

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

67.19 **62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT**
67.20 **HEALTH PROGRAMS.**

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

67.30 For the purpose of this section, "health insurer" includes self-insured plans, group health
67.31 plans (as defined in section 607(1) of the Employee Retirement Income Security Act of
67.32 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or
68.1 other parties that are by contract legally responsible to pay a claim for a health-care item
68.2 or service for an individual receiving benefits under paragraph (b).

68.3 (b) No plan offered by a health insurer issued or renewed to provide coverage to a
68.4 Minnesota resident shall contain any provision denying or reducing benefits because services
68.5 are rendered to a person who is eligible for or receiving medical benefits pursuant to title
68.6 XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B;
68.7 or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2;
68.8 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits
68.9 under plans covered by this section shall use eligibility for medical programs named in this
68.10 section as an underwriting guideline or reason for nonacceptance of the risk.

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

THE FOLLOWING SECTION IS FROM ARTICLE 1

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

3.16 **62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT**
3.17 **HEALTH PROGRAMS.**

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

3.27 For the purpose of this section, "health insurer" includes self-insured plans, group health
3.28 plans (as defined in section 607(1) of the Employee Retirement Income Security Act of
3.29 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or
3.30 other parties that are by contract legally responsible to pay a claim for a health-care item
3.31 or service for an individual receiving benefits under paragraph (b).

3.32 (b) No plan offered by a health insurer issued or renewed to provide coverage to a
3.33 Minnesota resident shall contain any provision denying or reducing benefits because services
3.34 are rendered to a person who is eligible for or receiving medical benefits pursuant to title
3.35 XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B;
3.36 or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2;
3.37 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits
4.1 under plans covered by this section shall use eligibility for medical programs named in this
4.2 section as an underwriting guideline or reason for nonacceptance of the risk.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE FOLLOWING SECTIONS ARE FROM ARTICLE 13

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

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

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

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

70.22 Subd. 6. **Application.** If the application of subdivision 5 before an enrollee has met their
70.23 health plan's **deducible** would result in: (1) health savings account ineligibility under United
70.24 States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United
70.25 States Code, title 42, section 18022(e), then subdivision 5 shall apply to diagnostic services
70.26 or testing only after the enrollee has met their health plan's deductible.

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

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

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

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

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

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

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

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

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

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

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

518.29 Subd. 6. **Application.** If the application of subdivision 5 before an enrollee has met their
518.30 health plan's **deductible** would result in: (1) health savings account ineligibility under United
518.31 States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United
519.1 States Code, title 42, section 18022(e), then subdivision 5 shall apply to diagnostic services
519.2 or testing only after the enrollee has met their health plan's deductible.

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

THE FOLLOWING SECTION IS FROM ARTICLE 1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

72.16 Subd. 3. **Medication therapy management.** This section does not apply to or affect
72.17 the coverage or reimbursement for medication therapy management services under section
72.18 62Q.676 or 256B.0625, subdivisions 5, 13h, and 28a.

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

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

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

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

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

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

- 72.27 (c) "Dispenser" means a person authorized by law to dispense a controlled substance,
72.28 pursuant to a valid prescription.
- 72.29 (d) "Electronic media" has the meaning given under Code of Federal Regulations, title
72.30 45, part 160.103.
- 73.1 (e) "E-prescribing" means the transmission using electronic media of prescription or
73.2 prescription-related information between a prescriber, dispenser, pharmacy benefit manager,
73.3 or group purchaser, either directly or through an intermediary, including an e-prescribing
73.4 network. E-prescribing includes, but is not limited to, two-way transmissions between the
73.5 point of care and the dispenser and two-way transmissions related to eligibility, formulary,
73.6 and medication history information.
- 73.7 (f) "Electronic prescription drug program" means a program that provides for
73.8 e-prescribing.
- 73.9 (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.
- 73.10 (h) "HL7 messages" means a standard approved by the standards development
73.11 organization known as Health Level Seven.
- 73.12 (i) "National Provider Identifier" or "NPI" means the identifier described under Code
73.13 of Federal Regulations, title 45, part 162.406.
- 73.14 (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.
- 73.15 (k) "NCPDP Formulary and Benefits Standard" means the most recent version of the
73.16 National Council for Prescription Drug Programs Formulary and Benefits Standard or the
73.17 most recent standard adopted by the Centers for Medicare and Medicaid Services for
73.18 e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social
73.19 Security Act and regulations adopted under it. The standards shall be implemented according
73.20 to the Centers for Medicare and Medicaid Services schedule for compliance.
- 73.21 (l) "NCPDP Real-Time Prescription Benefit Standard" means the most recent National
73.22 Council for Prescription Drug Programs Real-Time Prescription Benefit Standard adopted
73.23 by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part
73.24 D as required by section 1860D-4(e)(2) of the Social Security Act, and regulations adopted
73.25 pursuant to that section.
- 73.26 ~~(m)~~ (m) "NCPDP SCRIPT Standard" means the most recent version of the National
73.27 Council for Prescription Drug Programs SCRIPT Standard, or the most recent standard
73.28 adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare
73.29 Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations
73.30 adopted under it. The standards shall be implemented according to the Centers for Medicare
73.31 and Medicaid Services schedule for compliance.
- 73.32 ~~(n)~~ (n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

- 74.1 (o) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision
74.2 15.
- 74.3 ~~(n)~~ (p) "Prescriber" means a licensed health care practitioner, other than a veterinarian,
74.4 as defined in section 151.01, subdivision 23.
- 74.5 ~~(o)~~ (q) "Prescription-related information" means information regarding eligibility for
74.6 drug benefits, medication history, or related health or drug information.
- 74.7 ~~(p)~~ (r) "Provider" or "health care provider" has the meaning given in section 62J.03,
74.8 subdivision 8.
- 74.9 (s) "Real-time prescription benefit tool" means a tool that is capable of being integrated
74.10 into a prescriber's e-prescribing system and that provides a prescriber with up-to-date and
74.11 patient-specific formulary and benefit information at the time the prescriber submits a
74.12 prescription.
- 74.13 Sec. 11. Minnesota Statutes 2022, section 62J.497, subdivision 3, is amended to read:
- 74.14 Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use
74.15 the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related
74.16 information.
- 74.17 (b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT
74.18 Standard for communicating and transmitting medication history information.
- 74.19 (c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP
74.20 Formulary and Benefits Standard for communicating and transmitting formulary and benefit
74.21 information.
- 74.22 (d) Providers, group purchasers, prescribers, and dispensers must use the national provider
74.23 identifier to identify a health care provider in e-prescribing or prescription-related transactions
74.24 when a health care provider's identifier is required.
- 74.25 (e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility
74.26 information and conduct health care eligibility benefit inquiry and response transactions
74.27 according to the requirements of section 62J.536.
- 74.28 (f) Group purchasers and pharmacy benefit managers must use a real-time prescription
74.29 benefit tool that complies with the NCPDP Real-Time Prescription Benefit Standard and
74.30 that, at a minimum, notifies a prescriber:
- 74.31 (1) if a prescribed drug is covered by the patient's group purchaser or pharmacy benefit
74.32 manager;
- 75.1 (2) if a prescribed drug is included on the formulary or preferred drug list of the patient's
75.2 group purchaser or pharmacy benefit manager;

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

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

75.5 (5) of a list of any available alternative drugs that are in the same class as the drug

75.6 originally prescribed and for which prior authorization is not required.

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

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

75.9 Subdivision 1. **Billing requirements.** (a) Each health care provider and health facility

75.10 shall comply with the federal Consolidated Appropriations Act, 2021, Division BB also

75.11 known as the "No Surprises Act," including any federal regulations adopted under that act.

75.12 (b) For the purposes of this section, "provider" or "facility" means any health care

75.13 provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that

75.14 is subject to relevant provisions of the No Surprises Act.

75.15 Subd. 2. **Investigations and compliance.** (a) The commissioner shall, to the extent

75.16 practicable, seek the cooperation of health care providers and facilities, and may provide

75.17 any support and assistance as available, in obtaining compliance with this section.

75.18 (b) The commissioner shall determine the manner and processes for fulfilling any

75.19 responsibilities and taking any of the actions in paragraphs (c) to (f).

75.20 (c) A person who believes a health care provider or facility has not complied with the

75.21 requirements of the No Surprises Act or this section may file a complaint with the

75.22 commissioner in the manner determined by the commissioner.

75.23 (d) The commissioner shall conduct compliance reviews and investigate complaints

75.24 filed under this section in the manner determined by the commissioner to ascertain whether

75.25 health care providers and facilities are complying with this section.

75.26 (e) The commissioner may report violations under this section to other relevant federal

75.27 and state departments and jurisdictions as appropriate, including the attorney general and

75.28 relevant licensing boards, and may also coordinate on investigations and enforcement of

75.29 this section with other relevant federal and state departments and jurisdictions as appropriate,

75.30 including the attorney general and relevant licensing boards.

76.1 (f) A health care provider or facility may contest whether the finding of facts constitute

76.2 a violation of this section according to the contested case proceeding in sections 14.57 to

76.3 14.62, subject to appeal according to sections 14.63 to 14.68.

76.4 (g) Any data collected by the commissioner as part of an active investigation or active

76.5 compliance review under this section are classified (1) if the data is not on individuals, it

76.6 is classified as protected nonpublic data pursuant to section 13.02 subdivision 13; or (2) if

THE FOLLOWING SECTIONS ARE FROM ARTICLE 3

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

95.23 Subdivision 1. **Billing requirements.** (a) Each health care provider and health facility

95.24 shall comply with Consolidated Appropriations Act, 2021, Division BB also known as the

95.25 "No Surprises Act," including any federal regulations adopted under that act.

95.26 (b) For the purposes of this section, "provider" or "facility" means any health care

95.27 provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that

95.28 is subject to relevant provisions of the No Surprises Act.

