CHAPTER 62J

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62J.01 FINDINGS.

The legislature finds that substantial numbers of Minnesotans have no health care coverage and that most of these residents are wage earners or their dependents. One-third of these individuals are children.

The legislature further finds that when these individuals enter the health care system they have often forgone preventive care and are in need of more expensive treatment that often exceeds their financial resources. Much of the cost for these uncompensated services to the uninsured are already in the health care system in the form of increased insurance and provider rates and property and income taxes.

The legislature further finds that these costs, spread among the already insured, represent a woefully inefficient method for providing basic preventive and acute care for the uninsured and represent an added cost to employers now providing health insurance to their employees.

The legislature further finds that it is necessary to ensure basic and affordable health care to all Minnesotans while addressing the economic pressures on the health care system as a whole in Minnesota.

History: *1989 c 327 s 1*

COST CONTROLS

62J.015 PURPOSE.

The legislature finds that the staggering growth in health care costs is having a devastating effect on the health and cost of living of Minnesota residents. The legislature further finds that the number of uninsured and underinsured residents is growing each year and that the cost of health care coverage for our insured residents is increasing annually at a rate that far exceeds the state's overall rate of inflation.

The legislature further finds that it must enact immediate and intensive cost containment measures to limit the growth of health care expenditures, reform insurance practices, and finance a plan that offers access to affordable health care for our permanent residents by capturing dollars now lost to inefficiencies in Minnesota's health care system.

The legislature further finds that controlling costs is essential to the maintenance of the many factors contributing to the quality of life in Minnesota: our environment, education system, safe communities, affordable housing, provision of food, economic vitality, purchasing power, and stable population.

It is, therefore, the intent of the legislature to lay a new foundation for the delivery and financing of health care in Minnesota and to call this new foundation the MinnesotaCare Act.

History: *1992 c 549 art 1 s 1; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72*

62J.016 GOALS OF RESTRUCTURING.

The state seeks to bring about changes in the health care delivery and financing system that will assure quality, affordable, and accessible health care for all Minnesotans. This goal will be accomplished by restructuring the delivery system, the financial incentives, and the regulatory environment in a way that will make health care providers and health plan companies more accountable to consumers, group purchasers, and communities for their costs and quality, their effectiveness in meeting the health care needs of all of their patients and enrollees, and their contributions to improving the health of the greater community.

History: *1994 c 625 art 1 s 1*

62J.017 IMPLEMENTATION TIMETABLE.

The state seeks to complete the restructuring of the health care delivery and financing system. Beginning July 1, 1994, measures will be taken to increase the public accountability of existing health plan companies, to promote the development of small, community-based integrated service networks, and to reduce administrative costs by standardizing third-party billing forms and procedures and utilization review requirements.

History: *1994 c 625 art 1 s 2; 1995 c 234 art 3 s 1; 1997 c 225 art 2 s 9*

62J.02 [Repealed, 1989 c 327 s 4]

62J.03 DEFINITIONS.

Subdivision 1. **Scope of definitions.** For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. **Clinically effective.** "Clinically effective" means that the use of a particular medical technology improves patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology demonstrates a clinical advantage over alternative technologies.

Subd. 3. [Repealed, 1997 c 225 art 2 s 63]

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health, unless another commissioner is specified.

Subd. 5. **Cost-effective.** "Cost-effective" means that the economic costs of using a particular technology to achieve improvement in a patient's health outcome are justified given a comparison to both the economic costs and the improvement in patient health outcome resulting from the use of alternative technologies.

Subd. 6. **Group purchaser.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated

service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Subd. 7. **Improvement in health outcome.** "Improvement in health outcome" means an improvement in patient clinical status, and an improvement in patient quality-of-life status, as measured by ability to function, ability to return to work, and other variables.

Subd. 8. **Provider or health care provider.** "Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

Subd. 9. **Safety.** "Safety" means a judgment of the acceptability of risk of using a technology in a specified situation.

Subd. 10. **Health plan company.** "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4.

Subd. 11. **Health care entity.** "Health care entity" includes clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations, integrated provider and plan systems, county-based purchasing plans, health carriers, health care providers as defined under section 62J.03, subdivision 8, and entities required to report under section 62J.84.

History: *1992 c 549 art 1 s 2; 1993 c 345 art 3 s 1; art 4 s 1; art 6 s 1; 1994 c 625 art 8 s 14,15; 1997 c 225 art 2 s 62; 1Sp2021 c 4 art 4 s 1; 2023 c 70 art 16 s 2*

62J.04 MONITORING THE RATE OF GROWTH OF HEALTH CARE SPENDING.

Subdivision 1. **Cost containment goals.** (a) The commissioner of health shall set annual cost containment goals for public and private spending on health care services for Minnesota residents, as provided in paragraph (b). The cost containment goals must be set at levels the commissioner determines to be realistic and achievable but that will reduce the rate of growth in health care spending by at least ten percent per year for the next five years. The commissioner shall set cost containment goals based on available data on spending and growth trends, including data from group purchasers, national data on public and private sector health care spending and cost trends, and trend information from other states.

(b) The commissioner shall set the following annual cost containment goals for public and private spending on health care services for Minnesota residents:

(1) for calendar year 1994, the cost containment goal must not exceed the change in the regional Consumer Price Index for urban consumers for calendar year 1993 plus 6.5 percentage points;

(2) for calendar year 1995, the cost containment goal must not exceed the change in the regional Consumer Price Index for urban consumers for calendar year 1994 plus 5.3 percentage points;

(3) for calendar year 1996, the cost containment goal must not exceed the change in the regional Consumer Price Index for urban consumers for calendar year 1995 plus 4.3 percentage points;

(4) for calendar year 1997, the cost containment goal must not exceed the change in the regional Consumer Price Index for urban consumers for calendar year 1996 plus 3.4 percentage points; and

(5) for calendar year 1998, the cost containment goal must not exceed the change in the regional Consumer Price Index for urban consumers for calendar year 1997 plus 2.6 percentage points.

The commissioner shall adjust the cost containment goal set for calendar year 1995 to recover savings in health care spending required for the period July 1, 1993, to December 31, 1993.

(c) The commissioner shall publish:

(1) the projected cost containment goal in the State Register by April 15 of the year immediately preceding the year in which the cost containment goal will be effective except for the year 1993, in which the cost containment goal shall be published by July 1, 1993;

(2) the quarterly change in the regional Consumer Price Index for urban consumers; and

(3) the Centers for Medicare and Medicaid Services forecast for total growth in the national health care expenditures.

Subd. 1a. **Cost containment goals.** The commissioner shall publish the final adjusted cost containment goal in the State Register by January 31 of the year that the cost containment goal is to be in effect. The adjusted cost containment goal must reflect the actual regional Consumer Price Index for urban consumers for the previous calendar year, and may deviate from the previously published projected cost containment goal to reflect differences between the actual regional Consumer Price Index for urban consumers and the projected Consumer Price Index for urban consumers. The commissioner shall report to the legislature by February 15 of each year on the implementation of the cost containment goal. This annual report shall describe the differences between the projected increase in health care expenditures, the actual expenditures based on data collected, and the impact and validity of cost containment goals within the overall health care reform strategy.

Subd. 2. [Renumbered 62J.35, subdivision 1]

Subd. 2a. [Renumbered 62J.35, subd 2]

Subd. 2b. [Renumbered 62J.35, subd 3]

Subd. 3. **Cost containment duties.** The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.38 and 62J.40 to monitor statewide achievement of the cost containment goals;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes

of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

(3) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

(6) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(8) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans; and

(9) make the cost containment goal data available to the public in a consumer-oriented manner.

Subd. 4. [Repealed, 1997 c 225 art 2 s 63]

Subd. 5. **Appeals.** A person aggrieved may appeal a decision made under this chapter through a contested case proceeding governed under chapter 14. The notice of appeal must be served on the commissioner within 30 days of receiving notice of the decision. The commissioner shall decide the contested case.

Subd. 6. **Rulemaking.** The commissioner shall adopt rules under chapter 14 to implement this chapter.

Subd. 7. [Repealed, 1997 c 225 art 2 s 63]

Subd. 8. [Repealed, 1994 c 625 art 8 s 74]

Subd. 9. **Growth limits; federal programs.** The commissioners of health and human services shall establish a rate methodology for Medicare and Medicaid risk-based contracting with health plan companies that is consistent with statewide growth limits.

History: *1992 c 549 art 1 s 3; 1993 c 247 art 1 s 1-6; 1993 c 345 art 1 s 1; art 3 s 2-4,18; art 5 s 7,8; art 6 s 2,3; 1994 c 625 art 8 s 16-18; 1995 c 234 art 3 s 2; art 5 s 2; 1997 c 150 s 1-3; 1997 c 187 art 1 s 5; 1998 c 254 art 1 s 11; 1999 c 245 art 2 s 2; 2000 c 260 s 83; 2002 c 277 s 32; 1Sp2003 c 14 art 7 s 88; 1Sp2011 c 9 art 2 s 1; art 6 s 3*

62J.041 INTERIM HEALTH PLAN COMPANY COST CONTAINMENT GOALS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan company" has the definition provided in section 62Q.01.

(c) "Total expenditures" means incurred claims or expenditures on health care services, administrative expenses, charitable contributions, and all other payments made by health plan companies out of premium revenues.

