

209.23

ARTICLE 5

209.24

HEALTH INSURANCE

209.25 Section 1. Minnesota Statutes 2016, section 62A.04, subdivision 1, is amended to read:

209.26 Subdivision 1. **Reference.** Any reference to "standard provisions" which may appear in
209.27 other sections and which refer to accident and sickness or accident and health insurance
209.28 shall hereinafter be construed as referring to accident and sickness policy provisions. The
209.29 provisions of subdivision 2, clauses (4), (5), (6), (7), (8), (9), (10), and (12); subdivision 3,
209.30 clauses (1), (3), (4), (5), (6), and (7); subdivision 6; and subdivision 10 do not apply to
210.1 accident and sickness or accident and health insurance that are health plans defined in section
210.2 62A.011, subdivision 3.

210.3 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
210.4 renewed on or after January 1, 2018.

210.5 Sec. 2. Minnesota Statutes 2016, section 62A.21, subdivision 2a, is amended to read:

210.6 Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain
210.7 a provision which permits continuation of coverage under the policy for the insured's ~~former~~
210.8 ~~spouse and dependent children upon~~ as defined in section 62Q.01, subdivision 2a, and
210.9 former spouse, who was covered on the day before entry of a valid decree of dissolution of
210.10 marriage. The coverage shall be continued until the earlier of the following dates:

210.11 (a) the date the insured's former spouse becomes covered under any other group health
210.12 plan; or

210.13 (b) the date coverage would otherwise terminate under the policy.

210.14 If the coverage is provided under a group policy, any required premium contributions
210.15 for the coverage shall be paid by the insured on a monthly basis to the group policyholder
210.16 for remittance to the insurer. The policy must require the group policyholder to, upon request,
210.17 provide the insured with written verification from the insurer of the cost of this coverage
210.18 promptly at the time of eligibility for this coverage and at any time during the continuation
210.19 period. In no event shall the amount of premium charged exceed 102 percent of the cost to
210.20 the plan for such period of coverage for other similarly situated spouses and dependent
210.21 children with respect to whom the marital relationship has not dissolved, without regard to
210.22 whether such cost is paid by the employer or employee.

210.23 Upon request by the insured's ~~former spouse or dependent child~~ children and former
210.24 spouse, who was covered on the day before entry of a valid decree of dissolution, a health

210.25 carrier must provide the instructions necessary to enable the child or former spouse to elect
210.26 continuation of coverage.

210.27 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
210.28 renewed on or after January 1, 2018.

210.29 Sec. 3. Minnesota Statutes 2016, section 62A.3075, is amended to read:

210.30 **62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.**

211.1 (a) A health plan company that provides coverage under a health plan for cancer
211.2 chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance
211.3 amount for a prescribed, orally administered anticancer medication that is used to kill or
211.4 slow the growth of cancerous cells than what the health plan requires for an intravenously
211.5 administered or injected cancer medication that is provided, regardless of formulation or
211.6 benefit category determination by the health plan company.

211.7 (b) A health plan company must not achieve compliance with this section by imposing
211.8 an increase in co-payment, deductible, or coinsurance amount for an intravenously
211.9 administered or injected cancer chemotherapy agent covered under the health plan.

211.10 (c) Nothing in this section shall be interpreted to prohibit a health plan company from
211.11 requiring prior authorization or imposing other appropriate utilization controls in approving
211.12 coverage for any chemotherapy.

211.13 (d) A plan offered by the commissioner of management and budget under section 43A.23
211.14 is deemed to be at parity and in compliance with this section.

211.15 (e) A health plan company is in compliance with this section if it does not include orally
211.16 administered anticancer medication in the fourth tier of its pharmacy benefit.

211.17 (f) A health plan company that provides coverage under a health plan for cancer
211.18 chemotherapy treatment must indicate the level of coverage for orally administered anticancer
211.19 medication within its pharmacy benefit filing with the commissioner.

211.20 **EFFECTIVE DATE.** This section is effective January 1, 2018, and applies to health
211.21 plans offered, sold, issued, or renewed on or after that date.

211.22 Sec. 4. Minnesota Statutes 2016, section 62D.105, subdivision 1, is amended to read:

211.23 Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to
211.24 covering the enrollee also provides coverage to the ~~spouse and~~ dependent children to the
211.25 limiting age as defined in section 62Q.01, subdivision 2a, of the enrollee and spouse who

211.26 was covered on the day before entry of a valid decree of dissolution shall: (1) permit the
211.27 spouse and dependent children to the limiting age as defined in section 62Q.01, subdivision
211.28 2a, to elect to continue coverage when the enrollee becomes enrolled for benefits under title
211.29 XVIII of the Social Security Act (Medicare); and (2) permit the dependent children to
211.30 continue coverage when they cease to be dependent children to the limiting age as defined
211.31 in section 62Q.01, subdivision 2a, under the generally applicable requirement of the plan.

211.32 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
211.33 renewed on or after January 1, 2018.

