ARTICLE 3
HEALTH CARE

Section 1. [62J.805] DEFINITIONS.

Subd. 1. Application. For purposes of sections 62J.805 to 62J.808, the following terms have the meanings given.

Subd. 2. Health care provider. "Health care provider" means:
(1) a health professional who is licensed or registered by Minnesota to provide health treatments and services within the professional's scope of practice and in accordance with state law;
(2) a group practice; or
(3) a hospital.

Subd. 3. Health plan. "Health plan" has the meaning given in section 62A.011, subdivision 3.

Subd. 4. Hospital. "Hospital" means a health care facility licensed as a hospital under sections 144.50 to 144.56.

Subd. 5. Group practice. "Group practice" has the meaning given to health care provider group practice in section 145D.01, subdivision 1.

Subd. 6. Medically necessary. "Medically necessary" means:
(1) safe and effective;
(2) not experimental or investigational, except as set forth in Code of Federal Regulations, title 42, section 411.15(o);
(3) furnished in accordance with acceptable medical standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
(4) furnished in a setting appropriate to the patient's medical need and condition;
(5) ordered and furnished by qualified personnel;
(6) meets, but does not exceed, the patient's medical need; and
(7) furnished in accordance with the patient's health plan or in a setting appropriate to the patient's medical need and condition.

Billing error. "Billing error" means an error in a bill from a health care provider to a patient for health treatment or services that affects the amount owed by the patient according to that bill. Billing error includes but is not limited to miscoding of a health treatment or service, an error in whether a health treatment or service is covered under the patient's health plan, or an error in determining the cost-sharing owed by the patient.

Medically necessary. "Medically necessary" means:
(1) safe and effective;
(2) not experimental or investigational, except as provided in Code of Federal Regulations, title 42, section 411.15(o);
(3) furnished in accordance with acceptable medical standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
(4) furnished in a setting appropriate to the patient's medical need and condition;
(5) ordered and furnished by qualified personnel;
(6) meets, but does not exceed, the patient's medical need; and
...
(7) is at least as beneficial as an existing and available medically appropriate alternative...

Subd. 7. **Miscode.** "Miscode" means a health care provider or a health care provider's designee, using a coding system and for billing purposes, assigns a numeric or alphanumeric code to a health treatment or service provided to a patient and the code assigned does not accurately reflect the health treatment or service provided based on factors that include the patient's diagnosis and the complexity of the patient's condition.

Subd. 8. **Payment.** "Payment" includes co-payments and coinsurance and deductible payments made by a patient.

Sec. 2. [623.806] **POLICY FOR COLLECTION OF MEDICAL DEBT.**

Subdivision 1. **Requirement.** Each health care provider must make available to the public the health care provider's policy for the collection of medical debt from patients. This policy must be made available by:

1. clearly posting it on the health care provider's website or for health professionals, on the website of the health clinic, group practice, or hospital at which the health professional is employed or under contract; and
2. providing a copy of the policy to any individual who requests it.

Subd. 2. **Content.** A policy made available under this section must at least specify the procedures followed by the health care provider for:

1. communicating with patients about the medical debt owed and collecting medical debt;
2. referring medical debt to a collection agency or law firm for collection; and
3. identifying medical debt as uncollectible or satisfied, and ending collection activities.

Sec. 3. [623.807] **DENIAL OF HEALTH TREATMENTS OR SERVICES DUE TO OUTSTANDING MEDICAL DEBT.**

(a) A health care provider must not deny medically necessary health treatments or services to a patient or any member of the patient's family or household because of outstanding or previously outstanding medical debt owed by the patient or any member of the patient's family or household to the health care provider, regardless of whether the health treatment or service may be available from another health care provider.

(b) As a condition of providing medically necessary health treatments or services in the circumstances described in paragraph (a), a health care provider may require the patient to enroll in a payment plan for the outstanding medical debt owed to the health care provider.

The payment plan must be reasonable and must take into account any information disclosed by the patient regarding the patient's ability to pay. Before entering into the payment plan, a health care provider must notify the patient that if the patient is unable to make all or part...
of the agreed-upon installment payments, the patient must communicate the patient's situation
to the health care provider and must pay an amount the patient can afford.

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Sec. 4. [62J.808] BILLING ERRORS; HEALTH TREATMENT OR SERVICES.

