256B.1976 MANAGED CARE ORGANIZATION ASSESSMENT.

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

(b) "Commissioner" means the commissioner of human services.

(c) "Enrollee" has the meaning given in section 62Q.01, except that enrollee does not include:

(1) an individual enrolled in a Medicare plan;

(2) a plan-to-plan enrollee; or

(3) an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, to the extent the imposition of the assessment under this section is preempted pursuant to United States Code, title 5, section 8909, subsection (f).

(d) "Managed care organization" or "MCO" means:

(1) an insurance company licensed under chapter 60A to sell health plans as defined in section 62A.011;

(2) a nonprofit health services plan corporation as defined in section 62C.02, subdivision 6;

(3) a health maintenance organization licensed under chapter 62D; or

(4) a county-based purchasing plan participating in a public health care program under chapter 256B or 256L.

(e) "Medical assistance" means the medical assistance program established under chapter 256B.

(f) "Medical assistance enrollee" means an enrollee in medical assistance or MinnesotaCare for whom the Department of Human Services directly pays the managed care organization a capitated payment.

(g) "Member months" means the number of months an enrollee is covered by an MCO in the calendar year immediately preceding the year of the assessment.

(h) "MinnesotaCare" means the MinnesotaCare program established under chapter 256L.

(i) "Plan-to-plan enrollee" means an individual who receives coverage for health care services through a health plan pursuant to a subcontract from another health plan.

Subd. 2. **MCO assessment.** (a) An annual assessment is imposed on managed care organizations for each calendar year beginning in calendar year 2026. The total annual assessment amount is equal to the sum of the amounts assessed for medical assistance enrollees under paragraph (b) and for nonmedical assistance enrollees under paragraph (c).

(b) The amount assessed for medical assistance enrollees is equal to the sum of the following:

(1) for medical assistance member months 0 to 60,000, $0 per member month;

(2) for medical assistance member months 60,001 to 100,000, $340 per member month;

(3) for medical assistance member months 100,001 to 200,000, $365 per member month; and

(4) for medical assistance member months 200,001 to 350,000, $380 per member month.

(c) The amount assessed for nonmedical assistance enrollees is equal to the sum of the following:

(1) for nonmedical assistance member months 0 to 60,000, $0 per member month;

(2) for nonmedical assistance member months 60,001 to 100,000, 50 cents per member month;

(3) for nonmedical assistance member months 100,001 to 200,000, 75 cents per member month; and

(4) for nonmedical assistance member months 200,001 to 350,000, $1 per member month.

(d) The commissioner must annually use the commissioner's authority as necessary to modify the rate of assessment provided under paragraph (e) such that the annual assessment imposed under this subdivision does not exceed the forecasted cumulative costs attributable to the program changes in subdivision 4, paragraph (e), and the appropriation in subdivision 4, paragraph (f).

(e) The commissioner must, after consultation with managed care organizations likely to be affected, modify the rate of assessment, as set forth in paragraphs (a) to (d), as necessary to:

(1) comply with federal law; obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72; ensure the state's aggregated health care-related taxes on managed care organizations do not exceed 5.75 percent of the net patient revenue attributable to those services; or otherwise maximize under this section federal financial participation for medical assistance; and

(2) comply with paragraph (d).

Subd. 3. **Assessment computation; collection.** (a) The commissioner must annually forecast the following for each managed care organization:

(1) total member months for the calendar year;

(2) total Medicare member months for the calendar year;

(3) total medical assistance member months for the calendar year;

(4) total plan-to-plan member months for the calendar year;

(5) total member months through the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, for the calendar year; and

(6) total other enrollment for the calendar year that is not otherwise counted in clauses (2) to (5).

(b) Managed care organizations must provide any information requested by the commissioner for the purpose of this subdivision, provided that the commissioner determines such information is necessary to accurately determine the information in paragraph (a).

(c) The commissioner may correct errors in data provided to the commissioner by a managed care organization to the extent necessary to accurately determine the information in paragraph (a).