212.1 Sec. 5. Minnesota Statutes 2016, section 62D.105, subdivision 2, is amended to read:

212.2 Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be
212.3 continued until the earlier of the following dates:

212.4 (1) the date coverage would otherwise terminate under the contract;

212.5 (2) 36 months after continuation by the spouse or dependent was elected; or

212.6 (3) the date the spouse or dependent children become covered under another group health
212.7 plan or Medicare.

212.8 If coverage is provided under a group policy, any required fees for the coverage shall
212.9 be paid by the enrollee on a monthly basis to the group contract holder for remittance to the
212.10 health maintenance organization. In no event shall the fee charged exceed 102 percent of
212.11 the cost to the plan for such coverage for other similarly situated spouse and dependent
212.12 children to the limiting age as defined in section 62Q.01, subdivision 2a, to whom subdivision
212.13 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

212.14 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
212.15 renewed on or after January 1, 2018.

212.16 Sec. 6. Minnesota Statutes 2016, section 62E.04, subdivision 11, is amended to read:

212.17 Subd. 11. ~~Essential health benefits package~~ **Affordable Care Act compliant plans.**
212.18 For individual or small group health plans that include the essential health benefits package
212.19 and are any policy of accident and health insurance subject to the requirements of the
212.20 Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold,
212.21 issued, or renewed on or after January 1, ~~2014~~ 2018, the requirements of this section do not
212.22 apply.

212.23 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
212.24 renewed on or after January 1, 2018.

212.25 Sec. 7. Minnesota Statutes 2016, section 62E.05, subdivision 1, is amended to read:

212.26 Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for
212.27 certification of a plan of health coverage as a qualified plan or a qualified Medicare
212.28 supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall
212.29 make a determination within 90 days as to whether the plan is qualified. All plans of health
212.30 coverage, except Medicare supplement policies, shall be labeled as "qualified" or
212.31 "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified
213.1 plans shall indicate whether they are number one, two, or three coverage plans. For any
213.2 policy of accident and health insurance subject to the requirements of the Affordable Care
213.3 Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or
213.4 renewed on or after January 1, 2018, the requirements of this section do not apply.

213.5 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
213.6 renewed on or after January 1, 2018.

213.7 Sec. 8. Minnesota Statutes 2016, section 62E.06, is amended by adding a subdivision to
213.8 read:

213.9 Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health
213.10 insurance subject to the requirements of the Affordable Care Act, as defined under section
213.11 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1,
213.12 2018, the requirements of this section do not apply.

213.13 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
213.14 renewed on or after January 1, 2018.

213.15 Sec. 9. **[62K.16] COVERAGE TERMINATION NOTIFICATION.**

213.16 (a) All individual health carriers issuing individual health plans must permit enrollees
213.17 to terminate their individual health plan coverage by directly contacting either the health
213.18 carrier or MNsure, if the enrollee purchased the coverage through MNsure. If an enrollee
213.19 terminates coverage by contacting the health carrier directly, the health carrier must inform
213.20 MNsure of the termination request.

213.21 (b) Health plan companies and MNsure shall develop a form that can be accessed by an
213.22 enrollee through either the health plan company's Web site or MNsure's Web site for the
213.23 purpose of terminating coverage online.

213.24 (c) Termination of coverage shall be effective the first day of the month following the
213.25 month in which the enrollee notified either the health carrier or MNsure.

213.26 Sec. 10. Minnesota Statutes 2016, section 62M.07, is amended to read:

213.27 **62M.07 PRIOR AUTHORIZATION OF SERVICES.**

213.28 (a) Utilization review organizations conducting prior authorization of services must have
213.29 written standards that meet at a minimum the following requirements:

213.30 (1) written procedures and criteria used to determine whether care is appropriate,
213.31 reasonable, or medically necessary;

214.1 (2) a system for providing prompt notification of its determinations to enrollees and
214.2 providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures
214.3 under clause (4);

214.4 (3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for
214.5 approving and disapproving prior authorization requests;

214.6 (4) written procedures for appeals of denials of prior authorization which specify the
214.7 responsibilities of the enrollee and provider, and which meet the requirements of sections
214.8 62M.06 and 72A.285, regarding release of summary review findings; and

214.9 (5) procedures to ensure confidentiality of patient-specific information, consistent with
214.10 applicable law.

214.11 (b) No utilization review organization, health plan company, or claims administrator
214.12 may conduct or require prior authorization of emergency confinement or emergency
214.13 treatment. The enrollee or the enrollee's authorized representative may be required to notify
214.14 the health plan company, claims administrator, or utilization review organization as soon
214.15 after the beginning of the emergency confinement or emergency treatment as reasonably
214.16 possible.

214.17 (c) If prior authorization for a health care service is required, the utilization review
214.18 organization, health plan company, or claim administrator must allow providers to submit
214.19 requests for prior authorization of the health care services without unreasonable delay by
214.20 telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day,
214.21 seven days a week. This paragraph does not apply to dental service covered under
214.22 MinnesotaCare or medical assistance.