(d) "Net expenditures" means total expenditures minus exempted taxes and assessments and payments or allocations made to establish or maintain reserves.

(e) "Exempted taxes and assessments" means direct payments for taxes to government agencies, contributions to the Minnesota Comprehensive Health Association, the medical assistance provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the Health Coverage Reinsurance Association, assessments by the Minnesota Life and Health Insurance Guaranty Association, assessments by the Minnesota Risk Adjustment Association, and any new assessments imposed by federal or state law.

(f) "Consumer cost-sharing or subscriber liability" means enrollee coinsurance, co-payment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. **Establishment.** The commissioner of health shall establish cost containment goals for the increase in net expenditures by each health plan company for calendar years 1994, 1995, 1996, and 1997. The cost containment goals must be the same as the annual cost containment goals for health care spending established under section 62J.04, subdivision 1, paragraph (b). Health plan companies that are affiliates may elect to meet one combined cost containment goal.

Subd. 3. **Determination of expenditures.** Health plan companies shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993; April 1, 1995, for calendar year 1994; April 1, 1996, for calendar year 1995; April 1, 1997, for calendar year 1996; and April 1, 1998, for calendar year 1997 all information the commissioner determines to be necessary to implement this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments and the election to meet one cost containment goal for affiliated health plan companies must be submitted to the commissioner by September 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.

Subd. 4. **Monitoring of reserves.** (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to assess the degree to which savings resulting from the establishment of cost containment goals are passed on to consumers in the form of lower premium rates.

(b) Health plan companies shall fully reflect in the premium rates the savings generated by the cost containment goals. No premium rate, currently reviewed by the Department of Health or Commerce, may be approved for those health plan companies unless the health plan company establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year. These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as a community integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end of the quarter and enrollment changes within each service area of the new organization. The reserve calculations shall be maintained by the commissioners as trade secret information, except to the extent that such information is also required to be filed by another provision of state law and is not treated as trade secret information under such other provisions.

(d) Health plan companies in paragraph (c) whose reserves are less than the required minimum or more than the required maximum at the end of the fiscal year shall submit a plan of corrective action to the commissioner of health or commerce under subdivision 7.

(e) The commissioner of commerce, in consultation with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements.

Subd. 5. **Notice.** The commissioner of health shall publish in the State Register and make available to the public by July 1, 1995, a list of all health plan companies that exceeded their cost containment goal for the 1994 calendar year. The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined cost containment goal for calendar years 1994 and 1995. The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its cost containment goal, at least 30 days before publishing the list, and shall provide each health plan company with ten days to provide an explanation for exceeding the cost containment goal. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. **Assistance by the commissioner of commerce.** The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health plan companies regulated by the commissioner of commerce.

Subd. 7. [Repealed by amendment, 1997 c 150 s 4]

History: *1993 c 345 art 2 s 4; 1994 c 625 art 3 s 4; 1995 c 234 art 3 s 9; 1997 c 150 s 4; 1997 c 225 art 2 s 62*

62J.0416 IDENTIFY STRATEGIES FOR REDUCTION OF ADMINISTRATIVE SPENDING AND LOW-VALUE CARE.

(a) The commissioner of health shall develop recommendations for strategies to reduce the volume and growth of administrative spending by health care organizations and group purchasers, and the magnitude of low-value care delivered to Minnesota residents. The commissioner shall:

(1) review the availability of data and identify gaps in the data infrastructure to estimate aggregated and disaggregated administrative spending and low-value care;

(2) based on available data, estimate the volume and change over time of administrative spending and low-value care in Minnesota;

(3) conduct an environmental scan and key informant interviews with experts in health care finance, health economics, health care management or administration, and the administration of health insurance benefits to determine drivers of spending growth for spending on administrative services or the provision of low-value care; and

(4) convene a clinical learning community and an employer task force to review the evidence from clauses (1) to (3) and develop a set of actionable strategies to address administrative spending volume and growth and the magnitude of the volume of low-value care.

(b) By March 31, 2025, the commissioner shall deliver the recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy.

History: *2023 c 70 art 16 s 3*

62J.0417 PAYMENT MECHANISMS IN RURAL HEALTH CARE.

(a) The commissioner shall develop a plan to assess readiness of rural communities and rural health care providers to adopt value-based, global budgeting or alternative payment systems and recommend steps needed to implement them. The commissioner may use the development of case studies and modeling of alternate payment systems to demonstrate value-based payment systems that ensure a baseline level of essential community or regional health services and address population health needs.

(b) The commissioner shall develop recommendations for pilot projects with the aim of ensuring financial viability of rural health care entities in the context of spending growth targets. The commissioner shall include the plan, recommendations, and related findings in the reports required under section 62J.312, subdivision 3.

History: *2023 c 70 art 16 s 4*

62J.042 [Repealed, 1997 c 150 s 6]

62J.045 [Repealed, 1995 c 234 art 8 s 57]

62J.05 [Repealed, 1997 c 225 art 2 s 63]

62J.051 [Repealed, 1997 c 225 art 2 s 63]

62J.052 PROVIDER COST DISCLOSURE.

Subdivision 1. [Repealed, 2007 c 147 art 15 s 22]

Subd. 2. **Pharmacies.** (a) Each pharmacy, as defined in section 151.01, subdivision 2, shall provide the following information to a patient upon request:

(1) the pharmacy's own usual and customary price for a prescription drug;

(2) a record, including all transactions on record with the pharmacy both past and present, of all co-payments and other cost-sharing paid to the pharmacy by the patient for up to two years; and

(3) the total amount of all co-payments and other cost-sharing paid to the pharmacy by the patient over the previous two years.

(b) The information required under paragraph (a) must be readily available at no cost to the patient.

History: *2005 c 147 art 11 s 2; 2006 c 255 s 21*

62J.06 MS 2024 [Repealed, 2026 c 127 art 1 s 44]

62J.07 Subdivision 1. [Repealed, 1Sp2011 c 9 art 6 s 97]

Subd. 2. [Repealed, 1Sp2011 c 9 art 6 s 97]

Subd. 3. [Repealed, 1Sp2011 c 9 art 6 s 97]

Subd. 4. [Repealed, 1995 c 234 art 8 s 57]

62J.09 [Repealed, 1999 c 245 art 2 s 6]

62J.15 Subdivision 1. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 1a. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 2. [Repealed, 1993 c 345 art 4 s 7; 1Sp2003 c 14 art 7 s 89]

62J.152 Subdivision 1. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 1a. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 2. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 3. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 4. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 5. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 6. [Repealed, 1995 c 234 art 3 s 10; 1Sp2003 c 14 art 7 s 89]

Subd. 7. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 8. [Repealed, 1Sp2003 c 14 art 7 s 89]

62J.156 MS 2024 [Repealed, 2026 c 127 art 1 s 44]

62J.17 EXPENDITURE REPORTING.

Subdivision 1. **Purpose.** To ensure access to affordable health care services for all Minnesotans it is necessary to restrain the rate of growth in health care costs. An important factor believed to contribute to escalating costs may be the purchase of costly new medical equipment, major capital expenditures, and the addition of new specialized services. After spending limits are established under section 62J.04, providers, patients, and communities will have the opportunity to decide for themselves whether they can afford capital expenditures or new equipment or specialized services within the constraints of a spending limit. In this environment, the state's role in reviewing these spending commitments can be more limited. However, during the interim period until spending targets are established, it is important to prevent unrestrained major spending commitments that will contribute further to the escalation of health care costs and make future cost containment efforts more difficult. In addition, it is essential to protect against the possibility that the legislature's expression of its attempt to control health care costs may lead a provider to make major spending commitments before targets or other cost containment constraints are fully implemented because the provider recognizes that the spending commitment may not be considered appropriate, needed, or affordable within the context of a fixed budget for health care spending. Therefore, the legislature finds that a requirement for reporting health care expenditures is necessary.

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

(b) "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

(c) "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

(d) "Major spending commitment" means an expenditure in excess of $1,000,000 for:

(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

(e) "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

(f) "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

(g) "Specialty care" includes but is not limited to cardiac, neurology, orthopedic, obstetrics, mental health, substance use disorder, and emergency services.

Subd. 3. **Hospital and nursing home moratoria preserved; nursing homes exempt.** Nothing in this section supersedes or limits the applicability of section 144.551 or 144A.071. This section does not apply to major spending commitments made by nursing homes or intermediate care facilities that are related to the provision of long-term care services to residents.

Subd. 4. [Repealed, 1993 c 345 art 6 s 26]

Subd. 4a. **Expenditure reporting.** Each hospital, outpatient surgical center, diagnostic imaging center, and physician, advanced practice registered nurse, or physician assistant clinic shall report annually to the commissioner on all major spending commitments, in the form and manner specified by the commissioner. The report shall include the following information:

(1) a description of major spending commitments made during the previous year, including the total dollar amount of major spending commitments and purpose of the expenditures;

(2) the cost of land acquisition, construction of new facilities, and renovation of existing facilities;

(3) the cost of purchased or leased medical equipment, by type of equipment;

(4) expenditures by type for specialty care and new specialized services;

(5) information on the amount and types of added capacity for diagnostic imaging services, outpatient surgical services, and new specialized services; and

(6) information on investments in electronic medical records systems.