95.29 Subd. 2. **Compliance.** The commissioner shall, to the extent practicable, seek the

95.30 cooperation of health care providers and facilities and may provide any support and assistance

95.31 as available, in obtaining compliance with this section.

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

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

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

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

76.17 **62J.824 FACILITY FEE DISCLOSURE.**

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

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

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

76.30 (d) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.24 (1) hospitals;

78.25 (2) outpatient surgical centers; and

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

78.29 (i) diagnostic radiology services;

78.30 (ii) diagnostic laboratory testing;

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

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

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

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

79.10 (vii) dental services.

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

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

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

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

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

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

97.15 (1) hospitals;

97.16 (2) outpatient surgical centers; and

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

97.20 (i) diagnostic radiology services;

97.21 (ii) diagnostic laboratory testing;

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

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

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

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

97.31 (vii) dental services.

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

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

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

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

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

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

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

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

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

80.7 (2) a biologics license application approved under United States Code, title ~~45~~ 42, section
80.8 262(a)(c).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

98.29 (2) a biologics license application approved under United States Code, title ~~45~~ 42, section
98.30 262(a)(c).

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

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

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

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

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

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

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

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

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

80.29 (i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision
80.30 8.

80.31 (j) "Price" means the wholesale acquisition cost as defined in United States Code, title
80.32 42, section 1395w-3a(c)(6)(B).

81.1 (k) "30-day supply" means the total daily dosage units of a prescription drug
81.2 recommended by the prescribing label approved by the FDA for 30 days. If the
81.3 FDA-approved prescribing label includes more than one recommended daily dosage, the
81.4 30-day supply is based on the maximum recommended daily dosage on the FDA-approved
81.5 prescribing label.

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

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

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

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

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

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

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

99.15 (i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision
99.16 8.

99.17 (j) "Price" means the wholesale acquisition cost as defined in United States Code, title
99.18 42, section 1395w-3a(c)(6)(B).

99.19 (k) "30-day supply" means the total daily dosage units of a prescription drug
99.20 recommended by the prescribing label approved by the FDA for 30 days. If the
99.21 FDA-approved prescribing label includes more than one recommended daily dosage, the
99.22 30-day supply is based on the maximum recommended daily dosage on the FDA-approved
99.23 prescribing label.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

82.16 (i) the national drug code;

82.17 (ii) the product name;

82.18 (iii) the dosage form;

82.19 (iv) the strength;

82.20 (v) the package size;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

101.3 (i) the national drug code;

101.4 (ii) the product name;

101.5 (iii) the dosage form;

101.6 (iv) the strength; ~~and~~

101.7 (v) the package size;

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

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

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

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

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

82.30 (i) to manufacture the prescription drug;

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

83.1 (iii) to distribute the prescription drug;

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

83.3 (7) the manufacturer's net profit attributable to the prescription drug during the previous
83.4 12-month period;

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

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

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

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

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

83.15 (13) if the prescription drug was acquired by the manufacturer during the previous
83.16 12-month period, all of the following information:

83.17 (i) price at acquisition;

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

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

83.20 (iv) date of acquisition; and

83.21 (v) acquisition price.

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

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

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

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

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

101.17 (i) to manufacture the prescription drug;

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

101.19 (iii) to distribute the prescription drug;

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

101.21 (7) the manufacturer's net profit attributable to the prescription drug during the previous
101.22 12-month period;

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

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

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

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

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

102.3 (13) if the prescription drug was acquired by the manufacturer during the previous
102.4 12-month period, all of the following information:

102.5 (i) price at acquisition;

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

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

102.8 (iv) date of acquisition; and

102.9 (v) acquisition price.

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

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

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

83.27 United States that is a new brand name drug with a price that is greater than the tier threshold
83.28 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
83.29 Medicare Part D program for a 30-day supply or for a course of treatment lasting less than
83.30 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold
84.1 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
84.2 Medicare Part D program for a 30-day supply or for a course of treatment lasting less than
84.3 30 days and is not at least 15 percent lower than the referenced brand name drug when the
84.4 generic or biosimilar drug is launched, the manufacturer must submit to the commissioner,
84.5 in the form and manner prescribed by the commissioner, the following information, if
84.6 applicable:

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

84.8 (i) the national drug code;

84.9 (ii) the product name;

84.10 (iii) the dosage form;

84.11 (iv) the strength;

84.12 (v) the package size;

84.13 ~~(1)~~ (2) the price of the prescription drug;

84.14 ~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a
84.15 breakthrough therapy designation or a priority review;

84.16 ~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the
84.17 prescription drug, listed separately:

84.18 (i) to manufacture the prescription drug;

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

84.20 (iii) to distribute the prescription drug; and

84.21 ~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

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

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

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

102.15 United States that is a new brand name drug with a price that is greater than the tier threshold
102.16 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
102.17 Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than
102.18 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold
102.19 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
102.20 Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than
102.21 30 days and is not at least 15 percent lower than the referenced brand name drug when the
102.22 generic or biosimilar drug is launched, the manufacturer must submit to the commissioner,
102.23 in the form and manner prescribed by the commissioner, the following information, if
102.24 applicable:

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

102.26 (i) the national drug code;

102.27 (ii) the product name;

102.28 (iii) the dosage form;

102.29 (iv) the strength; and

102.30 (v) the package size;

103.1 ~~(1)~~ (2) the price of the prescription drug;

103.2 ~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a
103.3 breakthrough therapy designation or a priority review;

103.4 ~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the
103.5 prescription drug, listed separately:

103.6 (i) to manufacture the prescription drug;

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

103.8 (iii) to distribute the prescription drug; and

103.9 ~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

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

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

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

84.29 (1) a list of the prescription drugs reported under subdivisions ~~3, 4, and 5~~ to 6 and 9 to
84.30 14, and the manufacturers of those prescription drugs; ~~and~~

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

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

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

85.7 (c) The commissioner shall not post to the department's website or a private entity
85.8 contracting with the commissioner shall not post any information described in this section
85.9 if the information is not public data under section 13.02, subdivision 8a; or, subject to section
85.10 62J.841, subdivision 2, paragraph (e), is trade secret information under section 13.37,
85.11 subdivision 1, paragraph (b); or, subject to section 62J.841, subdivision 2, paragraph (e),
85.12 is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States
85.13 Code, title 18, section 1836, as amended. If a manufacturer believes information should be
85.14 withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly
85.15 and specifically identify that information and describe the legal basis in writing when the
85.16 manufacturer submits the information under this section. If the commissioner disagrees
85.17 with the manufacturer's request to withhold information from public disclosure, the
85.18 commissioner shall provide the manufacturer written notice that the information will be
85.19 publicly posted 30 days after the date of the notice.

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

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

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

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

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

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

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

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

103.23 (c) The commissioner shall not post to the department's website or a private entity
103.24 contracting with the commissioner shall not post any information described in this section
103.25 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
103.26 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information
103.27 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section
103.28 1836, as amended. If a manufacturer believes information should be withheld from public
103.29 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify
103.30 that information and describe the legal basis in writing when the manufacturer submits the
103.31 information under this section. If the commissioner disagrees with the manufacturer's request
104.1 to withhold information from public disclosure, the commissioner shall provide the
104.2 manufacturer written notice that the information will be publicly posted 30 days after the
104.3 date of the notice.

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

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

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

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

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

86.8 (b) The commissioner may consult with representatives of the ~~manufacturers reporting~~
86.9 ~~entities~~ to establish a standard format for reporting information under this section and section
86.10 62J.841 and may use existing reporting methodologies to establish a standard format to
86.11 minimize administrative burdens to the state and ~~manufacturers reporting entities~~.

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

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

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

86.18 (1) failing to register under subdivision 15;

86.19 ~~(2)~~ (2) failing to submit timely reports or notices as required by this section and section
86.20 62J.841;

86.21 ~~(3)~~ (3) failing to provide information required under this section and section 62J.841;
86.22 ~~or~~

86.23 ~~(4)~~ (4) providing inaccurate or incomplete information under this section and section
86.24 62J.841; or

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

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

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

87.1 (d) The commissioner may remit or mitigate civil penalties under this section and section
87.2 62J.841 upon terms and conditions the commissioner considers proper and consistent with
87.3 public health and safety.

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

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

104.18 of the information reported under this section; in posting information pursuant to subdivision
104.19 6; and in taking any other action for the purpose of implementing this section.

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

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

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

104.27 (1) failing to register under subdivision 15;

104.28 ~~(2)~~ (2) failing to submit timely reports or notices as required by this section;

104.29 ~~(3)~~ (3) failing to provide information required under this section; ~~or~~

104.30 ~~(4)~~ (4) providing inaccurate or incomplete information under this section.

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

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

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

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

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

87.10 Subd. 9. **Legislative report.** (a) No later than May 15, ~~2022~~ 2024, and by January 15

87.11 of each year thereafter, the commissioner shall report to the chairs and ranking minority

87.12 members of the legislative committees with jurisdiction over commerce and health and

87.13 human services policy and finance on the implementation of this section and section 62J.841,

87.14 including but not limited to the effectiveness in addressing the following goals:

87.15 (1) promoting transparency in pharmaceutical pricing for the state, health carriers, and

87.16 other payers;

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

87.18 (3) assisting the state, health carriers, and other payers in the management of

87.19 pharmaceutical costs and limiting formulary changes due to prescription drug cost increases

87.20 during a coverage year.

87.21 (b) The report must include a summary of the information submitted to the commissioner

87.22 under subdivisions 3, 4, ~~and 5~~ to 6 and 9 to 14, and section 62J.841.

87.23 (c) The provisions in this subdivision shall not be severable from section 62Q.83. If this

87.24 subdivision or its application to any individual, entity, or circumstance is found to be void

87.25 for any reason, section 62Q.83 shall be void also.