- 214.23 (d) Any prior authorization for a prescription drug must remain valid for the duration
214.24 of an enrollee's contract term. These requirements related to the validity of prior authorization
214.25 apply only if:
- 214.26 (1) the drug continues to be prescribed for a patient with a condition that requires ongoing
214.27 medication therapy;
- 214.28 (2) the drug has not otherwise been deemed unsafe by the Food and Drug Administration;
- 214.29 (3) the drug has not been withdrawn by the manufacturer or the Food and Drug
214.30 Administration;
- 214.31 (4) there is no evidence of the enrollee's abuse or misuse of the prescription drug; and
- 215.1 (5) no independent source of research, clinical guidelines, or evidence-based standards
215.2 has issued drug-specific warnings or recommended changes in drug usage.
- 215.3 This paragraph does not apply to individuals enrolled in a public health care program under
215.4 chapter 256B or 256L; or assigned to the restricted recipient program under Minnesota
215.5 Rules, parts 9505.2160 to 9505.2245.
- 215.6 Sec. 11. **[62Q.575] ACCESS TO PRIMARY CARE PROVIDERS.**
- 215.7 Subdivision 1. **Provider network.** (a) No health plan company offering an individual
215.8 health plan that is not a grandfathered plan shall deny a primary care provider the right to
215.9 contract with the health plan company as an in-network provider if the primary care provider
215.10 meets one of the following criteria:
- 215.11 (1) is certified as a health care home by the commissioner of health under section
215.12 256B.0751. To remain eligible for in-network status under this section, the primary care
215.13 provider must maintain certification as a health care home; or
- 215.14 (2) is in the process of becoming certified as a health care home under section 256B.0751.
215.15 To remain eligible for in-network status under this subdivision, the primary care provider
215.16 must complete the certification process within six months to remain an in-network provider.
- 215.17 (b) A health plan company may require the primary care provider to meet reasonable
215.18 data, utilization review, and quality assurance requirements on the same basis as other
215.19 in-network providers.

- 215.20 (c) The primary care provider must agree to serve all enrollees of the health care company
215.21 who select or designate the primary care provider, if designation is required.
- 215.22 (d) The primary care provider and health plan company may negotiate the payment rate
215.23 for covered services provided by the primary care provider. The rate must not be less than
215.24 the rate paid by the health plan company to the provider under a different category of
215.25 coverage or health product, or other arrangement within a category of coverage.
- 215.26 Subd. 2. **Cost-sharing or other conditions.** No health plan company shall impose a
215.27 co-payment, fee, or other cost-sharing requirement for selecting or designating a primary
215.28 care provider of the enrollee's choosing or impose other conditions that limit the enrollee's
215.29 ability to utilize a primary care provider of the enrollee's choosing, unless the health plan
215.30 company imposes the same cost-sharing requirements, fees, conditions, or limits upon an
215.31 enrollee's selection or designation of any of the health plan company's in-network primary
215.32 care providers.
- 216.1 Subd. 3. **Care coordination.** (a) As part of the provider contract with primary care
216.2 providers that are certified health care homes, the contract must include a care coordination
216.3 payment for providing care coordination services. The care coordination payment under
216.4 this subdivision must be a per enrollee, per month payment and must be in addition to the
216.5 payment rate for the covered services provided by the primary care provider.
- 216.6 (b) The care coordination payment may vary based on care complexity, but must at least
216.7 be equal to the payment amounts established under section 256B.0753.
- 216.8 (c) The health plan company shall not impose a co-payment, fee, or other cost-sharing
216.9 requirement for care coordination services.
- 216.10 Subd. 4. **Notice.** The health plan company shall provide notice to enrollees of the
216.11 provisions of this section.
- 216.12 Subd. 5. **Definition.** For purposes of this section, "primary care provider" means a
216.13 physician licensed under chapter 147 or an advanced practice registered nurse licensed
216.14 under chapter 148 who specializes in the practice of family medicine, general internal
216.15 medicine, obstetrics and gynecology, or general pediatrics; or a health care clinic that
216.16 specializes in the above-mentioned areas and utilizes a primary care team that includes
216.17 physicians, physician assistants, or advanced practice registered nurses.
- 216.18 Subd. 6. **Limitations.** (a) This section does not apply to enrollees who are enrolled in
216.19 a public health care program under chapter 256B or 256L, or the Minnesota restricted
216.20 recipient program pursuant to Minnesota Rules, part 9505.2238.