For hospitals and outpatient surgical centers, this information shall be included in reports to the commissioner that are required under section 144.698. For diagnostic imaging centers, this information shall be included in reports to the commissioner that are required under section 144.565. For all other health care providers that are subject to this reporting requirement, reports must be submitted to the commissioner by March 1 each year for the preceding calendar year.

Subd. 5. [Repealed, 1993 c 345 art 6 s 26]

Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review each major spending commitment and determine whether the major spending commitment was appropriate. In making the determination, the commissioner may consider the following criteria: the major spending commitment's impact on the cost, access, and quality of health care; the clinical effectiveness and cost-effectiveness of the major spending commitment; and the alternatives available to the provider. If the major expenditure is determined to not be appropriate, the commissioner shall notify the provider.

(b) The commissioner may not prevent or prohibit a major spending commitment subject to retrospective review. However, if the provider fails the retrospective review, any major spending commitments by that provider for the five-year period following the commissioner's decision are subject to prospective review under subdivision 6a.

Subd. 6. [Repealed, 1993 c 345 art 6 s 26]

Subd. 6a. **Prospective review and approval.** (a) No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under subdivision 7.

(c) The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under subdivision 7. In making this determination, the commissioner may also consider relevant information from other sources. The commissioner shall make a decision on the application within 60 days after an application is received.

(d) The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

Subd. 7. **Exceptions.** (a) The reporting requirement in subdivision 4a does not apply to:

(1) a major spending commitment made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school, or by a federal or foundation grant or clinical trials;

(2) a major spending commitment for building maintenance including heating, water, electricity, and other maintenance-related expenditures; and

(3) a major spending commitment for activities, not directly related to the delivery of patient care services, including food service, laundry, housekeeping, and other service-related activities.

(b) In addition to the exceptions listed in paragraph (a), the reporting requirement in subdivision 4a does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

Subd. 8. **Radiation therapy facilities.** (a) This subdivision shall apply only to those major spending commitments that are related to the purchase, construction, or leasing of a radiation therapy facility.

(b) The term "provider" shall mean:

(1) a provider as defined in section 62J.03, subdivision 8;

(2) a person or organization that, upon engaging in an activity related to a major spending commitment, will become a provider as defined in section 62J.03, subdivision 8;

(3) an organization under common control with an organization described in clause (1) or (2); or

(4) an organization that manages a person or organization described in clause (1), (2), or (3).

(c) In conducting the retrospective or prospective review, the commissioner shall consider the criteria described in subdivision 5a, paragraph (a), in determining whether the major spending commitment was appropriate. In addition, the commissioner shall consider the following criteria:

(1) the alternatives available to patients in terms of avoiding an unwarranted duplication based on whether additional capacity is needed of services, facilities, or equipment in and around the location of the major spending commitment; and

(2) the best interests of the patients, including conflicts of interest that may be present in influencing the utilization of the services, facility, or equipment relating to the major spending commitment.

(d) In addition to subdivision 6a, paragraph (c), the commissioner has the authority to pursue the following remedies:

(1) assessment of fines against providers violating subdivision 6a, paragraph (a), of up to triple the amount of the major spending commitment;

(2) securing a permanent injunction against providers violating subdivision 6a, paragraph (a), halting the purchase or construction of a facility, prohibiting the operation of a facility, or the providing of a service related to the major spending commitment; and

(3) obtaining a court order to invalidate any purchase agreement, management agreement, lease, or other contract relating to the major spending commitment or the conduct of any activity relating to the major spending commitment.

(e) If a provider fails the retrospective review of a major spending commitment that is identified under this subdivision, the prospective review and approval required under subdivision 6a shall be limited to major spending commitments that are identified under this subdivision.

(f) The provisions of this subdivision do not apply to radiation therapy facilities owned and operated or managed by a hospital licensed under chapter 144.

History: *1992 c 549 art 1 s 8; 1993 c 345 art 6 s 9-11; 1995 c 234 art 8 s 8-10; 1997 c 225 art 2 s 21; 1998 c 254 art 1 s 12; 2000 c 307 s 1; 1Sp2003 c 14 art 7 s 11; 2007 c 147 art 9 s 1-4; 1Sp2011 c 9 art 2 s 2; 2020 c 115 art 4 s 3; 2022 c 58 s 7; 2022 c 98 art 4 s 51; 2023 c 70 art 3 s 1; 2026 c 127 art 1 s 2*

62J.19 [Repealed, 1995 c 234 art 8 s 57]

62J.21 [Repealed, 1993 c 247 art 1 s 21]

62J.212 PUBLIC HEALTH GOALS.

The commissioner shall establish specific public health goals including, but not limited to, increased delivery of prenatal care, improved birth outcomes, and expanded childhood immunizations. The commissioner shall consider the community public health goals and the input of the statewide advisory committee on community health in establishing the statewide goals.

History: *1993 c 345 art 5 s 9; 1995 c 234 art 5 s 4*

62J.22 PARTICIPATION OF FEDERAL PROGRAMS.

The commissioner of health shall seek the full participation of federal health care programs under this chapter, including Medicare, medical assistance, veterans administration programs, and other federal programs. The commissioner of human services shall submit waiver requests and take other action necessary to obtain federal approval to allow participation of the medical assistance program. If federal approval is not given for one or more federal programs, data on the amount of health care spending that is collected under section 62J.04 shall be adjusted so that state and regional spending limits take into account the failure of the federal program to participate.

History: *1992 c 549 art 1 s 11; 1997 c 225 art 2 s 22*

62J.23 PROVIDER CONFLICTS OF INTEREST.

Subdivision 1. **Rules prohibiting conflicts of interest.** The commissioner of health shall adopt rules restricting financial relationships or payment arrangements involving health care providers under which a person benefits financially by referring a patient to another person, recommending another person, or furnishing or recommending an item or service. The rules must be compatible with, and no less restrictive than, the federal Medicare antikickback statute, in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and regulations adopted under it. However, the commissioner's rules may be more restrictive than the federal law and regulations and may apply to additional provider groups and business and professional arrangements. When the state rules restrict an arrangement or relationship that is permissible under federal laws and regulations, including an arrangement or relationship expressly permitted under the federal safe harbor regulations, the fact that the state requirement is more restrictive than federal requirements must be clearly stated in the rule.

Subd. 2. **Restrictions.** (a) From July 1, 1992, until rules are adopted by the commissioner under this section, the restrictions in the federal Medicare antikickback statutes in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and rules adopted under the federal statutes, apply to all persons in the state, regardless of whether the person participates in any state health care program.

(b) Nothing in paragraph (a) shall be construed to prohibit an individual from receiving a discount or other reduction in price or a limited-time free supply or samples of a prescription drug, medical supply, or medical equipment offered by a pharmaceutical manufacturer, medical supply or device manufacturer, health plan company, or pharmacy benefit manager, so long as:

(1) the discount or reduction in price is provided to the individual in connection with the purchase of a prescription drug, medical supply, or medical equipment prescribed for that individual;

(2) it otherwise complies with the requirements of state and federal law applicable to enrollees of state and federal public health care programs;

(3) the discount or reduction in price does not exceed the amount paid directly by the individual for the prescription drug, medical supply, or medical equipment; and

(4) the limited-time free supply or samples are provided by a physician, advanced practice registered nurse, physician assistant, or pharmacist, as provided by the federal Prescription Drug Marketing Act.

For purposes of this paragraph, "prescription drug" includes prescription drugs that are administered through infusion, injection, or other parenteral methods, and related services and supplies.

(c) No benefit, reward, remuneration, or incentive for continued product use may be provided to an individual or an individual's family by a pharmaceutical manufacturer, medical supply or device manufacturer, or pharmacy benefit manager, except that this prohibition does not apply to:

(1) activities permitted under paragraph (b);

(2) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan company, or pharmacy benefit manager providing to a patient, at a discount or reduced price or free of charge, ancillary products necessary for treatment of the medical condition for which the prescription drug, medical supply, or medical equipment was prescribed or provided; and

(3) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan company, or pharmacy benefit manager providing to a patient a trinket or memento of insignificant value.

(d) Nothing in this subdivision shall be construed to prohibit a health plan company from offering a tiered formulary with different co-payment or cost-sharing amounts for different drugs.

Subd. 3. **Penalty.** The commissioner may assess a fine against a person who violates this section. The amount of the fine is $1,000 or 110 percent of the estimated financial benefit that the person realized as a result of the prohibited financial arrangement or payment relationship, whichever is greater. A person who is in compliance with a transition plan approved by the commissioner under subdivision 2, or who is making a good faith effort to obtain the commissioner's approval of a transition plan, is not in violation of this section.

Subd. 4. **Chapter 62N networks.** (a) The legislature finds that the formation and operation of community integrated service networks will accomplish the purpose of the federal Medicare antikickback statute, which is to reduce the overutilization and overcharging that may result from inappropriate provider incentives. Accordingly, it is the public policy of the state of Minnesota to support the development of community integrated service networks. The legislature finds that the federal Medicare antikickback laws should not

be interpreted to interfere with the development of community integrated service networks or to impose liability for arrangements between an integrated service network or a community integrated service network and its participating entities.

(b) An arrangement between a community integrated service network and any or all of its participating entities is not subject to liability under subdivisions 1 and 2.

Subd. 5. **Audits of exempt providers.** The commissioner may audit the referral patterns of providers that qualify for exceptions under the federal Stark Law, United States Code, title 42, section 1395nn. The commissioner has access to provider records according to section 144.99, subdivision 2. The commissioner shall report to the legislature any audit results that reveal a pattern of referrals by a provider for the furnishing of health services to an entity with which the provider has a direct or indirect financial relationship.