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Subdivision 1. Billing and acceptance of payment. (a) If a health care provider or
health plan company determines or receives notice from a patient or other person that a bill
from the health care provider to a patient for health treatment or services may contain one
or more billing errors, the health care provider or health plan company must review the bill
and correct any billing errors found. While the review is being conducted, the health care
provider must not bill the patient for any health treatment or service subject to review for
potential billing errors. A health care provider may bill the patient for the health treatment
and services that were reviewed for potential billing errors under this subdivision only after
the review is complete, any billing errors are corrected, and a notice of completed review
required under subdivision 3 is transmitted to the patient.

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(b) If, after completing the review under paragraph (a) and correcting any billing errors,
a health care provider or health plan company determines the patient overpaid the health
care provider under that bill, the health care provider must refund to the patient, within 30
days after completing the review, the amount the patient overpaid under that bill.

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Subdivision 2. Notice to patient of potential billing error. (a) If a health care provider or
health plan company determines or receives notice from a patient or other person that a bill
from the health care provider to a patient for health treatment or services may contain one
or more billing errors, the health care provider or health plan company must notify the patient:

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(1) of the potential billing error;

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(2) that the health care provider or health plan company will review the bill and correct
any billing errors found; and

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(3) that while the review is being conducted, the health care provider will not bill the
patient for any health treatment or service subject to review for potential billing errors.
Subd. 3. Billing and payment after completion of review. The health care provider and health plan company may bill the patient for, and accept payment from the patient for, the health treatment or service that was subject to the miscoding review only after the review is complete and any miscoded health treatments or services have been correctly coded.

Sec. 5. Minnesota Statutes 2022, section 62V.05, subdivision 12, is amended to read:

Subd. 12. Reports on interagency agreements and intra-agency transfers. The MNsure Board shall provide quarterly reports to the chair and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on legislative reports on interagency agreements and intra-agency transfers according to section 15.8395.

(1) interagency agreements or service-level agreements and any renewals or extensions of existing interagency or service-level agreements with a state department under section 15.01, state agency under section 15.012, or the Department of Information Technology Services, with a value of more than $100,000, or related agreements with the same department or agency with a cumulative value of more than $100,000, and

(2) transfers of appropriations of more than $100,000,000 between accounts within or between agencies.

The report must include the statutory citation authorizing the agreement, transfer or dollar amount, purpose, and effective date of the agreement, the duration of the agreement, and a copy of the agreement.

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

Sec. 6. Minnesota Statutes 2022, section 62V.08, is amended to read:

62V.08 REPORTS.

(a) MNsure shall submit a report to the legislature by January 15, 2015, March 31, 2015, and each January 15, March 31 thereafter, on: (1) the performance of MNsure operations; (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4) practices and procedures that have been implemented to ensure compliance with data practices laws, and a description of any violations of data practices laws or procedures; and

30 days after the health care provider or health plan company determines or receives notice that the patient's bill may contain one or more billing errors.

Subd. 3. Notice to patient of completed review. When a health care provider or health plan company completes a review of a bill for potential billing errors, the health care provider or health plan company must notify the patient that the review is complete. Explain in detail how any identified billing errors were corrected or explain in detail why the health care provider or health plan company did not modify the bill as requested by the patient or other person, and include applicable coding guidelines, references to health records, and other relevant information. This notice must be transmitted to the patient within 30 days after the health care provider or health plan company completes the review.

THE FOLLOWING LANGUAGE IS FROM HOUSE ARTICLE 4, SECTIONS 46 TO 48.
40.8 (5) the effectiveness of the outreach and implementation activities of MNsure in reducing the rate of uninsurance.
40.9 (b) MNsure must publish its administrative and operational costs on a website to educate consumers on those costs. The information published must include: (1) the amount of premiums and federal premium subsidies collected; (2) the amount and source of revenue received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and source of any other fees collected for purposes of supporting operations; and (4) any misuse of funds as identified in accordance with section 3.975. The website must be updated at least annually.
40.10 Sec. 7. Minnesota Statutes 2022, section 62V.11, subdivision 4, is amended to read:
40.11 Subd. 4. Review of costs. The board shall submit for review the annual budget of MNsure for the next fiscal year by March 31 of each year, beginning March 31, 2014.