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

87.27 read:

87.28 Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than

87.29 January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the

87.30 department's website a list of prescription drugs that the commissioner determines to represent

87.31 a substantial public interest and for which the department intends to request data under

88.1 subdivisions 9 to 14, subject to paragraph (c). The commissioner shall base its inclusion of

88.2 prescription drugs on any information the commissioner determines is relevant to providing

88.3 greater consumer awareness of the factors contributing to the cost of prescription drugs in

88.4 the state, and the department shall consider drug product families that include prescription

88.5 drugs:

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

88.7 quarter;

88.8 (2) for which average claims paid amounts exceeded 125 percent of the price as of the

88.9 claim incurred date during the most recent calendar quarter for which claims paid amounts

88.10 are available; or

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

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

105.11 Subd. 9. **Legislative report.** (a) No later than May 15, ~~2022~~, and by January 15 of each

105.12 year thereafter, the commissioner shall report to the chairs and ranking minority members

105.13 of the legislative committees with jurisdiction over commerce and health and human services

105.14 policy and finance on the implementation of this section, including but not limited to the

105.15 effectiveness in addressing the following goals:

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

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

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

105.19 (b) The report must include a summary of the information submitted to the commissioner

105.20 under subdivisions 3, 4, and ~~5~~ 11 to 14.

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

105.22 read:

105.23 Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than

105.24 January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the

105.25 department's website a list of prescription drugs that the department determines to represent

105.26 a substantial public interest and for which the department intends to request data under

105.27 subdivisions 11 to 14, subject to paragraph (c). The department shall base its inclusion of

105.28 prescription drugs on any information the department determines is relevant to providing

105.29 greater consumer awareness of the factors contributing to the cost of prescription drugs in

105.30 the state, and the department shall consider drug product families that include prescription

105.31 drugs:

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

106.2 (2) for which average claims paid amounts exceeded 125 percent of the price as of the

106.3 claim incurred date during the most recent calendar quarter for which claims paid amounts

106.4 are available; or

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

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

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

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

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

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

88.24 (2) which the manufacturer manufactures or repackages;

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

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

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

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

89.1 (i) the national drug code;

89.2 (ii) the product name;

89.3 (iii) the dosage form;

89.4 (iv) the strength; and

89.5 (v) the package size;

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

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

89.8 (ii) the introduced to market date; or

89.9 (iii) the acquisition date;

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

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

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

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

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

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

106.18 (2) which the manufacturer manufactures or repackages;

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

106.20 (4) for which the manufacturer has not submitted data under subdivision 3 during the
106.21 120-day period prior to the date of the notification to report.

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

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

106.26 (i) the national drug code;

106.27 (ii) the product name;

106.28 (iii) the dosage form;

106.29 (iv) the strength; and

106.30 (v) the package size;

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

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

107.3 (ii) the introduced to market date; or

107.4 (iii) the acquisition date;

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

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

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

89.16 (i) to manufacture the prescription drug;

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

89.18 (iii) to distribute the prescription drug;

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

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

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

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

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

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

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

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

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

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

90.11 (i) the price at acquisition;

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

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

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

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

107.11 (i) to manufacture the prescription drug;

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

107.13 (iii) to distribute the prescription drug;

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

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

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

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

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

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

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

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

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

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

108.6 (i) the price at acquisition;

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

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

90.14 (iv) the date of acquisition; and
90.15 (v) the acquisition price.
90.16 (c) The manufacturer may submit any documentation necessary to support the information
90.17 reported under this subdivision.
90.18 Sec. 24. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to
90.19 read:
90.20 Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a)
90.21 Beginning January 1, 2024, a pharmacy must submit to the commissioner the information
90.22 described in paragraph (b) for any prescription drug included in a notification to report
90.23 issued to the pharmacy by the department under subdivision 9.
90.24 (b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the
90.25 commissioner no later than 60 days after the date of the notification to report, in the form
90.26 and manner prescribed by the commissioner, the following information, if applicable:
90.27 (1) a description of the drug with the following listed separately:
90.28 (i) the national drug code;
90.29 (ii) the product name;
90.30 (iii) the dosage form;
91.1 (iv) the strength; and
91.2 (v) the package size;
91.3 (2) the number of units of the drug acquired during the 12-month period prior to the date
91.4 of the notification to report;
91.5 (3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month
91.6 period prior to the date of the notification to report;
91.7 (4) the total rebate receivable amount accrued by the pharmacy for the drug during the
91.8 12-month period prior to the date of the notification to report;
91.9 (5) the number of pricing units of the drug dispensed by the pharmacy during the
91.10 12-month period prior to the date of the notification to report;
91.11 (6) the total payment receivable by the pharmacy for dispensing the drug including
91.12 ingredient cost, dispensing fee, and administrative fees during the 12-month period prior
91.13 to the date of the notification to report;
91.14 (7) the total rebate payable amount accrued by the pharmacy for the drug during the
91.15 12-month period prior to the date of the notification to report; and

108.9 (iv) the date of acquisition; and
108.10 (v) the acquisition price.
108.11 (c) The manufacturer may submit any documentation necessary to support the information
108.12 reported under this subdivision.
108.13 Sec. 16. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to
108.14 read:
108.15 Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a)
108.16 Beginning January 1, 2024, a pharmacy must submit to the commissioner the information
108.17 described in paragraph (b) for any prescription drug included in a notification to report
108.18 issued to the pharmacy by the department under subdivision 10.
108.19 (b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the
108.20 commissioner no later than 60 days after the date of the notification to report, in the form
108.21 and manner prescribed by the commissioner, the following information, if applicable:
108.22 (1) a description of the drug with the following listed separately:
108.23 (i) the national drug code;
108.24 (ii) the product name;
108.25 (iii) the dosage form;
108.26 (iv) the strength; and
108.27 (v) the package size;
108.28 (2) the number of units of the drug acquired during the 12-month period prior to the date
108.29 of the notification to report;
109.1 (3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month
109.2 period prior to the date of the notification to report;
109.3 (4) the total rebate receivable amount accrued by the pharmacy for the drug during the
109.4 12-month period prior to the date of the notification to report;
109.5 (5) the number of pricing units of the drug dispensed by the pharmacy during the
109.6 12-month period prior to the date of the notification to report;
109.7 (6) the total payment receivable by the pharmacy for dispensing the drug including
109.8 ingredient cost, dispensing fee, and administrative fees during the 12-month period prior
109.9 to the date of the notification to report;
109.10 (7) the total rebate payable amount accrued by the pharmacy for the drug during the
109.11 12-month period prior to the date of the notification to report; and

91.16 (8) the average cash price paid by consumers per pricing unit for prescriptions dispensed
91.17 where no claim was submitted to a health care service plan or health insurer during the
91.18 12-month period prior to the date of the notification to report.

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

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

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

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

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

91.31 (i) the national drug code;

92.1 (ii) the product name;

92.2 (iii) the dosage form;

92.3 (iv) the strength; and

92.4 (v) the package size;

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

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

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

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

92.15 (6) the total rebate payable amount accrued by the PBM for the drug product during the
92.16 12-month period prior to the date of the notification to report.

109.12 (8) the average cash price paid by consumers per pricing unit for prescriptions dispensed
109.13 where no claim was submitted to a health care service plan or health insurer during the
109.14 12-month period prior to the date of the notification to report.

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

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

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

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

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

109.27 (i) the national drug code;

109.28 (ii) the product name;

109.29 (iii) the dosage form;

109.30 (iv) the strength; and

109.31 (v) the package size;

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

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

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

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

110.11 (6) the total rebate payable amount accrued by the PBM for the drug product during the
110.12 12-month period prior to the date of the notification to report.

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

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

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

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

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

92.29 (i) the national drug code;

92.30 (ii) the product name;

93.1 (iii) the dosage form;

93.2 (iv) the strength; and

93.3 (v) the package size;

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

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

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

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

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

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

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

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

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

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

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

110.27 (i) the national drug code;

110.28 (ii) the product name;

110.29 (iii) the dosage form;

110.30 (iv) the strength; and

110.31 (v) the package size;

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

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

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

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

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

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

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

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

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

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

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

94.1 Sec. 29. **[62J.84] REPORTING PRESCRIPTION DRUG PRICES; FORMULARY**
94.2 **DEVELOPMENT AND PRICE STABILITY.**

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

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

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

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

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

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

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

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

94.19 (2) brand name, if applicable;

94.20 (3) generic name, if applicable;

94.21 (4) wholesale acquisition cost for one unit;

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

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

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

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

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

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

94.23 (6) average wholesale price; and

94.24 (7) status as brand name or generic.

94.25 (c) The effective date of the information described in paragraph (b) must be included in

94.26 the report to the commissioner.

94.27 (d) A manufacturer must report the information described in this subdivision in the form

94.28 and manner specified by the commissioner.

94.29 (e) Information reported under this subdivision is classified as public data not on

94.30 individuals, as defined in section 13.02, subdivision 14, and must not be classified by the

95.1 manufacturer as trade secret information, as defined in section 13.37, subdivision 1, paragraph

95.2 (b).

95.3 (f) A manufacturer's failure to report the information required by this subdivision is

95.4 grounds for disciplinary action under section 151.071, subdivision 2.

95.5 Subd. 3. **Public posting of prescription drug price information.** By October 1 of each

95.6 year, beginning October 1, 2024, the commissioner must post the information reported

95.7 under subdivision 2 on the department's website, as required by section 62J.84, subdivision

95.8 6.

95.9 Subd. 4. **Price change.** (a) If a drug subject to price reporting under subdivision 2 is

95.10 included in the formulary of a health plan submitted to and approved by the commissioner

95.11 of commerce for the next calendar year under section 62A.02, subdivision 1, the manufacturer

95.12 may increase the wholesale acquisition cost of the drug for the next calendar year only after

95.13 providing the commissioner with at least 90 days written notice.

95.14 (b) A manufacturer's failure to meet the requirements of paragraph (a) is grounds for

95.15 disciplinary action under section 151.071, subdivision 2.

95.16 Subd. 5. **Not severable.** The provisions of this section shall not be severable from section

95.17 62Q.83. If any provision of this section or its application to any individual, entity, or

95.18 circumstance is found to be void for any reason, section 62Q.83 shall be void also.