- 216.21 (b) This section does not waive any exclusions of coverage under the terms and conditions
216.22 of the enrollee's health plan.
- 216.23 (c) This section only applies to individual health plans.
- 216.24 Subd. 7. **Enforcement.** The commissioner of health shall enforce this section.
- 216.25 **EFFECTIVE DATE.** This section is effective January 1, 2018, and applies to any
216.26 individual health plan offered, sold, issued, or renewed on or after that date.
- 216.27 Sec. 12. **[62Q.678] NETWORK OFFERINGS.**
- 216.28 (a) In counties where a health plan company actively markets an individual health plan,
216.29 the health plan company must offer, in those counties, at least one individual health plan
216.30 with a provider network that includes in-network access to more than a single health care
216.31 provider system or a health plan that includes more than one primary care location in a
217.1 county. This section is applicable only for the plan year in which the health plan company
217.2 actively markets an individual health plan.
- 217.3 (b) The commissioner of health shall enforce this section.
- 217.4 **EFFECTIVE DATE.** This section is effective January 1, 2018, and applies to any health
217.5 plan offered, sold, issued, or renewed on or after that date.
- 217.6 Sec. 13. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND**
217.7 **MANAGEMENT.**
- 217.8 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
217.9 the meanings given them.
- 217.10 (b) "Drug" has the meaning given in section 151.01, subdivision 5.
- 217.11 (c) "Enrollee contract year" means the 12-month term during which benefits associated
217.12 with health plan company products are in effect.
- 217.13 (d) "Formulary" means a list of prescription drugs that have been developed by clinical
217.14 and pharmacy experts and represents the health plan company's medically appropriate and
217.15 cost-effective prescription drugs approved for use.
- 217.16 (e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and
217.17 includes an entity that performs pharmacy benefits management for the health plan company.
217.18 For purposes of this definition, "pharmacy benefits management" means the administration

- 217.19 or management of prescription drug benefits provided by the health plan company for the
217.20 benefit of its enrollees and may include, but is not limited to, procurement of prescription
217.21 drugs, clinical formulary development and management services, claims processing, and
217.22 rebate contracting and administration.
- 217.23 (f) "Prescription" has the meaning given in section 151.01, subdivision 16a.
- 217.24 **Subd. 2. Prescription drug benefit disclosure.** (a) A health plan company that provides
217.25 prescription drug benefit coverage and uses a formulary must make its formulary and related
217.26 benefit information available by electronic means and, upon request, in writing, at least 30
217.27 days prior to annual renewal dates.
- 217.28 (b) Formularies must be organized and disclosed consistent with the most recent version
217.29 of the United States Pharmacopeia's (USP) Model Guidelines.
- 217.30 (c) For each item or category of items on the formulary, the specific enrollee benefit
217.31 terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.
- 218.1 **Subd. 3. Formulary changes.** (a) Once a formulary has been established, a health plan
218.2 company may, at any time during the enrollee's contract year:
- 218.3 (1) expand its formulary by adding drugs to the formulary;
- 218.4 (2) reduce co-payments or coinsurance; or
- 218.5 (3) move a drug to a benefit category that reduces an enrollee's cost.
- 218.6 (b) A health plan company may remove a brand name drug from its formulary or place
218.7 a brand name drug in a benefit category that increases an enrollee's cost only upon the
218.8 addition to the formulary of a generic or multisource brand name drug rated as therapeutically
218.9 equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable
218.10 according to the FDA Purple Book at a lower cost to the enrollee, and upon at least a 60-day
218.11 notice to prescribers, pharmacists, and affected enrollees.
- 218.12 (c) A health plan company may change utilization review requirements or move drugs
218.13 to a benefit category that increases an enrollee's cost during the enrollee's contract year upon
218.14 at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that
218.15 these changes do not apply to enrollees who are currently taking the drugs affected by these
218.16 changes for the duration of the enrollee's contract year.
- 218.17 (d) A health plan company may remove any drugs from its formulary that have been
218.18 deemed unsafe by the Food and Drug Administration, that have been withdrawn by either

218.19 the Food and Drug Administration or the product manufacturer, or when an independent
218.20 source of research, clinical guidelines, or evidence-based standards has issued drug-specific
218.21 warnings or recommended changes in drug usage.

218.22 Subd. 4. **Exclusions.** This section does not apply to individuals enrolled in a public
218.23 health care program under chapter 256B or 256L, or assigned to the restricted recipient
218.24 program under Minnesota Rules, parts 9505.2160 to 9505.2245.

218.25 Sec. 14. Minnesota Statutes 2016, section 317A.811, subdivision 1, is amended to read:

218.26 Subdivision 1. **When required.** (a) Except as provided in subdivision 6, the following
218.27 corporations shall notify the attorney general of their intent to dissolve, merge, or consolidate,
218.28 or to transfer all or substantially all of their assets:

218.29 (1) a corporation that holds assets for a charitable purpose as defined in section 501B.35,
218.30 subdivision 2; ~~or~~

218.31 (2) a health maintenance organization operating under chapter 62D;

218.32 (3) a service plan corporation operating under chapter 62C; or

219.1 ~~(2)~~ (4) a corporation that is exempt under section 501(c)(3) of the Internal Revenue Code
219.2 of 1986, or any successor section.