History: *1992 c 549 art 1 s 12; 1993 c 247 art 1 s 17; 1993 c 345 art 6 s 13; 1994 c 625 art 8 s 23; 1997 c 225 art 2 s 62; 1Sp2003 c 14 art 7 s 12; 2004 c 280 s 1; 2004 c 288 art 6 s 7; 1Sp2019 c 9 art 9 s 1; 2020 c 115 art 4 s 4; 1Sp2021 c 4 art 3 s 15; 2022 c 58 s 8*

62J.25 MANDATORY MEDICARE ASSIGNMENT.

(a) Effective January 1, 1993, a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 115 percent of the Medicare-approved amount for any Medicare-covered service provided.

(b) Effective January 1, 1994, a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 110 percent of the Medicare-approved amount for any Medicare-covered service provided.

(c) Effective January 1, 1995, a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 105 percent of the Medicare-approved amount for any Medicare-covered service provided.

(d) Effective January 1, 1996, a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of the Medicare-approved amount for any Medicare-covered service provided.

(e) This section does not apply to ambulance services as defined in section 144E.001, subdivision 3, or medical supplies and equipment. A vendor of medical supplies and equipment that does not accept assignment under the federal Medicare program with respect to a purchase or lease of Medicare-covered supplies or equipment shall notify any purchaser who is a Medicare beneficiary and Minnesota resident, prior to the purchase, or at any time upon the request of the purchaser, that the vendor charges an amount in excess of the Medicare-approved amount.

History: *1992 c 549 art 1 s 13; 1997 c 199 s 14; 1997 c 225 art 2 s 23; 1998 c 339 s 1*

62J.26 EVALUATION OF PROPOSED HEALTH COVERAGE MANDATES.

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

(1) "commissioner" means the commissioner of commerce;

(2) "enrollee" has the meaning given in section 62Q.01, subdivision 2b;

(3) "health plan" means a health plan as defined in section 62A.011, subdivision 3, but includes coverage listed in clauses (7) and (10) of that definition;

(4) "mandated health benefit proposal" or "proposal" means a proposal that would statutorily require a health plan company to do the following:

(i) provide coverage or increase the amount of coverage for the treatment of a particular disease, condition, or other health care need;

(ii) provide coverage or increase the amount of coverage of a particular type of health care treatment or service or of equipment, supplies, or drugs used in connection with a health care treatment or service;

(iii) provide coverage for care delivered by a specific type of provider;

(iv) require a particular benefit design or impose conditions on cost-sharing for:

(A) the treatment of a particular disease, condition, or other health care need;

(B) a particular type of health care treatment or service; or

(C) the provision of medical equipment, supplies, or a prescription drug used in connection with treating a particular disease, condition, or other health care need; or

(v) impose limits or conditions on a contract between a health plan company and a health care provider.

(b) "Mandated health benefit proposal" does not include health benefit proposals:

(1) amending the scope of practice of a licensed health care professional; or

(2) that make state law consistent with federal law.

Subd. 2. **Evaluation process and content.** (a) The commissioner, in consultation with the commissioners of health and management and budget, must evaluate all mandated health benefit proposals as provided under subdivision 3.

(b) The purpose of the evaluation is to provide the legislature with a complete and timely analysis of all ramifications of any mandated health benefit proposal. The evaluation must include, in addition to other relevant information, the following to the extent applicable:

(1) scientific and medical information on the mandated health benefit proposal, on the potential for harm or benefit to the patient, and on the comparative benefit or harm from alternative forms of treatment, and must include the results of at least one professionally accepted and controlled trial comparing the medical consequences of the proposed therapy, alternative therapy, and no therapy;

(2) public health, economic, and fiscal impacts of the mandated health benefit proposal on persons receiving health services in Minnesota, on the relative cost-effectiveness of the proposal, and on the health care system in general;

(3) the extent to which the treatment, service, equipment, or drug is generally utilized by a significant portion of the population;

(4) the extent to which insurance coverage for the mandated health benefit proposal is already generally available;

(5) the extent to which the mandated health benefit proposal, by health plan category, would apply to the benefits offered to the health plan's enrollees;

(6) the extent to which the mandated health benefit proposal will increase or decrease the cost of the treatment, service, equipment, or drug;

(7) the extent to which the mandated health benefit proposal may increase enrollee premiums; and

(8) if the proposal applies to a qualified health plan as defined in section 62A.011, subdivision 7, the cost to the state to defray the cost of the mandated health benefit proposal using commercial market reimbursement rates in accordance with Code of Federal Regulations, title 45, section 155.170.

(c) The commissioner shall consider actuarial analysis done by health plan companies and any other proponent or opponent of the mandated health benefit proposal in determining the cost of the proposal.

(d) The commissioner must summarize the nature and quality of available information on these issues, and, if possible, must provide preliminary information to the public. The commissioner may conduct research on these issues or may determine that existing research is sufficient to meet the informational needs of the legislature. The commissioner may seek the assistance and advice of researchers, community leaders, or other persons or organizations with relevant expertise. The commissioner must provide the public with at least 45 days' notice when requesting information pursuant to this section. The commissioner must notify the chief authors of a bill when a request for information is issued.

(e) Information submitted to the commissioner pursuant to this section that meets the definition of trade secret information, as defined in section 13.37, subdivision 1, paragraph (b), is nonpublic data.

Subd. 3. **Requirements for evaluation.** (a) No later than August 1 of the year preceding the legislative session in which an incumbent legislator is planning on introducing a bill containing a mandated health benefit proposal or is planning on offering an amendment to a bill that adds a mandated health benefit, the prospective author must notify the chair of one of the standing legislative committees that have jurisdiction over the subject matter of the proposal. No later than 15 days after notification is received, the chair must notify the commissioner that an evaluation of a mandated health benefit proposal is required to be completed in accordance with this section in order to inform the legislature before any action is taken on the proposal by either house of the legislature.

(b) The commissioner must conduct an evaluation described in subdivision 2 of each mandated health benefit proposal for which an evaluation is required under paragraph (a).

(c) If the evaluation of multiple proposals are required, the commissioner must consult with the chairs of the standing legislative committees having jurisdiction over the subject matter of the mandated health benefit proposals to prioritize the evaluations and establish a reporting date for each proposal to be evaluated.

(d) The commissioner must maintain the ability to conduct an evaluation for one mandated health benefit proposal per even-numbered year that is introduced or offered by a legislator who was not seated by the deadline for notification under paragraph (a). The commissioner must conduct an evaluation of the mandated health benefit proposal offered or introduced pursuant to this paragraph in an expedited manner, taking into consideration the complexity of the proposal.

Subd. 4. **Sources of funding.** (a) The commissioner shall not use any funds for purposes of this section other than as provided in this subdivision or as specified in an appropriation.

(b) The commissioner may seek and accept funding from sources other than the state to pay for evaluations under this section to supplement or replace state appropriations. Any money received under this paragraph must be deposited in the state treasury, credited to a separate account for this purpose in the special revenue fund, and is appropriated to the commissioner for purposes of this section.

(c) If an evaluation is required under this section, the commissioner may use for purposes of the evaluation:

(1) any funds appropriated to the commissioner specifically for purposes of this section; or

(2) funds available under paragraph (b), if use of the funds for evaluation of that mandated health benefit proposal is consistent with any restrictions imposed by the source of the funds.

(d) The commissioner must ensure that the source of the funding has no influence on the process or outcome of the evaluation.

Subd. 5. **Report to legislature.** The commissioner must submit a written report on the evaluation to the author of the proposal and to the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance policy and finance no later than 180 days after the commissioner receives notification from a chair as required under subdivision 3.

Subd. 6. **Adoption of forms.** (a) No later than July 1, 2026, the commissioner of commerce must adopt forms for:

(1) an incumbent legislator to notify the chair of the mandated health benefit proposal under subdivision 3, paragraph (a); and

(2) the chair to notify the commissioner of the mandated health benefit proposal under subdivision 3, paragraph (a).

(b) The forms adopted under this subdivision must include all information needed from the legislator introducing or offering the mandated health benefit proposal for the commissioner to conduct the required evaluation.

History: *1Sp2003 c 14 art 7 s 13; 2008 c 204 s 42; 2009 c 101 art 2 s 109; 1Sp2021 c 4 art 4 s 2-6; 2023 c 57 art 2 s 20,21; 1Sp2025 c 4 art 3 s 9,10*

62J.29 [Repealed, 1993 c 345 art 6 s 26]

62J.2911 [Repealed, 1997 c 237 s 22]

62J.2912 [Repealed, 1997 c 237 s 22]

62J.2913 [Repealed, 1997 c 237 s 22]

62J.2914 [Repealed, 1997 c 237 s 22]

62J.2915 [Repealed, 1997 c 237 s 22]

62J.2916 [Repealed, 1997 c 237 s 22]

62J.2917 [Repealed, 1997 c 237 s 22]

62J.2918 [Repealed, 1997 c 237 s 22]

62J.2919 [Repealed, 1997 c 237 s 22]

62J.2920 [Repealed, 1997 c 237 s 22]

62J.2921 [Repealed, 1997 c 237 s 22]

INFORMATION CLEARINGHOUSE

62J.2930 INFORMATION CLEARINGHOUSE.