95.19 Sec. 30. Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

95.20 Subd. 4. **Network adequacy.** (a) Each designated provider network must include a

95.21 sufficient number and type of providers, including providers that specialize in mental health

95.22 and substance use disorder services, to ensure that covered services are available to all

95.23 enrollees without unreasonable delay. In determining network adequacy, the commissioner

95.24 of health shall consider availability of services, including the following:

95.25 (1) primary care physician services are available and accessible 24 hours per day, seven

95.26 days per week, within the network area;

THE FOLLOWING SECTION IS FROM ARTICLE 13

519.5 Sec. 3. Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

519.6 Subd. 4. **Network adequacy.** (a) Each designated provider network must include a

519.7 sufficient number and type of providers, including providers that specialize in mental health

519.8 and substance use disorder services, to ensure that covered services are available to all

519.9 enrollees without unreasonable delay. In determining network adequacy, the commissioner

519.10 of health shall consider availability of services, including the following:

519.11 (1) primary care physician services are available and accessible 24 hours per day, seven

519.12 days per week, within the network area;

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

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

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

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

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

96.10 (b) The commissioner may establish sufficiency by referencing any reasonable criteria,
96.11 which include but are not limited to:

96.12 (1) ratios of providers to enrollees by specialty;

96.13 (2) ratios of primary care professionals to enrollees;

96.14 (3) geographic accessibility of providers;

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

96.16 (5) hours of operation;

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

96.18 (i) low-income persons;

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

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

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

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

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

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

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

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

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

519.28 (1) provider to covered person ratios by specialty;

519.29 (2) primary care provider to covered person ratios;

519.30 (3) geographic accessibility of providers;

519.31 (4) geographic variation and population dispersion;

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

520.2 (6) hours of operation;

520.3 (7) the ability of the network to meet the needs of covered persons, which may include:
520.4 (i) low-income persons; (ii) children and adults with serious, chronic, or complex health
520.5 conditions, physical disabilities, or mental illness; or (iii) persons with limited English
520.6 proficiency and persons from underserved communities;

520.7 (8) other health care service delivery system options, including telehealth, mobile clinics,
520.8 and centers of excellence; and

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

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

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

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

THE FOLLOWING SECTIONS ARE FROM ARTICLE 3

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

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

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

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

THE FOLLOWING SECTIONS ARE FROM ARTICLE 13

520.13 Sec. 4. Minnesota Statutes 2022, section 62Q.096, is amended to read:

520.14 **62Q.096 CREDENTIALING OF PROVIDERS.**

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

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

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

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

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

520.24 (b) In order to ensure timely access by patients to mental health services, between July
520.25 1, 2023, and June 30, 2025, a health plan company must credential and enter into a contract
520.26 for mental health services with any provider of mental health services that:

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

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

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

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

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

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

97.13 (4) for which an enrollee:

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

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

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

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

521.3 (4) is accepting new patients; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

99.11 (2) the provider's standard charge.

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

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

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

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

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

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

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

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

100.3 (2) the provider's standard charge.

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

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

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

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

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

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

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

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

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

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

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

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

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

101.15 (2) consensus statements as defined in this section;

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

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

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

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

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

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

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

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

102.1 (1) is not a nonprofit entity;

102.2 (2) has more than 50 percent of the value of its ownership interest owned directly or

102.3 indirectly by five or fewer owners; and

102.4 (3) has no publicly traded ownership interest.

102.5 For purposes of this paragraph:

102.6 (i) ownership interests owned by a corporation, partnership, limited liability company,

102.7 estate, trust, or similar entity are considered owned by that entity's shareholders, partners,

521.12 Sec. 5. **[62Q.481] COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED**
521.13 **MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.**

521.14 Subdivision 1. **Cost-sharing limits.** (a) A health plan must limit the amount of any

521.15 enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more

521.16 than \$25 per one-month supply for each prescription drug regardless of the amount or type

521.17 of medication required to fill the prescription and to no more than \$50 per month in total

521.18 for all related medical supplies. The cost-sharing limit for related medical supplies does not

521.19 increase with the number of chronic diseases for which an enrollee is treated. Coverage

521.20 under this section shall not be subject to any deductible.

521.21 (b) If application of this section before an enrollee has met their plan's deductible would

521.22 result in: (1) health savings account ineligibility under United States Code, title 26, section

521.23 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section

521.24 18022(e), then this section shall apply to that specific prescription drug or related medical

521.25 supply only after the enrollee has met their plan's deductible.

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

521.27 (b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of

521.28 epinephrine auto-injectors.

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

521.30 (d) "Related medical supplies" means syringes, insulin pens, insulin pumps, test strips,

521.31 glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and

522.1 other medical supply items necessary to effectively and appropriately treat a chronic disease

522.2 or administer a prescription drug prescribed to treat a chronic disease.

522.3 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health

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

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

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

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

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

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

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

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

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

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

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

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

- 103.10 (h) "Therapeutic equivalent version" means a drug, device, or product that can be expected
103.11 to have the same clinical effect and safety profile when administered to a patient under the
103.12 conditions specified in the labeling, and that:
- 103.13 (1) is approved as safe and effective;
- 103.14 (2) is a pharmaceutical equivalent: (i) containing identical amounts of the same active
103.15 drug ingredient in the same dosage form and route of administration; and (ii) meeting
103.16 compendial or other applicable standards of strength, quality, purity, and identity;
- 103.17 (3) is bioequivalent in that:
- 103.18 (i) the drug, device, or product does not present a known or potential bioequivalence
103.19 problem and meets an acceptable in vitro standard; or
- 103.20 (ii) if the drug, device, or product does present a known or potential bioequivalence
103.21 problem, it is shown to meet an appropriate bioequivalence standard;
- 103.22 (4) is adequately labeled; and
- 103.23 (5) is manufactured in compliance with current manufacturing practice regulations.
- 103.24 Subd. 2. **Required coverage; cost sharing prohibited.** (a) A health plan must provide
103.25 coverage for contraceptive methods and services.
- 103.26 (b) A health plan company must not impose cost-sharing requirements, including co-pays,
103.27 deductibles, or coinsurance, for contraceptive methods or services.
- 103.28 (c) A health plan company must not impose any referral requirements, restrictions, or
103.29 delays for contraceptive methods or services.
- 103.30 (d) A health plan must include at least one of each type of Food and Drug Administration
103.31 approved contraceptive method in its formulary. If more than one therapeutic equivalent
104.1 version of a contraceptive method is approved, a health plan must include at least one
104.2 therapeutic equivalent version in its formulary, but is not required to include all therapeutic
104.3 equivalent versions.
- 104.4 (e) For each health plan, a health plan company must list the contraceptive methods and
104.5 services that are covered without cost-sharing in a manner that is easily accessible to
104.6 enrollees, health care providers, and representatives of health care providers. The list for
104.7 each health plan must be promptly updated to reflect changes to the coverage.
- 104.8 (f) If an enrollee's attending provider recommends a particular contraceptive method or
104.9 service based on a determination of medical necessity for that enrollee, the health plan must
104.10 cover that contraceptive method or service without cost-sharing. The health plan company
104.11 issuing the health plan must defer to the attending provider's determination that the particular
104.12 contraceptive method or service is medically necessary for the enrollee.

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

104.18 (1) an employee enrolls in the health plan; or
104.19 (2) the effective date of the health plan, whichever occurs first.

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

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

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

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

105.6 (1) an employee enrolls in the health plan; or
105.7 (2) the effective date of the health plan, whichever occurs first.

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

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

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

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

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

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

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

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

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

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

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

THE FOLLOWING SECTIONS ARE FROM ARTICLE 3

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

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

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

112.19 **62Q.556 UNAUTHORIZED PROVIDER SERVICES CONSUMER**
112.20 **PROTECTIONS AGAINST BALANCE BILLING.**

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

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

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

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

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

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

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

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

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

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

- 113.25 (b) A health plan company must attempt to negotiate the reimbursement, less any
 113.26 applicable enrollee cost sharing under paragraph (a), for the ~~unauthorized nonparticipating~~
 113.27 provider services with the nonparticipating provider. If a health plan company's and
 113.28 nonparticipating provider's attempts the attempt to negotiate reimbursement for the health
 113.29 care nonparticipating provider services ~~de~~ does not result in a resolution, the health plan
 113.30 company or provider may elect to refer the matter for binding arbitration, chosen in
 113.31 accordance with paragraph (c). A nondisclosure agreement must be executed by both parties
 113.32 prior to engaging an arbitrator in accordance with this section. The cost of arbitration must
 113.33 be shared equally between the parties. either party may initiate the federal independent
 114.1 dispute resolution process pursuant to the No Surprises Act, including any federal regulations
 114.2 adopted under that act.
- 114.3 (c) The commissioner of health, in consultation with the commissioner of the Bureau
 114.4 of Mediation Services, must develop a list of professionals qualified in arbitration, for the
 114.5 purpose of resolving disputes between a health plan company and nonparticipating provider
 114.6 arising from the payment for unauthorized provider services. The commissioner of health
 114.7 shall publish the list on the Department of Health website, and update the list as appropriate.
- 114.8 (d) The arbitrator must consider relevant information, including the health plan company's
 114.9 payments to other nonparticipating providers for the same services, the circumstances and
 114.10 complexity of the particular case, and the usual and customary rate for the service based on
 114.11 information available in a database in a national, independent, not-for-profit corporation,
 114.12 and similar fees received by the provider for the same services from other health plans in
 114.13 which the provider is nonparticipating, in reaching a decision.
- 114.14 Subd. 3. **Annual data reporting.** (a) Beginning April 1, 2024, a health plan company
 114.15 must report annually to the commissioner of health:
- 114.16 (1) the total number of claims and total billed and paid amounts for nonparticipating
 114.17 provider services, by service and provider type, submitted to the health plan in the prior
 114.18 calendar year; and
- 114.19 (2) the total number of enrollee complaints received regarding the rights and protections
 114.20 established by the No Surprises Act in the prior calendar year.
- 114.21 (b) The commissioners of commerce and health shall develop the form and manner for
 114.22 health plan companies to comply with paragraph (a).
- 114.23 Subd. 4. **Enforcement.** (a) Any provider or facility, including a health care provider or
 114.24 facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject
 114.25 to the relevant provisions of the No Surprises Act is subject to the requirements of this
 114.26 section and section 62J.811.
- 114.27 (b) The commissioner of commerce or health shall enforce this section.