219.3 (b) The notice must include:

219.4 (1) the purpose of the corporation that is giving the notice;

219.5 (2) a list of assets owned or held by the corporation for charitable purposes;

219.6 (3) a description of restricted assets and purposes for which the assets were received;

219.7 (4) a description of debts, obligations, and liabilities of the corporation;

219.8 (5) a description of tangible assets being converted to cash and the manner in which
219.9 they will be sold;

219.10 (6) anticipated expenses of the transaction, including attorney fees;

219.11 (7) a list of persons to whom assets will be transferred, if known;

- 219.12 (8) the purposes of persons receiving the assets; and
- 219.13 (9) the terms, conditions, or restrictions, if any, to be imposed on the transferred assets.
- 219.14 The notice must be signed on behalf of the corporation by an authorized person.
- 219.15 Sec. 15. Minnesota Statutes 2016, section 317A.811, is amended by adding a subdivision
219.16 to read:
- 219.17 Subd. 1a. **Nonprofit health care entity; notice and approval required.** A corporation
219.18 that is a health maintenance organization or a service plan corporation is subject to notice
219.19 and approval requirements for certain transactions under section 317A.814.
- 219.20 Sec. 16. **[317A.814] NONPROFIT HEALTH CARE ENTITY CONVERSIONS.**
- 219.21 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.
- 219.22 (b) "Commissioner" means the commissioner of commerce if the nonprofit health care
219.23 entity at issue is a service plan corporation operating under chapter 62C, and the
219.24 commissioner of health if the nonprofit health care entity at issue is a health maintenance
219.25 organization operating under chapter 62D.
- 219.26 (c) "Conversion benefit entity" means a foundation, corporation, limited liability
219.27 company, trust, partnership, or other entity that receives public benefit assets, or their value,
219.28 in connection with a conversion transaction.
- 220.1 (d) "Conversion transaction" or "transaction" means a transaction in which a nonprofit
220.2 health care entity merges, consolidates, converts, or transfers all or a substantial portion of
220.3 its assets to an entity that is not a nonprofit corporation organized under this chapter that is
220.4 also exempt under United States Code, title 26, section 501(c)(3). The substitution of a new
220.5 corporate member that transfers the control, responsibility for, or governance of a nonprofit
220.6 health care entity is also considered a transaction for purposes of this section.
- 220.7 (e) "Family member" means a spouse, parent, or child or other legal dependent.
- 220.8 (f) "Nonprofit health care entity" means a service plan corporation operating under
220.9 chapter 62C and a health maintenance organization operating under chapter 62D.
- 220.10 (g) "Public benefit assets" means the entirety of a nonprofit health care entity's assets,
220.11 whether tangible or intangible.

220.12 (h) "Related organization" has the meaning given in section 317A.011.

220.13 Subd. 2. **Private inurement.** A nonprofit health care entity must not enter into a
220.14 conversion transaction if a person who has been an officer, director, or other executive of
220.15 the nonprofit health care entity, or of a related organization, or a family member of that
220.16 person:

220.17 (1) has or will receive any compensation or other financial benefit, directly or indirectly,
220.18 in connection with the conversion transaction;

220.19 (2) has held or will hold, regardless of whether guaranteed or contingent, an ownership
220.20 stake, stock, securities, investment, or other financial interest in, or receive any type of
220.21 compensation or other financial benefit from, any entity to which the nonprofit health care
220.22 entity transfers public benefit assets in connection with a conversion transaction; or

220.23 (3) has held or will hold, regardless of whether guaranteed or contingent, an ownership
220.24 stake, stock, securities, investment, or other financial interest in, or receive any type of
220.25 compensation or other financial benefit from, any entity that has or will have a business
220.26 relationship with any entity to which the nonprofit health care entity transfers public benefit
220.27 assets in connection with a conversion transaction.

220.28 Subd. 3. **Attorney general notice and approval required.** (a) Before entering into a
220.29 conversion transaction, the nonprofit health care entity must notify the attorney general as
220.30 specified under section 317A.811, subdivision 1. The notice required by this subdivision
220.31 also must include an itemization of the nonprofit health care entity's public benefit assets
220.32 and the valuation that the entity attributes to those assets, a proposed plan for distribution
220.33 of the value of those assets to a conversion benefit entity that meets the requirements of
221.1 subdivision 5, and other information from the health maintenance organization or the
221.2 proposed conversion benefit entity that the attorney general reasonably considers necessary
221.3 for review of the proposed transaction.

221.4 (b) A copy of the notice and other information required under this subdivision must be
221.5 given to the commissioner.