(d) For purposes of calculating the information in paragraph (a) for a managed care organization, the commissioner must count any individual that was an enrollee of a health plan at any point of the calendar year, regardless of the enrollee's duration as an enrollee of the health plan.

(e) The commissioner must annually use the information in paragraph (a) to compute the assessment for each managed care organization.

(f) The commissioner must collect the annual assessment for each managed care organization in four equal installments, in the manner determined by the commissioner.

(g) Managed care organizations must pay the four installments under paragraph (f) on the following schedule:

(1) the first installment is due by March 31;

(2) the second installment is due by July 31;

(3) the third installment is due by September 30; and

(4) the fourth installment is due by November 30.

(h) The commissioner is prohibited from collecting any amount under this section until 20 days after the commissioner has notified the managed care organization of:

(1) the effective date of this section; and

(2) the annual assessment amount.

(i) In the event of a merger, acquisition, or other transaction that results in the transfer of health plan responsibility to another managed care organization or similar entity, the surviving, acquiring, or controlling managed care organization or similar entity is responsible for paying the full assessment amount as provided in this section that would have been the responsibility of the managed care organization to which that full assessment amount was assessed upon the effective date of the transaction. If a transaction results in the transfer of health plan responsibility for only some of a health plan's enrollees under this section but not all enrollees, the full assessment amount as provided in this section remains the responsibility of the managed care organization to which that full assessment amount was assessed.

(j) The commissioner is prohibited from collecting any assessment under this subdivision during any period of time when the assessment is not considered a permissible health care-related tax under Code of Federal Regulations, title 42, section 433.68, or would result in a net loss of federal financial participation.

Subd. 4. **MCO assessment expenditures.** (a) All amounts collected by the commissioner under this section must be deposited in the special revenue fund.

(b) The arrangement under this section must be implemented in managed care through the prospective capitation rate setting process and must follow all federal requirements, including Code of Federal Regulations, title 42, section 438.5, paragraph (e).

(c) The assessment money must be used to supplement money for medical assistance from the general fund.

(d) The commissioner must disclose to all managed care organizations, in a time and manner determined by the commissioner, the following information:

(1) the assessments imposed on each managed care organization pursuant to this section; and

(2) an accounting of all money raised by the MCO assessment.

(e) All amounts collected by the commissioner under this section, except for the amount necessary for the appropriation under paragraph (f), are annually appropriated from the special revenue fund to the

commissioner to provide nonfederal money for medical assistance and MinnesotaCare program rate changes made in Laws 2025, First Special Session chapter 3, article 8, related to:

(1) behavioral health home services under section 256B.0757;

(2) mental health rates reimbursed under the resource-based relative value scale to 100 percent of the Medicare Physician Fee Schedule under section 256B.76, subdivision 6;

(3) mental health services under section 256B.761; and

(4) mental health services provided by masters-prepared mental health professionals and physician assistants resulting from the repeal of section 256B.0625, subdivision 38.

(f) Reasonable costs for administering the MCO assessment are annually appropriated from the special revenue fund to the commissioner.

(g) A payment rate adjusted under this paragraph may not be lower than the base payment rate for the service in effect on December 31, 2025.

(h) If provider payment rates are adjusted as the result of insufficient revenue from the MCO assessment relative to the medical assistance and MinnesotaCare program changes in paragraphs (e), clauses (1) to (4), and (f), as directed in Laws 2025, First Special Session chapter 3, article 8, the commissioner must:

(1) provide the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy an overview of the changes and recommended statutory language to codify the adjusted payment rate methodology; and

(2) consult with impacted providers and provide a public comment period of at least 30 days prior to seeking federal approval for rate changes.

History: *1Sp2025 c 3 art 8 s 33*

NOTE: This section, as added by Laws 2025, First Special Session chapter 3, article 8, section 33, is effective January 1, 2026, or upon federal approval for the assessment established in this section to be considered a permissible health care-related tax under Code of Federal Regulations, title 42, section 433.68, eligible for federal financial participation, including but not limited to federal approval of a waiver under Code of Federal Regulations, title 42, section 433.72, if such waiver is necessary to receive health care-related taxes without a reduction in federal financial participation, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 33, the effective date.