89.22 (5) the effectiveness of the outreach and implementation activities of MNsure in reducing the rate of uninsurance.
89.23 (b) MNsure must publish its administrative and operational costs on a website to educate consumers on those costs. The information published must include: (1) the amount of premiums and federal premium subsidies collected; (2) the amount and source of revenue received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and source of any other fees collected for purposes of supporting operations; and (4) any misuse of funds as identified in accordance with section 3.975. The website must be updated at least annually.
89.24 Sec. 48. Minnesota Statutes 2022, section 62V.11, subdivision 4, is amended to read:
89.25 Subd. 4. Review of costs. The board shall submit for review the annual budget of MNsure for the next fiscal year by March 31 of each year, beginning March 31, 2025.
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36.30 Sec. 5. Minnesota Statutes 2023 Supplement, section 144.587, subdivision 1, is amended to read:
36.31 Subdivision 1. Definitions. (a) The terms defined in this subdivision apply to this section and sections 144.588 to 144.589.
36.32 (b) "Charity care" means the provision of free or discounted care to a patient according to a hospital's financial assistance policies.
36.33 (c) "Hospital" means a private, nonprofit, or municipal hospital licensed under sections 144.50 to 144.56.
36.34 (d) "Insurance affordability program" has the meaning given in section 256B.02, subdivision 19.
36.35 (e) "Navigator" has the meaning given in section 62V.02, subdivision 9.
36.36 (f) "Presumptive eligibility" has the meaning given in section 256B.057, subdivision 12.
36.37 (g) "Revenue recapture" means the use of the procedures in chapter 270A to collect debt.
36.38 (h) "Uninsured service or treatment" means any service or treatment that is not covered by:
36.39 (1) a health plan, contract, or policy that provides health coverage to a patient; or
36.40 (2) any other type of insurance coverage, including but not limited to no-fault automobile coverage, workers' compensation coverage, or liability coverage.
36.41 (i) "Unreasonable burden" includes requiring a patient to apply for enrollment in a state or federal program for which the patient is obviously or categorically ineligible or has been found to be ineligible in the previous 12 months.
Subd. 4. Prohibited actions. (a) A hospital must not initiate one or more of the following actions until the hospital determines that the patient is ineligible for charity care or denies an application for charity care:

1. offering to enroll or enrolling the patient in a payment plan;
2. changing the terms of a patient's payment plan;
3. offering the patient a loan or line of credit, application materials for a loan or line of credit, or assistance with applying for a loan or line of credit, for the payment of medical debt;
4. referring a patient's debt for collections, including in-house collections, third-party collections, revenue recapture, or any other process for the collection of debt; or
5. accepting a credit card payment of over $500 for the medical debt owed to the hospital.

(b) A violation of section 621.807 is a violation of this subdivision.

Sec. 9. [145.076] INFORMED CONSENT REQUIRED FOR SENSITIVE EXAMINATIONS.

Subdivision 1. Definition. For the purposes of this section, "sensitive examination" means a pelvic, breast, urogenital, or rectal examination.

Subd. 2. Informed consent required; exceptions. A health professional, or a student or resident participating in a course of instruction, clinical training, or a residency program for a health profession, shall not perform a sensitive examination on an anesthetized or unconscious patient unless:

1. the patient or the patient's legally authorized representative provided prior, written informed consent to the sensitive examination, and the sensitive examination is necessary for preventive, diagnostic, or treatment purposes;
2. the patient or the patient's legally authorized representative provided prior, written informed consent to a surgical procedure or diagnostic examination, and the sensitive examination is within the scope of care ordered for that surgical procedure or diagnostic examination;
the patient is unconscious and incapable of providing informed consent, and the
sensitive examination is necessary for diagnostic or treatment purposes; or
(a) a court ordered a sensitive examination to be performed for purposes of collection
of evidence.

Subd. 3. Penalty: ground for disciplinary action. A person who violates this section
is subject to disciplinary action by the health-related licensing board regulating the person.

EFFECTIVE DATE. This section is effective August 1, 2024, and applies to crimes
committed on or after that date.

Sec. 10. Minnesota Statutes 2023 Supplement, section 151.74, subdivision 3, is amended
to read:

Subd. 3. Access to urgent-need insulin. (a) MNsure shall develop an application form
to be used by an individual who is in urgent need of insulin. The application must ask the
individual to attest to the eligibility requirements described in subdivision 2. The form shall
be accessible through MNsure's website. MNsure shall also make the form available to
pharmacies and health care providers who prescribe or dispense insulin, hospital emergency
departments, urgent care clinics, and community health clinics. By submitting a completed,
signed, and dated application to a pharmacy, the individual attests that the information
contained in the application is correct.