221.6 Subd. 4. **Review elements.** (a) The attorney general may approve, conditionally approve,
221.7 or not approve a conversion transaction under this section. In making a decision whether
221.8 to approve, conditionally approve, or not approve a proposed transaction, the attorney
221.9 general, in consultation with the commissioner, shall consider any factors the attorney
221.10 general considers relevant, including whether:

221.11 (1) the proposed transaction complies with this chapter and chapter 501B and other
221.12 applicable laws;

- 221.13 (2) the proposed transaction involves or constitutes a breach of charitable trust;
- 221.14 (3) the nonprofit health care entity will receive full and fair value for its public benefit
221.15 assets;
- 221.16 (4) the full and fair value of the public benefit assets to be transferred has been
221.17 manipulated in a manner that causes or has caused the value of the assets to decrease;
- 221.18 (5) the proceeds of the proposed transaction will be used consistent with the public
221.19 benefit for which the assets are held by the nonprofit health care entity;
- 221.20 (6) the proposed transaction will result in a breach of fiduciary duty, as determined by
221.21 the attorney general, including whether:
- 221.22 (i) conflicts of interest exist related to payments to or benefits conferred upon officers,
221.23 directors, board members, and executives of the nonprofit health care entity or a related
221.24 organization;
- 221.25 (ii) the nonprofit health care entity's board of directors exercised reasonable care and
221.26 due diligence in deciding to pursue the transaction, in selecting the entity with which to
221.27 pursue the transaction, and in negotiating the terms and conditions of the transaction; and
- 221.28 (iii) the nonprofit health care entity's board of directors considered all reasonably viable
221.29 alternatives, including any competing offers for its public benefit assets, or alternative
221.30 transactions;
- 222.1 (7) the transaction will result in private inurement to any person, including owners,
222.2 stakeholders, or directors, officers, or key staff of the nonprofit health care entity or entity
222.3 to which the nonprofit health care entity proposes to transfer public benefit assets;
- 222.4 (8) the conversion benefit entity meets the requirements of subdivision 5; and
- 222.5 (9) the attorney general and the commissioner have been provided with sufficient
222.6 information by the nonprofit health care entity to adequately evaluate the proposed transaction
222.7 and the effects on the public, provided the attorney general or the commissioner has notified
222.8 the nonprofit health care entity or the proposed conversion benefit entity of any inadequacy
222.9 of the information and has provided a reasonable opportunity to remedy that inadequacy.
- 222.10 In addition, the attorney general shall consider the public comments received regarding
222.11 the proposed conversion transaction and the proposed transaction's likely effect on the
222.12 availability, accessibility, and affordability of health care services to the public.

- 222.13 (b) The attorney general must consult with the commissioner in making a decision
222.14 whether to approve or disapprove a transaction.
- 222.15 Subd. 5. **Conversion benefit entity requirements.** (a) A conversion benefit entity must
222.16 be an existing or new domestic nonprofit corporation organized under this chapter and also
222.17 be exempt under United States Code, title 26, section 501(c)(3).
- 222.18 (b) The conversion benefit entity must be completely independent of any influence or
222.19 control by the nonprofit health care entity and related organizations, all entities to which
222.20 the nonprofit health care entity transfers any public benefit assets in connection with a
222.21 conversion transaction, and the directors, officers, and other executives of those organizations
222.22 or entities.
- 222.23 (c) The conversion benefit entity must have in place procedures and policies to prohibit
222.24 conflicts of interest, including but not limited to prohibiting conflicts of interests relating
222.25 to any grant-making activities that may benefit:
- 222.26 (1) the directors, officers, or other executives of the conversion benefit entity;
- 222.27 (2) any entity to which the nonprofit health care entity transfers any public benefit assets
222.28 in connection with a conversion transaction; or
- 222.29 (3) any directors, officers, or other executives of any entity to which the nonprofit health
222.30 care entity transfers any public benefit assets in connection with a conversion transaction.
- 222.31 (d) The charitable purpose and grant-making functions of the conversion benefit entity
222.32 must be dedicated to meeting the health care needs of the people of this state.
- 223.1 Subd. 6. **Public comment.** Before issuing a decision under subdivision 7, the attorney
223.2 general may solicit public comment regarding the proposed conversion transaction. The
223.3 attorney general may hold one or more public meetings or solicit written or electronic
223.4 correspondence. If a meeting is held, notice of the meeting must be published in a qualified
223.5 newspaper of general circulation in this state at least seven days before the meeting.
- 223.6 Subd. 7. **Period for approval or disapproval; extension.** (a) Within 150 days of
223.7 receiving notice of a proposed transaction, the attorney general shall notify the nonprofit
223.8 health care entity in writing of its decision to approve, conditionally approve, or disapprove
223.9 the transaction. If the transaction is not approved, the notice must include the reason for the
223.10 decision. If the transaction is conditionally approved, the notice must specify the conditions
223.11 that must be met. The attorney general may extend this period for an additional 90 days if
223.12 necessary to obtain additional information.

223.13 (b) The time periods under this subdivision are suspended during the time when a request
223.14 from the attorney general for additional information is outstanding.

223.15 Subd. 8. **Transfer of value of assets required.** If a proposed conversion transaction is
223.16 approved or conditionally approved by the attorney general, the nonprofit health care entity
223.17 shall transfer the entirety of the full and fair value of its public benefit assets to one or more
223.18 conversion benefit entities as part of the transaction.