Subdivision 1. **Establishment.** The commissioner of health shall establish an information clearinghouse within the Department of Health to facilitate the ability of consumers, employers, providers, health plan companies, and others to obtain information on health reform activities in Minnesota. The commissioner shall make available through the clearinghouse updates on federal and state health reform activities, including information developed or collected by the Department of Health on cost containment or other research initiatives, the development of voluntary purchasing pools, action plans submitted by health plan companies, reports or recommendations of entities on technology assessments, and reports or recommendations from other formal committees applicable to health reform activities. The clearinghouse shall also refer requestors to sources of further information or assistance. The clearinghouse is subject to chapter 13.

Subd. 2. **Information on health plan companies.** The information clearinghouse shall provide information on all health plan companies operating in a specific geographic area to consumers and purchasers who request it.

Subd. 3. **Consumer information.** (a) The information clearinghouse or another entity designated by the commissioner shall provide consumer information to health plan company enrollees to:

(1) assist enrollees in understanding their rights;

(2) explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, and the Departments of Health and Commerce;

(3) provide information on coverage options in each region of the state;

(4) provide information on the availability of purchasing pools and enrollee subsidies; and

(5) help consumers use the health care system to obtain coverage.

(b) The information clearinghouse or other entity designated by the commissioner for the purposes of this subdivision shall not:

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

(3) serve as an advocate for consumers in disputes with health plan companies.

(c) Nothing in this subdivision shall interfere with the ombudsman program established under section 256B.6903 or other existing ombudsman programs.

Subd. 4. MS 2024 [Repealed, 2026 c 127 art 1 s 44]

History: *1995 c 234 art 5 s 5; 1997 c 225 art 2 s 62; 1999 c 245 art 2 s 7; 2009 c 173 art 3 s 1; 2022 c 98 art 2 s 1; 2026 c 127 art 1 s 3*

62J.30 [Repealed, 1995 c 234 art 5 s 24]

DATA COLLECTION AND RESEARCH INITIATIVES

62J.301 RESEARCH AND DATA INITIATIVES.

Subdivision 1. **Definitions.** (a) For purposes of sections 62J.2930 to 62J.42, the following definitions apply:

(b) "Health outcomes data" means data used in research designed to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition, in order to determine the most appropriate and cost-effective means to prevent, diagnose, treat, or manage the condition, or in order to develop and test methods for reducing inappropriate or unnecessary variations in the type and frequency of interventions.

(c) "Encounter level data" means data related to the utilization of health care services by, and the provision of health care services to individual patients, enrollees, or insureds, including claims data, abstracts of medical records, and data from patient interviews and patient surveys.

Subd. 2. **Statement of purpose.** The commissioner of health shall conduct data and research initiatives in order to monitor and improve the efficiency and effectiveness of health care in Minnesota.

Subd. 3. **General duties.** The commissioner shall:

(1) collect and maintain data which enable population-based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;

(2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;

(3) collect and maintain data for the purposes of setting cost containment goals under section 62J.04, and measuring cost containment goal compliance;

(4) conduct applied research using existing and new data and promote applications based on existing research;

(5) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plan companies, as defined in section 62Q.01, subdivision 4;

(6) work closely with health plan companies and health care providers to promote improvements in health care efficiency and effectiveness; and

(7) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management.

Subd. 4. **Information to be collected.** (a) The data collected may include health outcomes data, patient functional status, and health status. The data collected may include information necessary to measure and make adjustments for differences in the severity of patient condition across different health care providers, and may include data obtained directly from the patient or from patient medical records, as provided in section 62J.321, subdivision 1.

(b) The commissioner may:

(1) collect the encounter level data required for the research and data initiatives of sections 62J.301 to 62J.42, using, to the greatest extent possible, standardized forms and procedures; and

(2) process the data collected to ensure validity, consistency, accuracy, and completeness, and as appropriate, merge data collected from different sources.

(c) For purposes of estimating total health care spending and forecasting rates of growth in health care spending, the commissioner may collect from health care providers data on patient revenues and health care spending during a time period specified by the commissioner. The commissioner may also collect data on health care revenues and spending from group purchasers of health care. Health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. Professional licensing boards and state agencies responsible for licensing, registering, or regulating providers and group purchasers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements.

Subd. 5. **Nonlimiting.** Nothing in this chapter shall be construed to limit the powers granted to the commissioner of health under chapter 62D, 62N, 144, or 144A.

History: *1995 c 234 art 5 s 6; 1997 c 150 s 5*

62J.31 [Repealed, 1995 c 234 art 5 s 24]

62J.311 ANALYSIS AND USE OF DATA.

Subdivision 1. **Data analysis.** The commissioner shall analyze the data collected to:

(1) assist the state in developing and refining its health policy in the areas of access, utilization, quality, and cost;

(2) assist the state in promoting efficiency and effectiveness in the financing and delivery of health services;

(3) monitor and track accessibility, utilization, quality, and cost of health care services within the state;

(4) evaluate the impact of health care reform activities;

(5) assist the state in its public health activities; and

(6) evaluate and determine the most appropriate methods for ongoing data collection.

Subd. 2. **Criteria for data and research initiatives.** (a) Data and research initiatives by the commissioner, pursuant to sections 62J.301 to 62J.42, must:

(1) serve the needs of the general public, public sector health care programs, employers and other purchasers of health care, health care providers, including providers serving large numbers of people with low-income, and health plan companies as applicable;

(2) be based on scientifically sound and statistically valid methods;

(3) be statewide in scope, to the extent feasible, in order to benefit health care purchasers and providers in all parts of Minnesota and to ensure broad and representative health care data for research comparisons and applications;

(4) emphasize data that is useful, relevant, and nonredundant of existing data. The initiatives may duplicate existing private data collection activities, if necessary to ensure that the data collected will be in the public domain;

(5) be structured to minimize the administrative burden on health plan companies, health care providers, and the health care delivery system, and minimize any privacy impact on individuals; and

(6) promote continuous improvement in the efficiency and effectiveness of health care delivery.

(b) Data and research initiatives related to public sector health care programs must:

(1) assist the state's current health care financing and delivery programs to deliver and purchase health care in a manner that promotes improvements in health care efficiency and effectiveness;

(2) assist the state in its public health activities, including the analysis of disease prevalence and trends and the development of public health responses;

(3) assist the state in developing and refining its overall health policy, including policy related to health care costs, quality, and access; and

(4) provide data that allows the evaluation of state health care financing and delivery programs.

History: *1995 c 234 art 5 s 7*

62J.312 CENTER FOR HEALTH CARE AFFORDABILITY.

Subdivision 1. **Center establishment; research and analysis.** (a) The commissioner shall establish a center for health care affordability within the Minnesota Department of Health. The commissioner, through the center, shall carry out the duties assigned under this section.

(b) The commissioner shall conduct research on and analyze the drivers of health care spending growth in order to increase transparency and identify strategies that help to reduce waste and low-value care; eliminate unproductive administrative spending; enhance the provision of effective, high-value care; consider the sustainability of health care spending growth and the relationship of health care spending growth to health equity; and identify delivery system, payment, and health care market reforms to increase health care affordability.

(c) To perform the duties under paragraph (b), the commissioner shall:

(1) identify additional data needed from health care entities and the level of granularity of required reporting, while limiting additional reporting burdens to the extent possible by ensuring effective use of existing data and reporting mechanisms;

(2) establish the form and manner for data reporting, including but not limited to data specifications, methods of reporting, and reporting schedules;

(3) assist reporting entities in submitting data and information; and

(4) conduct background research and environmental scans, perform qualitative and quantitative analyses, and perform economic modeling.

Subd. 2. **Public input.** (a) The commissioner shall obtain public feedback on the research agenda for the center for health care affordability and on the research activities conducted under this section by consulting with health care entities, licensed physicians and other health care providers, employers and other purchasers,

the commissioners of human services and management and budget, patients and patient advocates, individuals with expertise in health care spending or health economics, and other stakeholders. The commissioner may convene an advisory body or bodies to obtain public feedback.

(b) The commissioner shall hold public hearings, at least annually, to share initial and final analyses conducted under this section, solicit community input on strategies to strengthen health care affordability, and hear testimony about experiences and challenges related to health care affordability.

Subd. 3. **Reporting.** The commissioner shall provide periodic reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy describing the analyses conducted under this section and making recommendations for strategies to address unsustainable rates of health care spending growth.

Subd. 4. **Contracting.** In carrying out the duties required by this section, the commissioner may contract with entities with expertise in health economics, health care finance, accounting, and actuarial science.

Subd. 5. **Access to information.** (a) The commissioner may request that a state agency provide data in a usable format as requested by the commissioner at no cost to the commissioner.

(b) The commissioner may also request from a state agency unique or custom data sets. That agency may charge the commissioner for providing the data at the same rate the agency would charge any other public or private entity.

(c) Unless specified elsewhere in statute, any information provided to the commissioner by a state agency must be de-identified. For purposes of this requirement, "de-identified" means that a process was used to prevent the identity of a person from being connected with information and to ensure that all identifiable information has been removed.

(d) Notwithstanding any provisions to the contrary, the commissioner may use data collected and maintained under section 62U.04 to carry out the duties required under this section.