(b) If the individual in urgent need of insulin, the individual may present a completed,
signed, and dated application form to a pharmacy. The individual must also:

(1) have a valid insulin prescription; and

(2) present the pharmacist with identification indicating Minnesota residency in the form
of a valid Minnesota identification card, driver's license or permit, individual taxpayer
identification number, or Tribal identification card as defined in section 171.072, paragraph
(b). If the individual in urgent need of insulin is under the age of 18, the individual's parent
or legal guardian must provide the pharmacist with proof of residency.

(c) Upon receipt of a completed and signed application, the pharmacist shall dispense
the prescribed insulin in an amount that will provide the individual with a 30-day supply.
The pharmacy must notify the health care practitioner who issued the prescription order no
later than 72 hours after the insulin is dispensed.

(d) The pharmacy may submit to the manufacturer of the dispensed insulin product or
to the manufacturer's vendor a claim for payment that is in accordance with the National
Council for Prescription Drug Program standards for electronic claims processing, unless

Sec. 16. Minnesota Statutes 2023 Supplement, section 151.74, subdivision 3, is amended
to read:

Subd. 3. Access to urgent-need insulin. (a) MNsure shall develop an application form
to be used by an individual who is in urgent need of insulin. The application must ask the
individual to attest to the eligibility requirements described in subdivision 2. The form shall
be accessible through MNsure's website. MNsure shall also make the form available to
pharmacies and health care providers who prescribe or dispense insulin, hospital emergency
departments, urgent care clinics, and community health clinics. By submitting a completed,
signed, and dated application to a pharmacy, the individual attests that the information
contained in the application is correct.

(b) If the individual in urgent need of insulin, the individual may present a completed,
signed, and dated application form to a pharmacy. The individual must also:

(1) have a valid insulin prescription; and

(2) present the pharmacist with identification indicating Minnesota residency in the form
of a valid Minnesota identification card, driver's license or permit, individual taxpayer
identification number, or Tribal identification card as defined in section 171.072, paragraph
(b). If the individual in urgent need of insulin is under the age of 18, the individual's parent
or legal guardian must provide the pharmacist with proof of residency.

(c) Upon receipt of a completed and signed application, the pharmacist shall dispense
the prescribed insulin in an amount that will provide the individual with a 30-day supply.
The pharmacy must notify the health care practitioner who issued the prescription order no
later than 72 hours after the insulin is dispensed.

(d) The pharmacy may submit to the manufacturer of the dispensed insulin product or
to the manufacturer's vendor a claim for payment that is in accordance with the National
Council for Prescription Drug Program standards for electronic claims processing, unless
the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the manufacturer or the manufacturer's vendor, the manufacturer or vendor shall reimburse the pharmacy in an amount that covers the pharmacy's acquisition cost.

(e) The pharmacy may collect an insulin copayment from the individual to cover the pharmacy's costs of processing and dispensing in an amount not to exceed $35 for the 30-day supply of insulin dispensed.

(f) The pharmacy shall also provide each eligible individual with the information sheet described in subdivision 7 and a list of trained navigators provided by the Board of Pharmacy for the individual to contact if the individual is in need of accessing needs to access ongoing insulin coverage options, including assistance in:

1. applying for medical assistance or MinnesotaCare;
2. applying for a qualified health plan offered through MNsure, subject to open and special enrollment periods;
3. accessing information on providers who participate in prescription drug discount programs, including providers who are authorized to participate in the 340B program under section 340b of the federal Public Health Services Act, United States Code, title 42, section 256b; and
4. accessing insulin manufacturers' patient assistance programs, co-payment assistance programs, and other foundation-based programs.

(g) The pharmacist shall retain a copy of the application form submitted by the individual to the pharmacy for reporting and auditing purposes.

(h) A manufacturer may submit to the commissioner of administration a request for reimbursement in an amount not to exceed $35 for each 30-day supply of insulin the manufacturer provides under paragraph (d). The commissioner of administration shall determine the manner and format for submitting and processing requests for reimbursement. After receiving a reimbursement request, the commissioner of administration shall reimburse the manufacturer in an amount not to exceed $35 for each 30-day supply of insulin the manufacturer provided under paragraph (d), in a valid prescription to the product's manufacturer.

EFFECTIVE DATE: This section is effective July 1, 2024.