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

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

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

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

115.8 (i) an acute condition;

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

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

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

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

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

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

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

115.23 (1) is receiving culturally appropriate services and the health plan company does not
115.24 have a provider in its preferred provider network with special expertise in the delivery of
115.25 those culturally appropriate services within the time and distance requirements of section
115.26 62D.124, subdivision 1; or

115.27 (2) does not speak English and the health plan company does not have a provider in its
115.28 preferred provider network who can communicate with the enrollee, either directly or through
115.29 an interpreter, within the time and distance requirements of section 62D.124, subdivision
115.30 1.

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

- 116.1 (c) This subdivision applies only to group coverage and continuation and conversion
116.2 coverage, and applies only to changes in health plans made by the employer.
- 116.3 Sec. 26. Minnesota Statutes 2022, section 62Q.73, subdivision 1, is amended to read:
- 116.4 Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:
- 116.5 (1) for individual health plans, a complaint decision relating to a health care service or
116.6 claim that is partially or wholly adverse to the complainant;
- 116.7 (2) an individual health plan that is grandfathered plan coverage may instead apply the
116.8 definition of adverse determination for group coverage in clause (3);
- 116.9 (3) for group health plans, a complaint decision relating to a health care service or claim
116.10 that has been appealed in accordance with section 62Q.70 and the appeal decision is partially
116.11 or wholly adverse to the complainant;
- 116.12 (4) any adverse determination, as defined in section 62M.02, subdivision 1a, that has
116.13 been appealed in accordance with section 62M.06 and the appeal did not reverse the adverse
116.14 determination;
- 116.15 (5) a decision relating to a health care service made by a health plan company licensed
116.16 under chapter 60A that denies the service on the basis that the service was not medically
116.17 necessary; ~~or~~
- 116.18 (6) the enrollee has met the requirements of subdivision 6, paragraph (c); ~~or~~
- 116.19 (7) a decision relating to a health plan's coverage of nonparticipating provider services
116.20 as described in and subject to section 62Q.556, subdivision 1, paragraph (a).
- 116.21 An adverse determination does not include complaints relating to fraudulent marketing
116.22 practices or agent misrepresentation.
- 116.23 Sec. 27. Minnesota Statutes 2022, section 62Q.73, subdivision 7, is amended to read:
- 116.24 Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse
116.25 determination that does not require a medical necessity determination, the external review
116.26 must be based on whether the adverse determination was in compliance with the enrollee's
116.27 health benefit plan or section 62Q.556, subdivision 1, paragraph (a).
- 116.28 (b) For an external review of any issue in an adverse determination by a health plan
116.29 company licensed under chapter 62D that requires a medical necessity determination, the
116.30 external review must determine whether the adverse determination was consistent with the
116.31 definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.
- 117.1 (c) For an external review of any issue in an adverse determination by a health plan
117.2 company, other than a health plan company licensed under chapter 62D, that requires a
117.3 medical necessity determination, the external review must determine whether the adverse

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

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

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

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

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

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

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

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

117.4 determination was consistent with the definition of medically necessary care in section
117.5 **62Q.53, subdivision 2.**

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

117.9 (1) medical records;

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

117.12 (3) consulting reports from health care professionals;

117.13 (4) the terms of coverage;

117.14 (5) federal Food and Drug Administration approval; and

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

- 106.31 and related benefit information available by electronic means and, upon request, in writing,
106.32 at least 30 days prior to annual renewal dates.
- 107.1 (b) Formularies must be organized and disclosed consistent with the most recent version
107.2 of the United States Pharmacopeia's Model Guidelines.
- 107.3 (c) For each item or category of items on the formulary, the specific enrollee benefit
107.4 terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.
- 107.5 Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan
107.6 company may, at any time during the enrollee's contract term:
- 107.7 (1) expand its formulary by adding drugs to the formulary;
- 107.8 (2) reduce co-payments or coinsurance; or
- 107.9 (3) move a drug to a benefit category that reduces an enrollee's cost.
- 107.10 (b) A health plan company may remove a brand name drug from the plan's formulary
107.11 or place a brand name drug in a benefit category that increases an enrollee's cost only upon
107.12 the addition to the formulary of a generic or multisource brand name drug rated as
107.13 therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as
107.14 interchangeable according to the FDA Purple Book at a lower cost to the enrollee, or a
107.15 biosimilar as defined by United States Code, title 42, section 262(i)(2), and upon at least a
107.16 60-day notice to prescribers, pharmacists, and affected enrollees.
- 107.17 (c) A health plan company may change utilization review requirements or move drugs
107.18 to a benefit category that increases an enrollee's cost during the enrollee's contract term
107.19 upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided
107.20 that these changes do not apply to enrollees who are currently taking the drugs affected by
107.21 these changes for the duration of the enrollee's contract term.
- 107.22 (d) A health plan company may remove any drugs from the plan's formulary that have
107.23 been deemed unsafe by the Food and Drug Administration, that have been withdrawn by
107.24 either the Food and Drug Administration or the product manufacturer, or when an
107.25 independent source of research, clinical guidelines, or evidence-based standards has issued
107.26 drug-specific warnings or recommended changes in drug usage.
- 107.27 (e) Health plan companies, managed care plans, and county-based purchasing plans
107.28 under section 256B.69 and chapter 256L may update their formulary or preferred drug list
107.29 quarterly, provided that these changes do not apply to enrollees who are currently taking
107.30 the drugs affected by these changes for the duration of the calendar year.
- 107.31 Subd. 4. **Exclusion.** This section does not apply to health plans offered under the state
107.32 employee group insurance program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

117.28 ~~(3) (4)~~ except for the identifier data described in ~~clause~~ clauses (2) and (3), the data must
117.29 not include information that is not included in a health care claim, dental care claim, or
117.30 equivalent encounter information transaction that is required under section 62J.536.

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

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

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

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

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

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

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

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

109.21 (c) Data collected under this subdivision are private data on individuals or nonpublic
109.22 data as defined in section 13.02. Notwithstanding the definition of summary data in section
109.23 13.02, subdivision 19, summary data prepared under this section may be derived from
109.24 nonpublic data. The commissioner shall establish procedures and safeguards to protect the
109.25 integrity and confidentiality of any data that it maintains.

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

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

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

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

118.23 **EFFECTIVE DATE.** Paragraph (a), clause (3), is effective retroactively from January
118.24 1, 2023, and applies to claims incurred on or after that date.

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

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

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

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

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

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

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

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

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

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

110.12 (c) Data collected under this subdivision are private data on individuals or nonpublic
110.13 data as defined in section 13.02. Notwithstanding the definition of summary data in section
110.14 13.02, subdivision 19, summary data prepared under this subdivision may be derived from
110.15 nonpublic data. The commissioner shall establish procedures and safeguards to protect the
110.16 integrity and confidentiality of any data maintained by the commissioner.

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

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

110.31 (b) Data collected under this subdivision are private data on individuals or nonpublic
110.32 data as defined in section 13.02. Notwithstanding the definition of summary data in section
110.33 13.02, subdivision 19, summary data prepared under this subdivision may be derived from
111.1 nonpublic data. The commissioner shall establish procedures and safeguards to protect the
111.2 integrity and confidentiality of any data maintained by the commissioner.

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

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

111.7 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
111.8 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's

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

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

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

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

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

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

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

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

120.24 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
120.25 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's

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

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

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

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

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

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

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

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

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

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

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

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

120.26 designee shall only use the data submitted under subdivisions 4 and, 5, 5a, and 5b for the
120.27 ~~following~~ purposes authorized in this subdivision and in subdivision 13:

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

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

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

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

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

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

121.7 (ii) not identify individual patients, ~~payers, or providers~~ but that may identify the
121.8 rendering or billing hospital, clinic, or medical practice so long as no individual health
121.9 professionals are identified and the commissioner finds the data to be accurate, valid, and
121.10 suitable for publication for such use;

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

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

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

121.18 (6) to conduct analyses of the impact of health care transactions on health care costs,
121.19 market consolidation, and quality under section 144.593, subdivision 6.

121.20 (b) The commissioner may publish the results of the authorized uses identified in
121.21 paragraph (a) so long as the data released publicly do not contain information or descriptions
121.22 in which the identity of individual hospitals, clinics, or other providers may be discerned.
121.23 The data published under this paragraph may identify hospitals, clinics, and medical practices
121.24 so long as no individual health professionals are identified and the commissioner finds the
121.25 data to be accurate, valid, and suitable for publication for such use.

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

112.7 ~~(d) The commissioner or the commissioner's designee may use the data submitted under~~
 112.8 ~~subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,~~
 112.9 ~~2023.~~

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

112.13 Sec. 41. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to
 112.14 read:

112.15 Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The
 112.16 commissioner may make any data submitted under this section, including data classified as
 112.17 private or nonpublic, available to individuals and organizations engaged in efforts to research
 112.18 or affect transformation in health care outcomes, access, quality, disparities, or spending,
 112.19 provided use of the data serves a public benefit and is not employed to:

112.20 (1) create an unfair market advantage for any participant in the health care market in the
 112.21 state of Minnesota, health plan companies, payers, and providers;

112.22 (2) reidentify or attempt to reidentify an individual in the data; and

112.23 (3) publicly report details derived from the data regarding any contract between a health
 112.24 plan company and a provider.