223.19 Subd. 9. **Assessment of costs.** The nonprofit health care entity or the conversion benefit
223.20 entity must reimburse the attorney general or a state agency for all reasonable and actual
223.21 costs incurred by the attorney general or a state agency in reviewing a proposed conversion
223.22 transaction, including attorney fees at the billing rate used by the attorney general for state
223.23 agencies and the costs for retention of actuarial, valuation, or other experts or consultants,
223.24 and administrative costs.

223.25 Subd. 10. **Annual report by conversion benefit entity.** A conversion benefit entity
223.26 must submit an annual report to the attorney general that contains a detailed description of
223.27 its charitable activities related to the use of the public benefit assets received under a
223.28 transaction that is approved under this section.

223.29 Subd. 11. **Penalties; remedies.** A conversion transaction entered into in violation of
223.30 this section is null and void. The attorney general is authorized to bring an action to unwind
223.31 a conversion transaction entered into in violation of this section and to recover the amount
223.32 of any private inurement received or held in violation of subdivision 2. In addition to this
223.33 recovery, the officers, directors, and other executives of each entity that is a party to and
223.34 materially participated in a conversion transaction entered into in violation of this section
224.1 may be subject to a civil penalty of up to the greater of either the entirety of any financial
224.2 benefit each one derived from the transaction, or \$1,000,000, as determined by the court.
224.3 The attorney general is authorized to enforce this section pursuant to section 8.31.

224.4 Subd. 12. **Relation to other law.** (a) This section is in addition to, and does not affect
224.5 or limit any power, remedy, or responsibility of a health maintenance organization, service
224.6 plan corporation, a conversion benefit entity, the attorney general, or the commissioner
224.7 under this chapter, chapter 62C, 62D, 501B, or other law.

224.8 (b) Nothing in this section authorizes a nonprofit health care entity to enter into a
224.9 conversion transaction not otherwise permitted under this chapter.

224.10 Sec. 17. Laws 2017, chapter 2, article 1, section 1, subdivision 3, is amended to read:

224.11 Subd. 3. **Eligible individual.** "Eligible individual" means a Minnesota resident who:

224.12 (1) is not receiving ~~a~~ an advanced premium tax credit under Code of Federal Regulations,
224.13 title 26, section 1.36B-2, as of the date their coverage is effectuated in a month in which
224.14 their coverage is effective;

224.15 (2) is not enrolled in public program coverage under Minnesota Statutes, section
224.16 256B.055, or 256L.04; and

224.17 (3) purchased an individual health plan from a health carrier in the individual market.

224.18 Sec. 18. Laws 2017, chapter 2, article 1, section 2, subdivision 4, is amended to read:

224.19 Subd. 4. **Data practices.** (a) The definitions in Minnesota Statutes, section 13.02, apply
224.20 to this subdivision.

224.21 (b) Government data on an enrollee or health carrier under this section are private data
224.22 on individuals or nonpublic data, except that the total reimbursement requested by a health
224.23 carrier and the total state payment to the health carrier are public data.

224.24 (c) Notwithstanding Minnesota Statutes, section 138.17, not public government data on
224.25 an enrollee or health carrier collected under this section must be destroyed by June 30, 2018,
224.26 or upon completion by the legislative auditor of the audits required by section 3, whichever
224.27 is later, except to the extent the legislative auditor maintains data for a longer period of time
224.28 in order to comply with generally accepted government auditing standards.

225.1 Sec. 19. Laws 2017, chapter 2, article 1, section 2, is amended by adding a subdivision to
225.2 read:

225.3 Subd. 5. **Data sharing.** (a) Notwithstanding any law to the contrary, the commissioner
225.4 of human services and the executive director of MNsure must disclose to the commissioner
225.5 of management and budget data on public program coverage enrollment under Minnesota
225.6 Statutes, sections 256B.055 and 256L.04, data on an enrollee's receipt of an advanced
225.7 premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2.

225.8 (b) Notwithstanding any law to the contrary, the commissioner of management and
225.9 budget must disclose data to health carriers on enrollees' enrollment in public program
225.10 coverage under Minnesota Statutes, section 256B.055 or 256L.04, to the extent that the
225.11 commissioner determines the disclosure is necessary for purposes of determining eligibility
225.12 for the premium subsidy program authorized by this act.

225.13 (c) Data disclosed under this subdivision may be used only for the purpose of
225.14 administration of the premium subsidy program under this act and may not be further
225.15 disclosed to any other person, except as otherwise provided by law.

225.16 Sec. 20. Laws 2017, chapter 2, article 1, section 3, is amended to read:

225.17 Sec. 3. **AUDITS.**

225.18 (a) The legislative auditor shall conduct audits of the health carriers' supporting data, as
225.19 prescribed by the commissioner, to determine whether payments align with criteria
225.20 established in sections 1 and 2. The commissioner of human services shall provide data as
225.21 necessary to the legislative auditor to complete the audit. The commissioner shall withhold
225.22 or charge back payments to the health carriers to the extent they do not align with the criteria
225.23 established in sections 1 and 2, as determined by the audit.