Sec. 11. Minnesota Statutes 2022, section 151.74, subdivision 6, is amended to read:

Subd. 6. Continuing safety net program; process. (a) The individual shall submit to a pharmacy the statement of eligibility provided by the manufacturer under subdivision 5, paragraph (b). Upon receipt of an individual's eligibility status, the pharmacy shall submit an order containing the name of the insulin product and the daily dosage amount as contained in a valid prescription to the product's manufacturer.

(b) A manufacturer may submit to the commissioner of administration a request for reimbursement in an amount not to exceed $35 for each 30-day supply of insulin the manufacturer provides under paragraph (d). The commissioner of administration shall determine the manner and format for submitting and processing requests for reimbursement. After receiving a reimbursement request, the commissioner of administration shall reimburse the manufacturer in an amount not to exceed $35 for each 30-day supply of insulin the manufacturer provided under paragraph (d), in a valid prescription to the product's manufacturer.

EFFECTIVE DATE: This section is effective July 1, 2024.
The pharmacy must include with the order to the manufacturer the following information:

1. The pharmacy's name and shipping address;
2. The pharmacy's office telephone number, fax number, email address, and contact name; and
3. Any specific days or times when deliveries are not accepted by the pharmacy.

Upon receipt of an order from a pharmacy and the information described in paragraph (b), the manufacturer shall send to the pharmacy a 90-day supply of insulin as ordered, unless a lesser amount is requested in the order, at no charge to the individual or pharmacy.

Except as authorized under paragraph (e), the pharmacy shall provide the insulin to the individual at no charge to the individual. The pharmacy shall not provide insulin received from the manufacturer to any individual other than the individual associated with the specific order. The pharmacy shall not seek reimbursement for the insulin received from the manufacturer or from any third-party payer.

The pharmacy may collect a co-payment from the individual to cover the pharmacy's costs for processing and dispensing in an amount not to exceed $50 for each 90-day supply if the insulin is sent to the pharmacy.

(f) The pharmacy may submit to a manufacturer a reorder for an individual if the individual's eligibility statement has not expired. Upon receipt of a reorder from a pharmacy, the pharmacy must send to the pharmacy an additional 90-day supply of the product, unless a lesser amount is requested, at no charge to the individual or pharmacy if the individual's eligibility statement has not expired.

Notwithstanding paragraph (c), a manufacturer may send the insulin as ordered directly to the individual if the manufacturer provides a mail order service option.

A manufacturer may submit to the commissioner of administration a request for reimbursement in an amount not to exceed $105 for each 90-day supply of insulin the manufacturer provides under paragraphs (c) and (f). The commissioner of administration shall determine the manner and format for submitting and processing requests for reimbursement. After receiving a reimbursement request, the commissioner of administration shall reimburse the manufacturer in an amount not to exceed $105 for each 90-day supply of insulin the manufacturer provides under paragraphs (c) and (f). If the manufacturer provides less than a 90-day supply of insulin under paragraphs (c) and (f), the manufacturer may submit a request for reimbursement not to exceed $35 for each 30-day supply of insulin provided.

This section is effective July 1, 2024.
Subdivision 1. Definitions. (a) For purposes of this section, the following terms have
the meanings given:

(b) "Board" means the Minnesota Board of Pharmacy under section 151.02.

c) "Manufacturer" means a manufacturer licensed under section 151.252 and engaged
in the manufacturing of prescription insulin.

Subd. 2. Assessment of registration fee. (a) The board shall assess each manufacturer
an annual registration fee of $100,000, except as provided in paragraph (b). The board shall
notify each manufacturer of this requirement beginning November 1, 2024, and each
November 1 thereafter.

(b) A manufacturer may request an exemption from the annual registration fee. The
Board of Pharmacy shall exempt a manufacturer from the annual registration fee if the
manufacturer can demonstrate to the board, in the form and manner specified by the board,
that sales of prescription insulin produced by that manufacturer and sold or delivered within
or into Minnesota totaled $2,000,000 or less in the previous calendar year.

Subd. 3. Payment of the registration fee; deposit of fee. (a) Each manufacturer must
pay the registration fee by March 1, 2025, and by each March 1 thereafter. In the event of
a change in ownership of the manufacturer, the new owner must pay the registration fee
that the original owner would have been assessed had the original owner retained ownership.

The board may assess a late fee of ten percent per month or any portion of a month that the
registration fee is paid after the due date.

(b) The registration fee, including any late fees, must be deposited in the insulin safety
net program account.