112.25 (b) To implement the provisions in paragraph (a), the commissioner must:

112.26 (1) establish detailed requirements for data access; a process for data users to apply for
 112.27 access to and use of the data; legally enforceable data use agreements to which data users
 112.28 must consent; a clear and robust oversight process for data access and use, including a data
 112.29 management plan, that ensures compliance with state and federal data privacy laws;
 112.30 agreements for state agencies and the University of Minnesota to ensure proper and efficient
 112.31 use and security of data; and technical assistance for users of the data and stakeholders;

113.1 (2) develop a fee schedule to support the cost of expanded use of the data, provided the
 113.2 fees charged under the schedule do not create a barrier to access for those most affected by
 113.3 disparities; and

113.4 (3) create a research advisory group to advise the commissioner on applications for data
 113.5 use under this subdivision, including an examination of the rigor of the research approach,
 113.6 the technical capabilities of the proposed users, and the ability of the proposed user to
 113.7 successfully safeguard the data.

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

121.29 ~~(d) The commissioner or the commissioner's designee may use the data submitted under~~
 121.30 ~~subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,~~
 121.31 ~~2023.~~

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

122.4 Sec. 33. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to
 122.5 read:

122.6 Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The
 122.7 commissioner or the commissioner's designee shall make the data submitted under
 122.8 subdivisions 4, 5, 5a, and 5b available to individuals and organizations engaged in research
 122.9 on, or efforts to effect transformation in, health care outcomes, access, quality, disparities,
 122.10 or spending, provided the use of the data serves a public benefit. Data made available under
 122.11 this subdivision may not be used to:

122.12 (1) create an unfair market advantage for any participant in the health care market in
 122.13 Minnesota, including health plan companies, payers, and providers;

122.14 (2) reidentify or attempt to reidentify an individual in the data; or

122.15 (3) publicly report contract details between a health plan company and provider and
 122.16 derived from the data.

122.17 (b) To implement paragraph (a), the commissioner shall:

122.18 (1) establish detailed requirements for data access; a process for data users to apply to
 122.19 access and use the data; legally enforceable data use agreements to which data users must
 122.20 consent; a clear and robust oversight process for data access and use, including a data
 122.21 management plan, that ensures compliance with state and federal data privacy laws;
 122.22 agreements for state agencies and the University of Minnesota to ensure proper and efficient
 122.23 use and security of data; and technical assistance for users of the data and for stakeholders;

122.24 (2) develop a fee schedule to support the cost of expanded access to and use of the data,
 122.25 provided the fees charged under the schedule do not create a barrier to access or use for
 122.26 those most affected by disparities; and

122.27 (3) create a research advisory group to advise the commissioner on applications for data
 122.28 use under this subdivision, including an examination of the rigor of the research approach,
 122.29 the technical capabilities of the proposed user, and the ability of the proposed user to
 122.30 successfully safeguard the data.

113.8 Sec. 42. Minnesota Statutes 2022, section 62U.10, subdivision 7, is amended to read:

113.9 Subd. 7. **Outcomes reporting; savings determination.** (a) ~~Beginning November 1,~~
113.10 ~~2016, and~~ Each November 1 thereafter, the commissioner of health shall determine the
113.11 actual total private and public health care and long-term care spending for Minnesota
113.12 residents related to each health indicator projected in subdivision 6 for the most recent
113.13 calendar year available. The commissioner shall determine the difference between the
113.14 projected and actual spending for each health indicator and for each year, and determine
113.15 the savings attributable to changes in these health indicators. The assumptions and research
113.16 methods used to calculate actual spending must be determined to be appropriate by an
113.17 independent actuarial consultant. If the actual spending is less than the projected spending,
113.18 the commissioner, in consultation with the commissioners of human services and management
113.19 and budget, shall use the proportion of spending for state-administered health care programs
113.20 to total private and public health care spending for each health indicator for the calendar
113.21 year two years before the current calendar year to determine the percentage of the calculated
113.22 aggregate savings amount accruing to state-administered health care programs.

113.23 (b) The commissioner may use the data submitted under section 62U.04, subdivisions
113.24 ~~4 and 5,~~ to 5b, to complete the activities required under this section, but may only report
113.25 publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

113.26 Sec. 43. Minnesota Statutes 2022, section 151.071, subdivision 2, is amended to read:

113.27 Subd. 2. **Grounds for disciplinary action.** (a) The following conduct is prohibited and
113.28 is grounds for disciplinary action:

113.29 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
113.30 registration contained in this chapter or the rules of the board. The burden of proof is on
113.31 the applicant to demonstrate such qualifications or satisfaction of such requirements;

114.1 (2) obtaining a license by fraud or by misleading the board in any way during the
114.2 application process or obtaining a license by cheating, or attempting to subvert the licensing
114.3 examination process. Conduct that subverts or attempts to subvert the licensing examination
114.4 process includes, but is not limited to: (i) conduct that violates the security of the examination
114.5 materials, such as removing examination materials from the examination room or having
114.6 unauthorized possession of any portion of a future, current, or previously administered
114.7 licensing examination; (ii) conduct that violates the standard of test administration, such as
114.8 communicating with another examinee during administration of the examination, copying
114.9 another examinee's answers, permitting another examinee to copy one's answers, or
114.10 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
114.11 impersonator to take the examination on one's own behalf;

114.12 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
114.13 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
114.14 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used
114.15 in this subdivision includes a conviction of an offense that if committed in this state would

114.16 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
114.17 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
114.18 withheld or not entered thereon. The board may delay the issuance of a new license or
114.19 registration if the applicant has been charged with a felony until the matter has been
114.20 adjudicated;

114.21 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
114.22 or applicant is convicted of a felony reasonably related to the operation of the facility. The
114.23 board may delay the issuance of a new license or registration if the owner or applicant has
114.24 been charged with a felony until the matter has been adjudicated;

114.25 (5) for a controlled substance researcher, conviction of a felony reasonably related to
114.26 controlled substances or to the practice of the researcher's profession. The board may delay
114.27 the issuance of a registration if the applicant has been charged with a felony until the matter
114.28 has been adjudicated;

114.29 (6) disciplinary action taken by another state or by one of this state's health licensing
114.30 agencies;

114.31 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
114.32 license or registration in another state or jurisdiction, failure to report to the board that
114.33 charges or allegations regarding the person's license or registration have been brought in
114.34 another state or jurisdiction, or having been refused a license or registration by any other
115.1 state or jurisdiction. The board may delay the issuance of a new license or registration if an
115.2 investigation or disciplinary action is pending in another state or jurisdiction until the
115.3 investigation or action has been dismissed or otherwise resolved; and

115.4 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
115.5 license or registration issued by another of this state's health licensing agencies, failure to
115.6 report to the board that charges regarding the person's license or registration have been
115.7 brought by another of this state's health licensing agencies, or having been refused a license
115.8 or registration by another of this state's health licensing agencies. The board may delay the
115.9 issuance of a new license or registration if a disciplinary action is pending before another
115.10 of this state's health licensing agencies until the action has been dismissed or otherwise
115.11 resolved;

115.12 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
115.13 any order of the board, of any of the provisions of this chapter or any rules of the board or
115.14 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
115.15 pharmacy;

115.16 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
115.17 of the board, of any of the provisions of this chapter or the rules of the board or violation
115.18 of any federal, state, or local law relating to the operation of the facility;

115.19 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
115.20 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of

115.21 a patient; or pharmacy practice that is professionally incompetent, in that it may create
115.22 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
115.23 actual injury need not be established;

115.24 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
115.25 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
115.26 technician or pharmacist intern if that person is performing duties allowed by this chapter
115.27 or the rules of the board;

115.28 (11) for an individual licensed or registered by the board, adjudication as mentally ill
115.29 or developmentally disabled, or as a chemically dependent person, a person dangerous to
115.30 the public, a sexually dangerous person, or a person who has a sexual psychopathic
115.31 personality, by a court of competent jurisdiction, within or without this state. Such
115.32 adjudication shall automatically suspend a license for the duration thereof unless the board
115.33 orders otherwise;

116.1 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
116.2 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
116.3 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
116.4 intern or performing duties specifically reserved for pharmacists under this chapter or the
116.5 rules of the board;

116.6 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
116.7 duty except as allowed by a variance approved by the board;

116.8 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
116.9 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
116.10 of material or as a result of any mental or physical condition, including deterioration through
116.11 the aging process or loss of motor skills. In the case of registered pharmacy technicians,
116.12 pharmacist interns, or controlled substance researchers, the inability to carry out duties
116.13 allowed under this chapter or the rules of the board with reasonable skill and safety to
116.14 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
116.15 of material or as a result of any mental or physical condition, including deterioration through
116.16 the aging process or loss of motor skills;

116.17 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
116.18 dispenser, or controlled substance researcher, revealing a privileged communication from
116.19 or relating to a patient except when otherwise required or permitted by law;

116.20 (16) for a pharmacist or pharmacy, improper management of patient records, including
116.21 failure to maintain adequate patient records, to comply with a patient's request made pursuant
116.22 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

116.23 (17) fee splitting, including without limitation:

116.24 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
116.25 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

116.26 (ii) referring a patient to any health care provider as defined in sections 144.291 to
116.27 144.298 in which the licensee or registrant has a financial or economic interest as defined
116.28 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
116.29 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
116.30 and

116.31 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
116.32 does not have a significant ownership interest, fills a prescription drug order and the
116.33 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price
117.1 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
117.2 benefit manager, or other person paying for the prescription or, in the case of veterinary
117.3 patients, the price for the filled prescription that is charged to the client or other person
117.4 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
117.5 an arrangement provided that the client or other person paying for the prescription is notified,
117.6 in writing and with each prescription dispensed, about the arrangement, unless such
117.7 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
117.8 production systems, in which case client notification would not be required;

117.9 (18) engaging in abusive or fraudulent billing practices, including violations of the
117.10 federal Medicare and Medicaid laws or state medical assistance laws or rules;

117.11 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
117.12 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
117.13 to a patient;

117.14 (20) failure to make reports as required by section 151.072 or to cooperate with an
117.15 investigation of the board as required by section 151.074;

117.16 (21) knowingly providing false or misleading information that is directly related to the
117.17 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
117.18 administration of a placebo;

117.19 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
117.20 established by any of the following:

117.21 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
117.22 of section 609.215, subdivision 1 or 2;

117.23 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
117.24 issued under section 609.215, subdivision 4;

117.25 (iii) a copy of the record of a judgment assessing damages under section 609.215,
117.26 subdivision 5; or

117.27 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
117.28 The board must investigate any complaint of a violation of section 609.215, subdivision 1
117.29 or 2;

117.30 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
117.31 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
117.32 duties permitted to such individuals by this chapter or the rules of the board under a lapsed
118.1 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
118.2 of the facility under a lapsed or nonrenewed license or registration; ~~and~~

118.3 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
118.4 from the health professionals services program for reasons other than the satisfactory
118.5 completion of the program; and

118.6 (25) for a drug manufacturer, failure to comply with section 62J.841.