(e) Any health care entity subject to reporting under this section that fails to provide data in the form and manner prescribed by the commissioner is subject to a fine paid to the commissioner of up to $500 for each day the data are past due. The commissioner may grant an extension of the reporting deadlines upon a showing of good cause by the entity. Any fine levied against the entity under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 and 14.69.

(f) Any data submitted to the commissioner must retain their original classification under the Minnesota Data Practices Act under chapter 13.

Subd. 6. MS 2023 Supp [Repealed, 2024 c 127 art 59 s 57]

History: *2023 c 70 art 16 s 5*

62J.32 [Repealed, 1995 c 234 art 5 s 24]

62J.321 DATA COLLECTION AND PROCESSING PROCEDURES.

Subdivision 1. **Data collection.** (a) The commissioner shall collect data from health care providers, health plan companies, and individuals in the most cost-effective manner, which does not unduly burden them. The commissioner may require health care providers and health plan companies to collect and provide patient health records and claim files, and cooperate in other ways with the data collection process. The commissioner may also require health care providers and health plan companies to provide mailing lists of

patients. Patient consent shall not be required for the release of data to the commissioner pursuant to sections 62J.301 to 62J.42 by any group purchaser, health plan company, health care provider; or agent, contractor, or association acting on behalf of a group purchaser or health care provider. Any group purchaser, health plan company, health care provider; or agent, contractor, or association acting on behalf of a group purchaser or health care provider, that releases data to the commissioner in good faith pursuant to sections 62J.301 to 62J.42 shall be immune from civil liability and criminal prosecution.

(b) When a group purchaser, health plan company, or health care provider submits patient identifying data to the commissioner pursuant to sections 62J.301 to 62J.42, and the data is submitted to the commissioner in electronic form, or through other electronic means including, but not limited to, the electronic data interchange system, the group purchaser, health plan company, or health care provider shall submit the patient identifying data in encrypted form, using an encryption method specified by the commissioner. Submission of encrypted data as provided in this paragraph satisfies the requirements of section 144.293, subdivision 7.

(c) The commissioner shall require all health care providers, group purchasers, and state agencies to use a standard patient identifier and a standard identifier for providers and health plan companies when reporting data under this chapter. The commissioner must encrypt patient identifiers to prevent identification of individual patients and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consistent with chapter 13 and sections 62J.55 and 144.291 to 144.298. This encryption must ensure that any data released must be in a form that makes it impossible to identify individual patients.

Subd. 2. **Failure to provide data.** The intentional failure to provide the data requested under this chapter is grounds for disciplinary or regulatory action against a regulated provider or group purchaser. The commissioner may assess a fine against a provider or group purchaser who refuses to provide data required by the commissioner. If a provider or group purchaser refuses to provide the data required, the commissioner may obtain a court order requiring the provider or group purchaser to produce documents and allowing the commissioner to inspect the records of the provider or group purchaser for purposes of obtaining the data required.

Subd. 3. **Data collection and review.** Data collection must continue for a sufficient time to permit: adequate analysis by researchers and appropriate providers, including providers who will be impacted by the data; feedback to providers; monitoring for changes in practice patterns; and the data and research criteria of section 62J.311, subdivision 2, to be fulfilled.

Subd. 4. **Use of existing data.** (a) The commissioner shall negotiate with private sector organizations currently collecting health care data of interest to the commissioner to obtain required data in a cost-effective manner and minimize administrative costs. The commissioner shall attempt to establish links between the health care data collected to fulfill sections 62J.301 to 62J.42 and existing private sector data and shall consider and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

(b) The commissioner shall use existing public sector data, such as those existing for medical assistance and Medicare, to the greatest extent possible. The commissioner shall establish links between existing public sector data and consider and implement methods to streamline public sector data collection in order to reduce public and private sector administrative costs.

Subd. 5. **Data classification.** (a) Data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 that identify individual patients or providers are private data on individuals. Data not on individuals are nonpublic data. The commissioner shall establish procedures and safeguards to ensure

that data released by the commissioner is in a form that does not identify specific patients, providers, employers, individual or group purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter.

(b) Raw unaggregated data collected from household and employer surveys used by the commissioner to monitor the number of uninsured individuals, reasons for lack of insurance coverage, and to evaluate the effectiveness of health care reform, are subject to the same data classifications as data collected pursuant to sections 62J.301 to 62J.42.

(c) Notwithstanding sections 13.03, subdivisions 6 to 8; 13.10, subdivisions 1 to 4; and 138.17, data received by the commissioner pursuant to sections 62J.301 to 62J.42, shall retain the classification designated under this section and shall not be disclosed other than pursuant to this section.

(d) Summary data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 may be disseminated under section 13.05, subdivision 7. For the purposes of this section, summary data includes nonpublic data not on individuals.

(e) Notwithstanding paragraph (a), the commissioner may publish nonpublic or private data collected pursuant to sections 62J.301 to 62J.42 on health care costs and spending, quality and outcomes, and utilization for health care institutions, individual health care professionals and groups of health care professionals, and group purchasers, with a description of the methodology used for analysis. The commissioner may not make public any patient identifying information except as specified in law. The commissioner shall not reveal the name of an institution, group of professionals, individual health care professional, or group purchaser until after the institution, group of professionals, individual health care professional, or group purchaser has had 21 days to review the data and comment. The commissioner shall include comments received in the release of the data.

(f) A provider or group purchaser may contest whether the data meets the criteria of section 62J.311, subdivision 2, paragraph (a), clause (2), in accordance with a contested case proceeding as set forth in sections 14.57 to 14.62, subject to appeal in accordance with sections 14.63 to 14.68. To obtain a contested case hearing, the provider or group purchaser must make a written request to the commissioner before the end of the time period for review and comment. Within ten days of the assignment of an administrative law judge, the provider or group purchaser shall make a clear showing to the administrative law judge of probable success in a hearing on the issue of whether the data are accurate and valid and were collected based on the criteria of section 62J.311, subdivision 2, paragraph (a), clause (2). If the administrative law judge determines that the provider or group purchaser has made such a showing, the data shall remain private or nonpublic during the contested case proceeding and appeal. If the administrative law judge determines that the provider or group purchaser has not made such a showing, the commissioner may publish the data immediately, with comments received in the release of the data. The contested case proceeding and subsequent appeal is not an exclusive remedy and any person may seek a remedy pursuant to section 13.08, subdivisions 1 to 4, or as otherwise authorized by law.

Subd. 5a. [Repealed, 1Sp2011 c 9 art 2 s 29]

Subd. 6. **Rulemaking.** The commissioner may adopt rules to implement sections 62J.301 to 62J.42.

Subd. 7. **Federal and other grants.** The commissioner may seek federal funding, and funding from private and other nonstate sources, for data and research initiatives.

Subd. 8. **Contracts and grants.** To carry out the duties assigned in sections 62J.301 to 62J.42, the commissioner may contract with or provide grants to private sector entities. Any contract or grant must

require the private sector entity to maintain the data which it receives according to the statutory provisions applicable to the data.

History: *1995 c 234 art 5 s 8; 1997 c 225 art 2 s 62; 1998 c 407 art 2 s 3; 1Sp2003 c 14 art 7 s 88; 2007 c 147 art 10 s 15*

62J.322 [Repealed, 2014 c 192 art 4 s 3]

62J.33 [Repealed, 1995 c 234 art 5 s 24]

62J.34 [Repealed, 1995 c 234 art 5 s 24]

62J.35 [Repealed, 1995 c 234 art 5 s 24]

62J.37 [Repealed, 1997 c 225 art 2 s 63]

62J.38 COST CONTAINMENT DATA FROM GROUP PURCHASERS.

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for each calendar year. Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data must distinguish between costs incurred for patient care and administrative costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and substance use disorder services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made during the calendar year for these purposes. The commissioner shall make public, by group purchaser data collected under this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation insurance plans and automobile insurance plans are exempt from complying with this paragraph as it relates to the submission of administrative costs.

(c) The commissioner may collect information on:

(1) premiums, benefit levels, managed care procedures, and other features of health plan companies;

(2) prices, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses; and

(3) information on health care services not provided through health plan companies, including information on prices, costs, expenditures, and utilization.

(d) All group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

History: *1993 c 345 art 3 s 10; 1994 c 625 art 8 s 28; 1995 c 234 art 5 s 11; 1Sp2001 c 9 art 16 s 4; 2002 c 379 art 1 s 113; 2022 c 98 art 4 s 51*

62J.381 [Repealed, 1Sp2011 c 9 art 2 s 29]

62J.40 COST CONTAINMENT DATA FROM STATE AGENCIES AND OTHER GOVERNMENTAL UNITS.

(a) All state departments or agencies that administer one or more health care programs shall provide to the commissioner of health any additional data on the health care programs they administer that is requested by the commissioner of health, including data in unaggregated form, for purposes of developing estimates of spending, setting spending limits, and monitoring actual spending. The data must be provided at the times and in the form specified by the commissioner of health.

(b) For purposes of estimating total health care spending as provided in section 62J.301, subdivision 4, clause (c), all local governmental units shall provide expenditure data to the commissioner. The commissioner shall consult with representatives of the affected local government units in establishing definitions, reporting formats, and reporting time frames. As much as possible, the data shall be collected in a manner that ensures that the data collected is consistent with data collected from the private sector and minimizes the reporting burden to local government.