Subd. 4. Insulin safety net program account. The insulin safety net program account
is established in the special revenue fund in the state treasury. Money in the account is
appropriated each fiscal year to:

1) the MNsure board in an amount sufficient to carry out assigned duties under section
151.74, subdivision 7; and

2) the Board of Pharmacy in an amount sufficient to cover costs incurred by the board
in assessing and collecting the registration fee under this section and in administering the
insulin safety net program under section 151.74.

Subd. 5. Insulin repayment account; annual transfer from health care access fund. (a)
The insulin repayment account is established in the special revenue fund in the state treasury.
Money in the account is appropriated each fiscal year to reimburse manufacturers for insulin dispensed under the insulin safety net program in section 151.74, in accordance with section 151.74, subdivisions 3, paragraph (b), and 6;
paragraph (h), and to cover costs incurred by the commissioner in providing these reimbursement payments.

(b) By June 30, 2025, and each June 30 thereafter, the commissioner of administration shall certify to the commissioner of management and budget the total amount expended in the prior fiscal year for:

1. Reimbursement to manufacturers for insulin dispensed under the insulin safety net program in section 151.74, in accordance with section 151.74, subdivisions 3, paragraph (h), and 6, paragraph (h), and

2. Costs incurred by the commissioner of administration in providing the reimbursement payments described in clause (1).

(g) The commissioner of administration and budget shall transfer from the health care access fund to the special revenue fund, beginning July 1, 2025, and each July 1 thereafter, an amount equal to the amount to which the commissioner of administration certified pursuant to paragraph (b).

Subd. 6. Contingent transfer by commissioner. If subdivisions 2 and 3, or the application of subdivisions 2 and 3 to any person or circumstance, are held invalid for any reason in a court of competent jurisdiction, the validity of subdivisions 2 and 3 does not affect other provisions of this act, and the commissioner of management and budget shall annually transfer from the health care access fund to the insulin safety net program account an amount sufficient to implement subdivision 4.

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

Sec. 13. Minnesota Statutes 2022, section 176.175, subdivision 2, is amended to read:

Subd. 2. Nonassignability. No claim for compensation or settlement of a claim for compensation owned by an injured employee or dependents is assignable. Except as otherwise provided in this chapter, any claim for compensation owned by an injured employee or dependents is exempt from seizure or sale for the payment of any debt or liability, up to a total amount of $1,000,000 per claim and subsequent award.

EFFECTIVE DATE. This section is effective July 1, 2024.
Sec. 14. [332C.01] DEFINITIONS.

Subdivision 1. Application. For purposes of this chapter, the following terms have the meanings given.

Subd. 2. Collecting party. "Collecting party" means a party engaged in the collection of medical debt. Collecting party does not include banks, credit unions, public officers, garnishees, and other parties complying with a court order or statutory obligation to garnish or levy a debtor's property.

Subd. 3. Debtor. "Debtor" means a person obligated or alleged to be obligated to pay any debt.

Subd. 4. Medical debt. "Medical debt" means debt incurred primarily for medically necessary health treatment or services. Medical debt does not include debt charged to a credit card unless the credit card is issued under a credit plan offered solely for the payment of health care treatment or services.


Subd. 6. Person. "Person" means any individual, partnership, association, or corporation.

Sec. 15. [332C.02] PROHIBITED PRACTICES.

No collecting party shall:

(1) in a collection letter, publication, invoice, or any oral or written communication, threaten wage garnishment or legal suit by a particular lawyer, unless the collecting party has actually retained the lawyer to do so;

(2) advertised, promoted, or offered for the payment of health care at the facility in which the credit card or other credit instrument is advertised, promoted, or offered;

(b) Medical debt does not include:

(1) debt charged to a credit card that is not advertised, promoted, or offered expressly for the payment of health care and is intended, advertised, promoted, or offered to make credit purchases for personal, family, or household purposes;

(2) debt incurred for veterinary services;

(3) debt incurred for dental services; or

(4) debt charged to a home equity line of credit.

Subd. 5. Medically necessary. "Medically necessary" has the meaning given in section 62J.805, subdivision 1.

Subd. 6. Person. "Person" means any individual, partnership, association, or corporation.

Sec. 21. [332C.02] PROHIBITED PRACTICES.

No collecting party shall:

(1) in a collection letter, publication, invoice, or any oral or written communication, threaten wage garnishment or legal suit by a particular lawyer, unless the collecting party has actually retained the lawyer to do so;
use or employ sheriffs or any other officer authorized to serve legal papers in connection with the collection of a claim, except when performing their legally authorized duties.