225.24 (b) The legislative auditor shall audit the extent to which health carriers provided premium
225.25 subsidies to persons meeting the residency and other eligibility requirements specified in
225.26 section 1, subdivision 3. The legislative auditor shall report to the commissioner the amount
225.27 of premium subsidies provided by each health carrier to persons not eligible for a premium
225.28 subsidy. The commissioner, in consultation with the commissioners of commerce and,
225.29 health, and human services shall develop and implement a process to recover from health
225.30 carriers the amount of premium subsidies received for enrollees determined to be ineligible
225.31 for premium subsidies by the legislative auditor. The legislative auditor, when conducting
225.32 the required audit, and the commissioner, when determining the amount of premium subsidy
225.33 to be recovered, may take into account the extent to which a health carrier makes use of the
226.1 Minnesota eligibility system, as defined in Minnesota Statutes, section 62V.055, subdivision
226.2 1.

226.3 Sec. 21. Laws 2017, chapter 2, article 1, section 5, is amended to read:

226.4 Sec. 5. **SUNSET.**

226.5 This article ~~sunsets June 30~~, other than section 2, subdivision 5, and section 3, sunsets
226.6 August 31, 2018.

226.7 Sec. 22. Laws 2017, chapter 2, article 1, section 7, is amended to read:

226.8 Sec. 7. **APPROPRIATIONS.**

226.9 (a) \$311,788,000 in fiscal year 2017 is appropriated from the general fund to the
226.10 commissioner of management and budget for premium assistance under section 2. This
226.11 appropriation is onetime and is available through ~~June 30~~ August 31, 2018.

226.12 (b) \$157,000 in fiscal year 2017 is appropriated from the general fund to the legislative
226.13 auditor for purposes of section 3. This appropriation is onetime.

226.14 (c) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018,
226.15 shall be transferred ~~on July 1~~ no later than August 31, 2018, from the general fund to the
226.16 budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

226.17 Sec. 23. Laws 2017, chapter 2, article 2, section 13, is amended to read:
226.18 Sec. 13. **62Q.556 UNAUTHORIZED PROVIDER SERVICES.**

226.19 Subdivision 1. **Unauthorized provider services.** (a) Except as provided in paragraph
226.20 (c), unauthorized provider services occur when an enrollee receives services:

226.21 (1) from a nonparticipating provider at a participating hospital or ambulatory surgical
226.22 center, when the services are rendered:

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

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

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

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

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

227.3 (c) The services described in paragraph (a), clause (2), are not unauthorized provider
227.4 services if the enrollee gives advance written consent to the provider acknowledging that
227.5 the use of a provider, or the services to be rendered, may result in costs not covered by the
227.6 health plan.

227.7 Subd. 2. **Prohibition.** (a) An enrollee's financial responsibility for the unauthorized
227.8 provider services shall be the same cost-sharing requirements, including co-payments,
227.9 deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable
227.10 to services received by the enrollee from a participating provider. A health plan company
227.11 must apply any enrollee cost sharing requirements, including co-payments, deductibles, and
227.12 coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit
227.13 to the same extent payments to a participating provider would be applied.

227.14 (b) A health plan company must attempt to negotiate the reimbursement, less any
227.15 applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services

227.16 with the nonparticipating provider. If a health plan company's and nonparticipating provider's
227.17 attempts to negotiate reimbursement for the health care services do not result in a resolution,
227.18 the health plan company or provider may elect to refer the matter for binding arbitration,
227.19 chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by
227.20 both parties prior to engaging an arbitrator in accordance with this section. The cost of
227.21 arbitration must be shared equally between the parties.

227.22 (c) The commissioner of health, in consultation with the commissioner of the Bureau
227.23 of Mediation Services, must develop a list of professionals qualified in arbitration, for the
227.24 purpose of resolving disputes between a health plan company and nonparticipating provider
227.25 arising from the payment for unauthorized provider services. The commissioner of health
227.26 shall publish the list on the department of health's Web Site, and update the list as appropriate.

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

227.33 Subd. 3. **Scope.** This section does not apply to services provided under chapter 256B or
227.34 256L.

228.1 Sec. 24. Laws 2017, chapter 2, article 2, section 13, the effective date, is amended to read:

228.2 **EFFECTIVE DATE.** This section is effective ~~90 days following final enactment~~ January
228.3 1, 2019, and applies to provider services provided on or after that date.

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

228.5 Sec. 25. **WAIVER.**

228.6 MNsure shall seek any federal waivers necessary to permit enrollees to contact health
228.7 carriers directly to terminate individual health plan coverage according to Minnesota Statutes,
228.8 section 62K.16, when the individual purchased the coverage through MNsure.

228.9 **EFFECTIVE DATE.** This section is effective January 1, 2018, or upon federal approval
228.10 if required, whichever is later.