(c) A state agency that purchases health care services, provides oversight over health insurance rates, collects taxes imposed under section 295.52, or regulates health care entities must provide to the commissioner nonpublic data the commissioner requests to satisfy statutory duties under sections 62J.301 to 62J.461, 62J.84, 62J.87, 62U.01 to 62U.10, 144.70, 145D.01, and 145D.02, with respect to monitoring the health care market, including but not limited to consolidation, transaction, corporate structure, utilization, quality, spending growth, and prescription drug supply chains.

(d) The commissioner may request unique or custom data sets from a state agency in a request under paragraph (c). The state agency may charge the commissioner a fee to provide data sets under paragraph (c) at the same rate the state agency charges another public or private entity for the same data.

(e) Data provided to the commissioner under paragraph (c) retains the data's original classification under chapter 13. Data provided to the commissioner under paragraph (c) may be included in public reports if the data are aggregated and deidentified.

History: *1993 c 345 art 3 s 11; 1995 c 234 art 5 s 12; 2026 c 124 art 3 s 4*

62J.41 Subdivision 1. [Repealed, 1Sp2011 c 9 art 2 s 29]

Subd. 2. [Repealed, 1Sp2011 c 9 art 2 s 29]

Subd. 3. [Repealed, 1995 c 234 art 5 s 24]

Subd. 4. [Repealed, 1995 c 234 art 5 s 24]

62J.42 QUALITY, UTILIZATION, AND OUTCOME DATA.

The commissioner shall also require group purchasers and health care providers to maintain and periodically report information on quality of care, utilization, and outcomes. The information must be provided at the times and in the form specified by the commissioner.

History: *1993 c 345 art 3 s 13*

62J.43 [Expired, 2004 c 288 art 7 s 2]

62J.431 EVIDENCE-BASED HEALTH CARE GUIDELINES.

Evidence-based guidelines must meet the following criteria:

(1) the scope and application are clear;

(2) authorship is stated and any conflicts of interest disclosed;

(3) authors represent all pertinent clinical fields or other means of input have been used;

(4) the development process is explicitly stated;

(5) the guideline is grounded in evidence;

(6) the evidence is cited and grated;

(7) the document itself is clear and practical;

(8) the document is flexible in use, with exceptions noted or provided for with general statements;

(9) measures are included for use in systems improvement; and

(10) the guideline has scheduled reviews and updating.

History: *2007 c 147 art 15 s 1*

62J.44 [Repealed, 1995 c 234 art 5 s 24]

62J.45 [Repealed, 1995 c 234 art 5 s 24]

62J.451 [Repealed, 1Sp2003 c 14 art 7 s 89]

62J.452 [Repealed, 1Sp2003 c 14 art 7 s 89]

62J.46 MONITORING AND REPORTS.

Subdivision 1. **Long-term care costs.** The commissioner shall use existing state data resources to monitor trends in public and private spending on long-term care costs and spending in Minnesota. The commissioner shall recommend to the legislature any additional data collection activities needed to monitor these trends. State agencies collecting information on long-term care spending and costs shall coordinate

with the Interagency Long-Term Care Planning Committee and the commissioner to facilitate the monitoring of long-term care expenditures in the state.

Subd. 2. **Cost shifting.** The commissioner shall monitor the extent to which reimbursement rates for government health care programs lead to the shifting of costs to private payers. By January 1, 1995, the commissioner shall report any evidence of cost shifting to the legislature and make recommendations on adjustments to the cost containment plan that should be made due to cost shifting.

History: *1993 c 345 art 3 s 16; 2001 c 161 s 13*

62J.461 340B COVERED ENTITY REPORT.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "340B covered entity" or "covered entity" means a covered entity as defined in United States Code, title 42, section 256b(a)(4), with a service address in Minnesota as of January 1 of the reporting year. 340B covered entity includes all entity types and grantees. All facilities that are identified as child sites or grantee associated sites under the federal 340B Drug Pricing Program are considered part of the 340B covered entity.

(c) "340B Drug Pricing Program" or "340B program" means the drug discount program established under United States Code, title 42, section 256b.

(d) "340B entity type" is the designation of the 340B covered entity according to the entity types specified in United States Code, title 42, section 256b(a)(4).

(e) "340B ID" is the unique identification number provided by the Health Resources and Services Administration to identify a 340B-eligible entity in the 340B Office of Pharmacy Affairs Information System.

(f) "Contract pharmacy" means a pharmacy with which a 340B covered entity has an arrangement to dispense drugs purchased under the 340B Drug Pricing Program.

(g) "Pricing unit" means the smallest dispensable amount of a prescription drug product that can be dispensed or administered.

Subd. 2. **Current registration.** Beginning April 1, 2024, each 340B covered entity must maintain a current registration with the commissioner in a form and manner prescribed by the commissioner. The registration must include the following information:

(1) the name of the 340B covered entity;

(2) the 340B ID of the 340B covered entity;

(3) the servicing address of the 340B covered entity; and

(4) the 340B entity type of the 340B covered entity.

Subd. 3. **Reporting by covered entities to the commissioner.** (a) Each 340B covered entity shall report to the commissioner by April 1 of each year the following information for transactions conducted by the 340B covered entity or on its behalf, and related to its participation in the federal 340B program for the previous calendar year:

(1) the aggregated acquisition cost for prescription drugs obtained under the 340B program;

(2) the aggregated payment amount received for drugs obtained under the 340B program and dispensed or administered to patients:

(i) that are net of the contracted price for insurance claims payments; and

(ii) that reflect the portion of payment received from grants, cash, or other payment types that relate to the dispensing or administering of drugs obtained under the 340B program;

(3) the number of pricing units dispensed or administered for prescription drugs described in clause (2); and

(4) the aggregated payments made:

(i) to contract pharmacies to dispense drugs obtained under the 340B program;

(ii) to any other entity that is not the covered entity and is not a contract pharmacy for managing any aspect of the covered entity's 340B program; and

(iii) for other internal, direct expenses related to administering the 340B program with a detailed description of the direct costs included.

The information under clauses (2) and (3) must be reported by payer type, including but not limited to commercial insurance, medical assistance, MinnesotaCare, and Medicare, in the form and manner prescribed by the commissioner.

(b) For covered entities that are hospitals, the information required under paragraph (a), clauses (1) to (3), must also be reported at the national drug code level for the 50 most frequently dispensed or administered drugs by the facility under the 340B program.

(c) Data submitted to the commissioner under paragraphs (a) and (b) are classified as nonpublic data, as defined in section 13.02, subdivision 9.

Subd. 4. **Enforcement and exceptions.** (a) Any covered entity subject to reporting under this section that fails to provide data in the form and manner prescribed by the commissioner is subject to the levy of a fine of up to $500 for each day the data are past due. Any fine levied against the entity under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) The commissioner may grant an entity an extension of or exemption from the reporting obligations under this section, upon a showing of good cause by the entity.

Subd. 5. **Reports to the legislature.** By November 15, 2024, and by November 15 of each year thereafter, the commissioner shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy, a report that aggregates the data submitted under subdivision 3, paragraphs (a) and (b). For all 340B entities whose net 340B revenue constitutes a significant share, as determined by the commissioner, of all net 340B revenue across all 340B covered entities in Minnesota, the following information must also be included in the report:

(1) the information submitted under subdivision 2; and

(2) for each 340B entity identified in subdivision 2, that entity's 340B net revenue as calculated using the data submitted under subdivision 3, paragraph (a), with net revenue being subdivision 3, paragraph (a), clause (2), less the sum of subdivision 3, paragraph (a), clauses (1) and (4).

For all other entities, the data in the report must be aggregated to the entity type or groupings of entity types in a manner that prevents the identification of an individual entity and any entity's specific data value reported for an individual data element.

History: *2024 c 127 art 59 s 2; 1Sp2025 c 3 art 2 s 1-3*

62J.47 [Repealed, 1999 c 86 art 1 s 83]

CRITERIA FOR AMBULANCE SERVICES REIMBURSEMENT

62J.48 CRITERIA FOR AMBULANCE SERVICES REIMBURSEMENT.

All ambulance services licensed under section 144E.10 are eligible for reimbursement under health plan companies. The commissioner shall require health plan companies to adopt the following reimbursement policies.

(1) All scheduled or prearranged air and ground ambulance transports must be reimbursed if requested by an attending physician, nurse, or physician assistant, and, if the person is an enrollee in a health plan company, if approved by a designated representative of a health plan company who is immediately available on a 24-hour basis. The designated representative must be a registered nurse or a physician assistant with at least three years of critical care or trauma experience, or a licensed physician.

(2) Reimbursement must be provided for all emergency ambulance calls in which a patient is transported or medical treatment rendered.

(3) Special transportation services must not be billed or reimbursed if the patient needs medical attention immediately before transportation.

History: *1994 c 625 art 4 s 1; 1995 c 234 art 8 s 11; 1997 c 199 s 14; 2022 c 58 s 9*

62J.49 AMBULANCE SERVICES FINANCIAL DATA.

Subdivision 1. **Establishment.** The director of the Office of Emergency Medical Services established under chapter 144E shall establish a financial data collection system for all ambulance services licensed in this state. To establish the financial database, the director may contract with an entity that has experience in ambulance service financial data collection.

Subd. 2. **Data classification.** All financial data collected by the director of the Office of Emergency Medical Services shall be classified as nonpublic data under section 13.02, subdivision 9.