(3) use or threaten to use methods of collection which violate Minnesota law;

(4) furnish legal advice to debtors or represent that the collecting party is competent or able to furnish legal advice to debtors;

(5) communicate with debtors in a misleading or deceptive manner by falsely using the stationery of a lawyer, forms or instruments which only lawyers are authorized to prepare, or instruments which simulate the form and appearance of judicial process;

(6) publish or cause to be published any list of debtors, use shame cards or shame automobiles, advertise or threaten to advertise for sale any claim as a means of forcing payment thereof, or use similar devices or methods of intimidation;

(7) operate under a name or in a manner which falsely implies the collecting party is a branch of or associated with any department of federal, state, county, or local government or an agency thereof;

(8) transact business or hold itself out as a debt settlement company, debt management company, debt adjuster, or any person who settles, adjusts, prorates, pools, liquidates, or pays the indebtedness of a debtor, unless there is no charge to the debtor, or the pooling or liquidation is done pursuant to court order or under the supervision of a creditor’s committee;

(9) unless an exemption in the law exists, violate Code of Federal Regulations, title 12, part 1006, while attempting to collect on any account, bill, or other indebtedness. For purposes of this section, Public Law 95-109 and Code of Federal Regulations, title 12, part 1006, apply to collecting parties;

(10) communicate with a debtor by use of an automatic telephone dialing system or an artificial or prerecorded voice for purposes of this clause, an automatic telephone dialing system or an artificial or prerecorded voice. For purposes of this clause, an automatic telephone dialing system or an artificial or prerecorded voice includes but is not limited to (i) artificial intelligence chat bots, and (ii) the usage of the term under the Telephone Consumer Protection Act, United States Code, title 47, section 227(b)(1)(A);

(11) in collection letters or publications, or in any oral or written communication, imply or suggest that medically necessary health treatment or services will be denied as a result of a medical debt;

(12) when a debtor has a listed telephone number, enlist the aid of a neighbor or third party to request that the debtor contact the collecting party, except a person who resides with the debtor or a third party with whom the debtor has authorized with the collecting party to place the request. This clause does not apply to a call back message left at the collector’s request.
debtor's place of employment which is limited solely to the collecting party's telephone
number and name; (13) when attempting to collect a medical debt, fail to provide the debtor with the full
name of the collecting party, as registered with the secretary of state;
(14) fail to return any amount of overpayment from a debtor to the debtor or to the state
of Minnesota pursuant to the requirements of chapter 345;
(15) accept currency or coin as payment for a medical debt without issuing an original
receipt to the debtor and maintaining a duplicate receipt in the debtor's payment records;
(16) attempt to collect any amount, including any interest, fee, charge, or expense
incidental to the charge-off obligation, from a debtor unless the amount is expressly
authorized by the agreement creating the medical debt or is otherwise permitted by law;
(17) falsify any documents with the intent to deceive;
(18) when initially contacting a Minnesota debtor by mail to collect a medical debt, fail
to include a disclosure on the contact notice, in a type size or font which is equal to or larger
than the largest other type of type size or font used in the text of the notice, that includes
and identifies the Office of the Minnesota Attorney General's general telephone number,
and states: "You have the right to hire your own attorney to represent you in this matter.";
(19) commence legal action to collect a medical debt outside the limitations period set
forth in section 541.055;
(20) report to a credit reporting agency any medical debt which the collecting party
knows or should know is or was originally owed to a health care provider, as defined in
section 62J.805, subdivision 2 or
(21) challenge a debtor's claim of exemption to garnishment or levy in a manner that is
baseless, frivolous, or otherwise in bad faith.
Sec. 16. [332C.03] MEDICAL DEBT CREDIT REPORTING PROHIBITED.
(a) A collecting party is prohibited from reporting medical debt to a consumer reporting
agency.
(b) A consumer reporting agency is prohibited from making a consumer report containing
an item of information that the consumer reporting agency knows or should know concerns:
(1) medical information; or (2) debt arising from: (i) the provision of medical care, treatment,
services, devices, medicines; or (ii) procedures to maintain, diagnose, or treat a person's
physical or mental health.
49.29 (c) For purposes of this section, "consumer report" and "medical information" have the meanings given in the Fair Credit Reporting Act.

49.30 United States Code, title 15, section 1681a.

50.1 (d) This section also applies to collection agencies and debt buyers licensed under Chapter 332.