118.7 (b) The provisions in clause (25) shall not be severable from section 62Q.83. If clause
118.8 (25) or its application to any individual, entity, or circumstance is found to be void for any
118.9 reason, section 62Q.83 shall be void also.

THE FOLLOWING SECTION IS FROM ARTICLE 13

527.22 Sec. 14. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

527.23 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and
527.24 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner
527.25 may issue separate contracts with requirements specific to services to medical assistance
527.26 recipients age 65 and older.

527.27 (b) A prepaid health plan providing covered health services for eligible persons pursuant
527.28 to chapters 256B and 256L is responsible for complying with the terms of its contract with
527.29 the commissioner. Requirements applicable to managed care programs under chapters 256B
527.30 and 256L established after the effective date of a contract with the commissioner take effect
527.31 when the contract is next issued or renewed.

528.1 (c) The commissioner shall withhold five percent of managed care plan payments under
528.2 this section and county-based purchasing plan payments under section 256B.692 for the
528.3 prepaid medical assistance program pending completion of performance targets. Each
528.4 performance target must be quantifiable, objective, measurable, and reasonably attainable,
528.5 except in the case of a performance target based on a federal or state law or rule. Criteria
528.6 for assessment of each performance target must be outlined in writing prior to the contract
528.7 effective date. Clinical or utilization performance targets and their related criteria must
528.8 consider evidence-based research and reasonable interventions when available or applicable
528.9 to the populations served, and must be developed with input from external clinical experts
528.10 and stakeholders, including managed care plans, county-based purchasing plans, and
528.11 providers. The managed care or county-based purchasing plan must demonstrate, to the
528.12 commissioner's satisfaction, that the data submitted regarding attainment of the performance
528.13 target is accurate. The commissioner shall periodically change the administrative measures
528.14 used as performance targets in order to improve plan performance across a broader range

528.15 of administrative services. The performance targets must include measurement of plan
528.16 efforts to contain spending on health care services and administrative activities. The
528.17 commissioner may adopt plan-specific performance targets that take into account factors
528.18 affecting only one plan, including characteristics of the plan's enrollee population. The
528.19 withheld funds must be returned no sooner than July of the following year if performance
528.20 targets in the contract are achieved. The commissioner may exclude special demonstration
528.21 projects under subdivision 23.

528.22 (d) The commissioner shall require that managed care plans:

528.23 (1) use the assessment and authorization processes, forms, timelines, standards,
528.24 documentation, and data reporting requirements, protocols, billing processes, and policies
528.25 consistent with medical assistance fee-for-service or the Department of Human Services
528.26 contract requirements for all personal care assistance services under section 256B.0659 and
528.27 community first services and supports under section 256B.85; ~~and~~

528.28 (2) by January 30 of each year that follows a rate increase for any aspect of services
528.29 under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking
528.30 minority members of the legislative committees with jurisdiction over rates determined
528.31 under section 256B.851 of the amount of the rate increase that is paid to each personal care
528.32 assistance provider agency with which the plan has a contract; ~~and~~

528.33 (3) use a six-month timely filing standard and provide an exemption to the timely filing
528.34 timelines for the resubmission of claims where there has been a denial, request for more
528.35 information, or system issue.

529.1 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall
529.2 include as part of the performance targets described in paragraph (c) a reduction in the health
529.3 plan's emergency department utilization rate for medical assistance and MinnesotaCare
529.4 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on
529.5 the health plan's utilization in 2009. To earn the return of the withhold each subsequent
529.6 year, the managed care plan or county-based purchasing plan must achieve a qualifying
529.7 reduction of no less than ten percent of the plan's emergency department utilization rate for
529.8 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described
529.9 in subdivisions 23 and 28, compared to the previous measurement year until the final
529.10 performance target is reached. When measuring performance, the commissioner must
529.11 consider the difference in health risk in a managed care or county-based purchasing plan's
529.12 membership in the baseline year compared to the measurement year, and work with the
529.13 managed care or county-based purchasing plan to account for differences that they agree
529.14 are significant.

529.15 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
529.16 the following calendar year if the managed care plan or county-based purchasing plan
529.17 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
529.18 was achieved. The commissioner shall structure the withhold so that the commissioner

529.19 returns a portion of the withheld funds in amounts commensurate with achieved reductions
529.20 in utilization less than the targeted amount.

529.21 The withhold described in this paragraph shall continue for each consecutive contract
529.22 period until the plan's emergency room utilization rate for state health care program enrollees
529.23 is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance
529.24 and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the
529.25 health plans in meeting this performance target and shall accept payment withholds that
529.26 may be returned to the hospitals if the performance target is achieved.

529.27 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
529.28 include as part of the performance targets described in paragraph (c) a reduction in the plan's
529.29 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
529.30 determined by the commissioner. To earn the return of the withhold each year, the managed
529.31 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
529.32 than five percent of the plan's hospital admission rate for medical assistance and
529.33 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
529.34 28, compared to the previous calendar year until the final performance target is reached.
529.35 When measuring performance, the commissioner must consider the difference in health risk
530.1 in a managed care or county-based purchasing plan's membership in the baseline year
530.2 compared to the measurement year, and work with the managed care or county-based
530.3 purchasing plan to account for differences that they agree are significant.

530.4 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
530.5 the following calendar year if the managed care plan or county-based purchasing plan
530.6 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
530.7 rate was achieved. The commissioner shall structure the withhold so that the commissioner
530.8 returns a portion of the withheld funds in amounts commensurate with achieved reductions
530.9 in utilization less than the targeted amount.

530.10 The withhold described in this paragraph shall continue until there is a 25 percent
530.11 reduction in the hospital admission rate compared to the hospital admission rates in calendar
530.12 year 2011, as determined by the commissioner. The hospital admissions in this performance
530.13 target do not include the admissions applicable to the subsequent hospital admission
530.14 performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting
530.15 this performance target and shall accept payment withholds that may be returned to the
530.16 hospitals if the performance target is achieved.

530.17 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall
530.18 include as part of the performance targets described in paragraph (c) a reduction in the plan's
530.19 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous
530.20 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare
530.21 enrollees, as determined by the commissioner. To earn the return of the withhold each year,
530.22 the managed care plan or county-based purchasing plan must achieve a qualifying reduction
530.23 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,

530.24 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five
530.25 percent compared to the previous calendar year until the final performance target is reached.

530.26 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
530.27 the following calendar year if the managed care plan or county-based purchasing plan
530.28 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the
530.29 subsequent hospitalization rate was achieved. The commissioner shall structure the withhold
530.30 so that the commissioner returns a portion of the withheld funds in amounts commensurate
530.31 with achieved reductions in utilization less than the targeted amount.

530.32 The withhold described in this paragraph must continue for each consecutive contract
530.33 period until the plan's subsequent hospitalization rate for medical assistance and
530.34 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
531.1 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
531.2 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
531.3 accept payment withholds that must be returned to the hospitals if the performance target
531.4 is achieved.

531.5 (h) Effective for services rendered on or after January 1, 2013, through December 31,
531.6 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
531.7 this section and county-based purchasing plan payments under section 256B.692 for the
531.8 prepaid medical assistance program. The withheld funds must be returned no sooner than
531.9 July 1 and no later than July 31 of the following year. The commissioner may exclude
531.10 special demonstration projects under subdivision 23.

531.11 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
531.12 withhold three percent of managed care plan payments under this section and county-based
531.13 purchasing plan payments under section 256B.692 for the prepaid medical assistance
531.14 program. The withheld funds must be returned no sooner than July 1 and no later than July
531.15 31 of the following year. The commissioner may exclude special demonstration projects
531.16 under subdivision 23.

531.17 (j) A managed care plan or a county-based purchasing plan under section 256B.692 may
531.18 include as admitted assets under section 62D.044 any amount withheld under this section
531.19 that is reasonably expected to be returned.

531.20 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
531.21 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
531.22 7.

531.23 (l) The return of the withhold under paragraphs (h) and (i) is not subject to the
531.24 requirements of paragraph (c).

