary action.** (a) 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;

(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 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 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;

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(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

(25) for a drug manufacturer, failure to comply with section 62J.841.

(b) The provisions in clause (25) shall not be severable from section 62Q.83. If clause (25) or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

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THE FOLLOWING SECTION IS FROM ARTICLE 13

Sec. 14. 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 timelines 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

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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.

EFFECTIVE DATE. This section is effective January 1, 2024.

THE FOLLOWING SECTION IS FROM ARTICLE 3

Sec. 44. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

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

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

(c) "Nonclaims-based payments" means payments to health care providers designed to support and reward value of health care services over volume of health care services and includes alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments.

(d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02, subdivision 9.

(e) "Primary care services" means integrated, accessible health care services provided by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care services include but are not limited to preventive services, office visits, administration of vaccines, annual physicals, pre-operative physicals, assessments, care coordination, development of treatment plans, management of chronic conditions, and diagnostic tests.

Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the evolving health care needs of Minnesotans, the commissioner shall report to the legislature by February 15, 2024, on the volume and distribution of health care spending across payment models used by health plan companies and third-party administrators, with a particular focus on value-based care models and primary care spending.

(b) The report must include specific health plan and third-party administrator estimates of health care spending for claims-based payments and nonclaims-based payments for the most recent available year, reported separately for Minnesotans enrolled in state health care programs, Medicare Advantage, and commercial health insurance. The report must also include recommendations on changes needed to gather better data from health plan companies and third-party administrators on the use of value-based payments that pay for value of health care services provided over volume of services provided, promote the health of all

Sec. 193. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

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

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

(c) "Nonclaims-based payments" means payments to health care providers designed to support and reward value of health care services over volume of health care services and includes alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments.

(d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02, subdivision 9.

(e) "Primary care services" means integrated, accessible health care services provided by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care services include but are not limited to preventive services, office visits, administration of vaccines, annual physicals, pre-operative physicals, assessments, care coordination, development of treatment plans, management of chronic conditions, and diagnostic tests.

Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the evolving health care needs of Minnesotans, the commissioner shall report to the legislature by February 15, 2024, on the volume and distribution of health care spending across payment models used by health plan companies and third-party administrators, with a particular focus on value-based care models and primary care spending.

(b) The report must include specific health plan and third-party administrator estimates of health care spending for claims-based payments and nonclaims-based payments for the most recent available year, reported separately for Minnesotans enrolled in state health care programs, Medicare Advantage, and commercial health insurance. The report must also include recommendations on changes needed to gather better data from health plan companies and third-party administrators on the use of value-based payments that pay for value of health care services provided over volume of services provided, promote the health of all

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Minnesotans, reduce health disparities, and support the provision of primary care services and preventive services.

(c) In preparing the report, the commissioner shall:

(1) describe the form, manner, and timeline for submission of data by health plan companies and third-party administrators to produce estimates as specified in paragraph (b);

(2) collect summary data that permits the computation of:

(i) the percentage of total payments that are nonclaims-based payments; and

(ii) the percentage of payments in item (i) that are for primary care services;

(3) where data was not directly derived, specify the methods used to estimate data elements;

(4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses of the magnitude of primary care payments using data collected by the commissioner under Minnesota Statutes, section 62U.04; and

(5) conduct interviews with health plan companies and third-party administrators to better understand the types of nonclaims-based payments and models in use, the purposes or goals of each, the criteria for health care providers to qualify for these payments, and the timing and structure of health plan companies or third-party administrators making these payments to health care provider organizations.

(d) Health plan companies and third-party administrators must comply with data requests from the commissioner under this section within 60 days after receiving the request.

(e) Data collected under this section is nonpublic data. Notwithstanding the definition of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

Sec. 45. **COMMISSIONER OF COMMERCE.**

The commissioner of commerce shall consult with health plan companies, pharmacies, and pharmacy benefit managers to develop guidance to implement coverage for the pharmacy services required by Minnesota Statutes, sections 62A.15, subdivisions 3d and 4; and 62D.1071.

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Minnesotans, reduce health disparities, and support the provision of primary care services and preventive services.

(c) In preparing the report, the commissioner shall:

(1) describe the form, manner, and timeline for submission of data by health plan companies and third-party administrators to produce estimates as specified in paragraph (b);

(2) collect summary data that permits the computation of:

(i) the percentage of total payments that are nonclaims-based payments; and

(ii) the percentage of payments in item (i) that are for primary care services;

(3) where data was not directly derived, specify the methods used to estimate data elements;

(4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses of the magnitude of primary care payments using data collected by the commissioner under Minnesota Statutes, section 62U.04; and

(5) conduct interviews with health plan companies and third-party administrators to better understand the types of nonclaims-based payments and models in use, the purposes or goals of each, the criteria for health care providers to qualify for these payments, and the timing and structure of health plan companies or third-party administrators making these payments to health care provider organizations.

(d) Health plan companies and third-party administrators must comply with data requests from the commissioner under this section within 60 days after receiving the request.

(e) Data collected under this section is nonpublic data. Notwithstanding the definition of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

THE FOLLOWING SECTION IS FROM ARTICLE 13

Sec. 17. **GEOGRAPHIC ACCESSIBILITY AND NETWORK ADEQUACY STUDY.**

(a) The commissioner of health, in consultation with the commissioner of commerce and stakeholders, must study and develop recommendations on additional methods, other than maximum distance and travel times for enrollees, to determine adequate geographic accessibility of health care providers and the adequacy of health care provider networks maintained by health plan companies. The commissioner may examine the effectiveness and feasibility of using the following methods to determine geographic accessibility and network adequacy:

(1) establishing ratios of providers to enrollees by provider specialty;

(2) establishing ratios of primary care providers to enrollees; and

(3) establishing maximum waiting times for appointments with participating providers.

(b) The commissioner must examine:

(1) geographic accessibility of providers under current law;

(2) geographic variation and population dispersion;

(3) how provider hours of operations limit access to care;

(4) the ability of existing networks to meet the needs of enrollees, which may include low-income persons; children and adults with serious, chronic, or complex health conditions, physical disabilities, or mental illness; or persons with limited English proficiency and persons from underserved communities;

(5) other health care service delivery options, including telehealth, mobile clinics, and centers of excellence; and

(6) the availability of services needed to meet the needs of enrollees requiring technologically advanced or specialty care services.

(c) The commissioner must submit to the legislature a report on the study and recommendations required by this section no later than January 15, 2024.

THE FOLLOWING SECTION IS FROM ARTICLE 3

Sec. 196. **STATEWIDE HEALTH CARE PROVIDER DIRECTORY.**

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

(b) "Health care provider" means a practicing provider that accepts reimbursement from a group purchaser.

(c) "Health care provider directory" means an electronic catalog and index that supports the management of health care provider information, both individual and organizational, in

a directory structure for public use to find available providers and networks and support state agency responsibilities.

(d) "Group purchaser" has the meaning given in Minnesota Statutes, section 62J.03, subdivision 6.

Subd. 2. **Health care provider directory.** The commissioner shall assess the feasibility and stakeholder commitment to develop, manage, and maintain a statewide electronic directory of health care providers. The assessment must take into consideration consumer information needs, state agency applications, stakeholder needs, technical requirements, alignment with national standards, governance, operations, legal and policy considerations, and existing directories. The commissioner shall conduct this assessment in consultation with stakeholders, including but not limited to consumers, group purchasers, health care providers, community health boards, and state agencies.

HOUSE REPEALS SECTION 62J.84, SUBDIVISION 5, IN UES2995-2, ARTICLE 3, SECTION 203, PARAGRAPH (B)