50.2 Sec. 17. [332C.04] DEFENDING MEDICAL DEBT CASES.

50.3 A debtor who successfully defends against a claim for payment of medical debt that is alleged by a collecting party must be awarded the debtor's costs, including a reasonable attorney fee as determined by the court, incurred in defending against the collecting party's claim for debt payment. For purposes of this section, a resolution mutually agreed upon by the debtor and collecting party is not a successful defense.

50.4 Sec. 18. [332C.05] ENFORCEMENT.

50.5 (a) The attorney general may enforce this chapter under section 8.31.

50.6 (b) A collecting party that violates this chapter is strictly liable to the debtor in question for the sum of:

50.7 (1) actual damage sustained by the debtor as a result of the violation;

50.8 (2) additional damages as the court may allow, but not exceeding $1,000 per violation; and

50.9 (3) in the case of any successful action to enforce the foregoing, the costs of the action, together with a reasonable attorney fee as determined by the court.

50.10 (c) A collecting party that willfully and maliciously violates this chapter is strictly liable to the debtor for three times the sums allowable under paragraph (b), clauses (1) and (2).

50.11 (d) The dollar amount limit under paragraph (b), clause (2), changes on July 1 of each even-numbered year in an amount equal to changes made in the Consumer Price Index, compiled by the United States Bureau of Labor Statistics. The Consumer Price Index for December 2024 is the reference base index. If the Consumer Price Index is revised, the percentage of change made under this section must be calculated on the basis of the revised Consumer Price Index. If a Consumer Price Index revision changes the reference base index, a revised reference base index must be determined by multiplying the reference base index that is effective at the time by the rebasing factor furnished by the Bureau of Labor Statistics.

50.12 (e) If the Consumer Price Index is superseded, the Consumer Price Index referred to in this section is the Consumer Price Index represented by the Bureau of Labor Statistics as most accurately reflecting changes in the prices paid by consumers for goods and services.
The attorney general must publish the base reference index under paragraph (f) in
the State Register no later than September 1, 2024. The attorney general must calculate and
then publish the revised Consumer Price Index under paragraph (g) in the State Register no
later than September 1 each even-numbered year.

(g) An action brought under this section benefits the public.

(h) A collecting party may not be held liable in any action brought under this section if
the collecting party shows by a preponderance of evidence that the violation:

1) was not intentional and resulted from a bona fide error made notwithstanding the
maintenance of procedures reasonably adopted to avoid any such error; or

2) was the result of inaccurate or incorrect information provided to the collecting party
by a health care provider as defined in section 62J.805, subdivision
that term is defined in section 62A.011, subdivision 2; or another collecting party currently
or previously engaged in collection of the medical debt in question.

Sec. 19. Minnesota Statutes 2022, section 519.05, is amended to read:

519.05 LIABILITY OF HUSBAND AND WIFE SPOUSES.

(a) A spouse is not liable to a creditor for any debts of the other spouse. Where husband
and wife are living together, they Spouses shall be jointly and severally liable for necessary
medical services that have been furnished to either spouse, including any claims arising
under sections 246.52, 256B.15, 256B.16, or 261.04, and necessary household articles and
supplies furnished to and used by the family. Notwithstanding this paragraph, in a proceeding
under chapter 518 the court may apportion such debt between the spouses.

(b) Either spouse may close a credit card account or other unsecured consumer line of
credit on which both spouses are contractually liable, by giving written notice to the creditor.

(c) Nothing in this section prevents a claim against an estate.
program established under Minnesota Statutes, section 151.74. This is a onetime appropriation and is available until December 31, 2024.

(c) $76,000 is appropriated in fiscal year 2021 from the health care access fund to the Board of Pharmacy to implement Minnesota Statutes, section 151.74. The base for this appropriation is $76,000 in fiscal year 2022; $76,000 in fiscal year 2023; $76,000 in fiscal year 2024; $38,000 in fiscal year 2025; and $0 in fiscal year 2026.

(d) $136,000 in fiscal year 2021 is appropriated from the health care access fund to the commissioner of health to implement the survey to assess program satisfaction in Minnesota Statutes, section 151.74, subdivision 12. The base for this appropriation is $80,000 in fiscal year 2022 and $0 in fiscal year 2023. This is a onetime appropriation.

Sec. 27. **REPEALER; SUNSET FOR THE LONG-TERM SAFETY NET INSULIN PROGRAM.**

Minnesota Statutes 2022, section 151.74, subdivision 16, is repealed.

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