531.25 (m) Managed care plans and county-based purchasing plans shall maintain current and
531.26 fully executed agreements for all subcontractors, including bargaining groups, for
531.27 administrative services that are expensed to the state's public health care programs.
531.28 Subcontractor agreements determined to be material, as defined by the commissioner after

118.10 Sec. 44. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**
118.11 Subdivision 1. Definitions. (a) The terms defined in this subdivision apply to this section.
118.12 (b) "Commissioner" means the commissioner of health.
118.13 (c) "Nonclaims-based payments" means payments to health care providers designed to
118.14 support and reward value of health care services over volume of health care services and
118.15 includes alternative payment models or incentives, payments for infrastructure expenditures
118.16 or investments, and payments for workforce expenditures or investments.
118.17 (d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02,
118.18 subdivision 9.
118.19 (e) "Primary care services" means integrated, accessible health care services provided
118.20 by clinicians who are accountable for addressing a large majority of personal health care
118.21 needs, developing a sustained partnership with patients, and practicing in the context of
118.22 family and community. Primary care services include but are not limited to preventive
118.23 services, office visits, administration of vaccines, annual physicals, pre-operative physicals,
118.24 assessments, care coordination, development of treatment plans, management of chronic
118.25 conditions, and diagnostic tests.
118.26 Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the
118.27 evolving health care needs of Minnesotans, the commissioner shall report to the legislature
118.28 by February 15, 2024, on the volume and distribution of health care spending across payment
118.29 models used by health plan companies and third-party administrators, with a particular focus
118.30 on value-based care models and primary care spending.
118.31 (b) The report must include specific health plan and third-party administrator estimates
118.32 of health care spending for claims-based payments and nonclaims-based payments for the
119.1 most recent available year, reported separately for Minnesotans enrolled in state health care
119.2 programs, Medicare Advantage, and commercial health insurance. The report must also
119.3 include recommendations on changes needed to gather better data from health plan companies
119.4 and third-party administrators on the use of value-based payments that pay for value of
119.5 health care services provided over volume of services provided, promote the health of all

531.29 taking into account state contracting and relevant statutory requirements, must be in the
531.30 form of a written instrument or electronic document containing the elements of offer,
531.31 acceptance, consideration, payment terms, scope, duration of the contract, and how the
531.32 subcontractor services relate to state public health care programs. Upon request, the
531.33 commissioner shall have access to all subcontractor documentation under this paragraph.
532.1 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
532.2 to section 13.02.

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

THE FOLLOWING SECTION IS FROM ARTICLE 3

284.14 Sec. 193. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**
284.15 Subdivision 1. Definitions. (a) The terms defined in this subdivision apply to this section.
284.16 (b) "Commissioner" means the commissioner of health.
284.17 (c) "Nonclaims-based payments" means payments to health care providers designed to
284.18 support and reward value of health care services over volume of health care services and
284.19 includes alternative payment models or incentives, payments for infrastructure expenditures
284.20 or investments, and payments for workforce expenditures or investments.
284.21 (d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02,
284.22 subdivision 9.
284.23 (e) "Primary care services" means integrated, accessible health care services provided
284.24 by clinicians who are accountable for addressing a large majority of personal health care
284.25 needs, developing a sustained partnership with patients, and practicing in the context of
284.26 family and community. Primary care services include but are not limited to preventive
284.27 services, office visits, administration of vaccines, annual physicals, pre-operative physicals,
284.28 assessments, care coordination, development of treatment plans, management of chronic
284.29 conditions, and diagnostic tests.
284.30 Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the
284.31 evolving health care needs of Minnesotans, the commissioner shall report to the legislature
284.32 by February 15, 2024, on the volume and distribution of health care spending across payment
285.1 models used by health plan companies and third-party administrators, with a particular focus
285.2 on value-based care models and primary care spending.
285.3 (b) The report must include specific health plan and third-party administrator estimates
285.4 of health care spending for claims-based payments and nonclaims-based payments for the
285.5 most recent available year, reported separately for Minnesotans enrolled in state health care
285.6 programs, Medicare Advantage, and commercial health insurance. The report must also
285.7 include recommendations on changes needed to gather better data from health plan companies
285.8 and third-party administrators on the use of value-based payments that pay for value of
285.9 health care services provided over volume of services provided, promote the health of all

119.6 Minnesotans, reduce health disparities, and support the provision of primary care services
119.7 and preventive services.

119.8 (c) In preparing the report, the commissioner shall:

119.9 (1) describe the form, manner, and timeline for submission of data by health plan
119.10 companies and third-party administrators to produce estimates as specified in paragraph
119.11 (b);

119.12 (2) collect summary data that permits the computation of:

119.13 (i) the percentage of total payments that are nonclaims-based payments; and

119.14 (ii) the percentage of payments in item (i) that are for primary care services;

119.15 (3) where data was not directly derived, specify the methods used to estimate data
119.16 elements;

119.17 (4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses
119.18 of the magnitude of primary care payments using data collected by the commissioner under
119.19 Minnesota Statutes, section 62U.04; and

119.20 (5) conduct interviews with health plan companies and third-party administrators to
119.21 better understand the types of nonclaims-based payments and models in use, the purposes
119.22 or goals of each, the criteria for health care providers to qualify for these payments, and the
119.23 timing and structure of health plan companies or third-party administrators making these
119.24 payments to health care provider organizations.

119.25 (d) Health plan companies and third-party administrators must comply with data requests
119.26 from the commissioner under this section within 60 days after receiving the request.

119.27 (e) Data collected under this section is nonpublic data. Notwithstanding the definition
119.28 of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared
119.29 under this section may be derived from nonpublic data. The commissioner shall establish
119.30 procedures and safeguards to protect the integrity and confidentiality of any data maintained
119.31 by the commissioner.

120.1 Sec. 45. **COMMISSIONER OF COMMERCE.**

120.2 The commissioner of commerce shall consult with health plan companies, pharmacies,
120.3 and pharmacy benefit managers to develop guidance to implement coverage for the pharmacy
120.4 services required by Minnesota Statutes, sections 62A.15, subdivisions 3d and 4; and
120.5 62D.1071.

285.10 Minnesotans, reduce health disparities, and support the provision of primary care services
285.11 and preventive services.

285.12 (c) In preparing the report, the commissioner shall:

285.13 (1) describe the form, manner, and timeline for submission of data by health plan
285.14 companies and third-party administrators to produce estimates as specified in paragraph
285.15 (b);

285.16 (2) collect summary data that permits the computation of:

285.17 (i) the percentage of total payments that are nonclaims-based payments; and

285.18 (ii) the percentage of payments in item (i) that are for primary care services;

285.19 (3) where data was not directly derived, specify the methods used to estimate data
285.20 elements;

285.21 (4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses
285.22 of the magnitude of primary care payments using data collected by the commissioner under
285.23 Minnesota Statutes, section 62U.04; and

285.24 (5) conduct interviews with health plan companies and third-party administrators to
285.25 better understand the types of nonclaims-based payments and models in use, the purposes
285.26 or goals of each, the criteria for health care providers to qualify for these payments, and the
285.27 timing and structure of health plan companies or third-party administrators making these
285.28 payments to health care provider organizations.

285.29 (d) Health plan companies and third-party administrators must comply with data requests
285.30 from the commissioner under this section within 60 days after receiving the request.

285.31 (e) Data collected under this section is nonpublic data. Notwithstanding the definition
285.32 of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared
286.1 under this section may be derived from nonpublic data. The commissioner shall establish
286.2 procedures and safeguards to protect the integrity and confidentiality of any data maintained
286.3 by the commissioner.

THE FOLLOWING SECTION IS FROM ARTICLE 13

533.5 Sec. 17. **GEOGRAPHIC ACCESSIBILITY AND NETWORK ADEQUACY STUDY.**

533.6 (a) The commissioner of health, in consultation with the commissioner of commerce

533.7 and stakeholders, must study and develop recommendations on additional methods, other

533.8 than maximum distance and travel times for enrollees, to determine adequate geographic

533.9 accessibility of health care providers and the adequacy of health care provider networks

533.10 maintained by health plan companies. The commissioner may examine the effectiveness

533.11 and feasibility of using the following methods to determine geographic accessibility and

533.12 network adequacy:

533.13 (1) establishing ratios of providers to enrollees by provider specialty;

533.14 (2) establishing ratios of primary care providers to enrollees; and

533.15 (3) establishing maximum waiting times for appointments with participating providers.

533.16 (b) The commissioner must examine:

533.17 (1) geographic accessibility of providers under current law;

533.18 (2) geographic variation and population dispersion;

533.19 (3) how provider hours of operations limit access to care;

533.20 (4) the ability of existing networks to meet the needs of enrollees, which may include

533.21 low-income persons; children and adults with serious, chronic, or complex health conditions,

533.22 physical disabilities, or mental illness; or persons with limited English proficiency and

533.23 persons from underserved communities;

533.24 (5) other health care service delivery options, including telehealth, mobile clinics, and

533.25 centers of excellence; and

533.26 (6) the availability of services needed to meet the needs of enrollees requiring

533.27 technologically advanced or specialty care services.

533.28 (c) The commissioner must submit to the legislature a report on the study and

533.29 recommendations required by this section no later than January 15, 2024.

THE FOLLOWING SECTION IS FROM ARTICLE 3

287.3 Sec. 196. **STATEWIDE HEALTH CARE PROVIDER DIRECTORY.**

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

287.5 the meanings given.

287.6 (b) "Health care provider" means a practicing provider that accepts reimbursement from

287.7 a group purchaser.

287.8 (c) "Health care provider directory" means an electronic catalog and index that supports

287.9 the management of health care provider information, both individual and organizational, in

Senate Language S2995-3	Health Insurance	May 05, 2023 08:54 AM	House Language UES2995-2
			287.10 <u>a directory structure for public use to find available providers and networks and support</u> 287.11 <u>state agency responsibilities.</u>
			287.12 <u>(d) "Group purchaser" has the meaning given in Minnesota Statutes, section 62J.03,</u> 287.13 <u>subdivision 6.</u>
			287.14 Subd. 2. Health care provider directory. <u>The commissioner shall assess the feasibility</u> 287.15 <u>and stakeholder commitment to develop, manage, and maintain a statewide electronic</u> 287.16 <u>directory of health care providers. The assessment must take into consideration consumer</u> 287.17 <u>information needs, state agency applications, stakeholder needs, technical requirements,</u> 287.18 <u>alignment with national standards, governance, operations, legal and policy considerations,</u> 287.19 <u>and existing directories. The commissioner shall conduct this assessment in consultation</u> 287.20 <u>with stakeholders, including but not limited to consumers, group purchasers, health care</u> 287.21 <u>providers, community health boards, and state agencies.</u>
			HOUSE REPEALS SECTION 62J.84, SUBDIVISION 5, IN UES2995-2, ARTICLE 3, SECTION 203, PARAGRAPH (B)