History: *1997 c 203 art 2 s 1; 2024 c 122 art 1 s 24; art 2 s 3; 2024 c 127 art 63 s 22; art 64 s 3*

HEALTH INFORMATION TECHNOLOGY

62J.495 ELECTRONIC HEALTH RECORD TECHNOLOGY.

Subdivision 1. **Implementation.** The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop uniform standards to be used for the interoperable electronic health records system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. Individual health care providers in private practice with no other providers and health care providers that

do not accept reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6, are excluded from the requirements of this section.

Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH Act to meet the standards and implementation specifications adopted under section 3004 as applicable.

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

(c) "Pharmaceutical electronic data intermediary" means any entity that provides the infrastructure to connect computer systems or other electronic devices utilized by prescribing practitioners with those used by pharmacies, health plans, third-party administrators, and pharmacy benefit managers in order to facilitate the secure transmission of electronic prescriptions, refill authorization requests, communications, and other prescription-related information between such entities.

(d) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act in division A, title XIII and division B, title IV of the American Recovery and Reinvestment Act of 2009, including federal regulations adopted under that act.

(e) "Interoperable electronic health record" means an electronic health record that securely exchanges health information with another electronic health record system that meets requirements specified in subdivision 3, and national requirements for certification under the HITECH Act.

(f) "Qualified electronic health record" means an electronic record of health-related information on an individual that includes patient demographic and clinical health information and has the capacity to:

(1) provide clinical decision support;

(2) support provider order entry;

(3) capture and query information relevant to health care quality; and

(4) exchange electronic health information with, and integrate such information from, other sources.

Subd. 2. **E-Health Advisory Committee.** (a) The commissioner shall establish an e-Health Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the adoption and effective use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for clinical data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data;

(3) recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions; and

(4) other related issues as requested by the commissioner.

(b) The members of the e-Health Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce; a representative of the Direct Care and

Treatment executive board; and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the commissioner to fulfill the requirements of section 3013, paragraph (g), of the HITECH Act.

(c) This subdivision expires June 30, 2031.

Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(b) The electronic health record must be a qualified electronic health record.

(c) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(d) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(e) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(f) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a health data intermediary as defined in section 62J.498.

(g) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in consultation with the e-Health Advisory Committee, shall update the statewide implementation plan required under subdivision 2 and released June 2008, to be consistent with the updated federal plans.

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

(1) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care. Communications about available financial and technical support shall include clear information about the interoperable health record requirements in subdivision 1, including a separate statement in bold-face type clarifying the exceptions to those requirements;

(2) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information, including the requirements in sections 144.291 to 144.298. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

(3) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, including the requirements in sections 144.291 to 144.298, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

(4) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards committees;

(2) reviewing and evaluating policy proposed by national HIT policy committees relating to the implementation of a nationwide health information technology infrastructure; and

(3) monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

Subd. 5. **Collection of data for assessment and eligibility determination.** (a) The commissioner of health, in consultation with the commissioner of human services, may require providers, dispensers, group purchasers, and pharmaceutical electronic data intermediaries to submit data in a form and manner specified by the commissioner to assess the status of adoption, effective use, and interoperability of electronic health records for the purpose of:

(1) demonstrating Minnesota's progress on goals established by the Office of the National Coordinator to accelerate the adoption and effective use of health information technology established under the HITECH Act;

(2) assisting the Centers for Medicare and Medicaid Services and the Department of Human Services in determining eligibility of health care professionals and hospitals to receive federal incentives for the

adoption and effective use of health information technology under the HITECH Act or other federal incentive programs;

(3) assisting the Office of the National Coordinator in completing required assessments of the impact of the implementation and effective use of health information technology in achieving goals identified in the national strategic plan, and completing studies required by the HITECH Act;

(4) providing the data necessary to assist the Office of the National Coordinator in conducting evaluations of regional extension centers as required by the HITECH Act; and

(5) other purposes as necessary to support the implementation of the HITECH Act.

(b) The commissioner shall coordinate with the commissioner of human services and other state agencies in the collection of data required under this section to:

(1) avoid duplicative reporting requirements;

(2) maximize efficiencies in the development of reports on state activities as required by HITECH; and

(3) determine health professional and hospital eligibility for incentives available under the HITECH Act.

(c) The commissioner must not collect data or publish analyses that identify, or could potentially identify, individual patients. The commissioner must not collect individual patient data in identified or de-identified form.

Subd. 6. **State agency information system.** Development of state agency information systems necessary to implement this section is subject to the authority of the Department of Information Technology Services in chapter 16E, including, but not limited to:

(1) evaluation and approval of the system as specified in section 16E.03, subdivisions 3 and 4;

(2) review of the system to ensure compliance with security policies, guidelines, and standards as specified in section 16E.03, subdivision 7; and

(3) assurance that the system complies with accessibility standards developed under section 16E.03, subdivision 9.

Subd. 7. **Authority to administer Minnesota electronic health record incentives program.** The commissioner of human services shall administer an electronic health record incentives program according to section 4201 of the American Recovery and Reinvestment Act, Public Law 111-5 and Code of Federal Regulations, title 42, part 495.

Subd. 8. **Definitions.** (a) For purposes of subdivisions 7 to 11, the following terms have the meanings given.

(b) "Certified electronic health record technology" has the same meaning as defined in Code of Federal Regulations, title 42, part 495.4.

(c) "Commissioner" means the commissioner of the Department of Human Services.

(d) "National Level Repository" or "NLR" has the same meaning as defined in Code of Federal Regulations, title 42, part 495.

(e) "SMHP" means the state Medicaid health information technology plan.

(f) "MEIP" means the Minnesota electronic health record incentive program in this section.

(g) "Pediatrician" means a physician who is certified by either the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.

Subd. 9. **Registration, application, and payment processing.** (a) Eligible providers and eligible hospitals must successfully complete the NLR registration process defined by the Centers for Medicare and Medicaid Services before applying for the Minnesota electronic health record incentives program.

(b) The commissioner shall collect any improper payments made under the Minnesota electronic health record incentives program.

(c) Eligible providers and eligible hospitals enrolled in the Minnesota electronic health record incentives program must retain all records supporting eligibility for a minimum of six years.

(d) The commissioner shall determine the allowable methodology options to be used by eligible providers and eligible hospitals for purposes of attesting to and calculating their Medicaid patient volume per Code of Federal Regulations, title 42, part 495.306.

(e) Minnesota electronic health record incentives program payments must be processed and paid to the tax identification number designated by the eligible provider or eligible hospital.

(f) The payment mechanism for Minnesota electronic health record incentives program payments must be determined by the commissioner.

(g) The commissioner shall determine the 12-month period selected by the state as referenced in Code of Federal Regulation, title 42, part 495.310 (g)(1)(i)(B).

Subd. 10. **Audits.** The commissioner is authorized to audit an eligible provider or eligible hospital that applies for an incentive payment through the Minnesota electronic health record incentives program, both before and after payment determination. The commissioner is authorized to use state and federal laws, regulations, and circulars to develop the department's audit criteria.

Subd. 11. **Provider appeals.** An eligible provider or eligible hospital who has received notification of an adverse action related to the Minnesota electronic health record incentives program may appeal the action pursuant to this section.

Subd. 12. **MEIP appeals.** An eligible provider or eligible hospital who has received notice of an appealable issue related to the Minnesota electronic health record incentives program may appeal the action in accordance with procedures in this section.

Subd. 13. **Definitions.** (a) For purposes of subdivisions 12 to 15, the following terms have the meanings given.

(b) "Provider" means an eligible provider or eligible hospital for purposes of the Minnesota electronic health record incentives program.

(c) "Appealable issue" means one or more of the following issues related to the Minnesota electronic health record incentives program:

(1) incentive payments;

(2) incentive payment amounts;

(3) provider eligibility determination; or

(4) demonstration of adopting, implementing, and upgrading, and meaningful use eligibility for incentives.

Subd. 14. **Filing an appeal.** To appeal, the provider shall file with the commissioner a written notice of appeal. The appeal must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the notice of action regarding the appealable issue. The notice of appeal must specify:

(1) the appealable issues;

(2) each disputed item;

(3) the reason for the dispute;

(4) the total dollar amount in dispute;

(5) the computation that the provider believes is correct;

(6) the authority relied upon for each disputed item;

(7) the name and address of the person or firm with whom contacts may be made regarding the appeal; and

(8) other information required by the commissioner.

Subd. 15. **Appeals review process.** (a) Upon receipt of an appeal notice satisfying subdivision 14, the commissioner shall review the appeal and issue a written appeal determination on each appealed item with 90 days. Upon mutual agreement, the commissioner and the provider may extend the time for issuing a determination for a specified period. The commissioner shall notify the provider of the appeal determination. The appeal determination takes effect upon the date of issuance specified in the determination.

(b) In reviewing the appeal, the commissioner may request additional written or oral information from the provider.

(c) The provider has the right to present information by telephone, in writing, or in person concerning the appeal to the commissioner prior to the issuance of the appeal determination within 30 days of the date the appeal was received by the commissioner. The provider must request an in-person conference in writing, separate from the appeal letter. Statements made during the review process are not admissible in a contested case hearing absent an express stipulation by the parties to the contested case.

(d) For an appeal item on which the provider disagrees with the appeal determination, the provider may file with the commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the commissioner for that appeal item. The commissioner shall refer any contested case demand to the Office of the Attorney General.

(e) A contested case hearing must be heard by an administrative law judge according to sections 14.48 to 14.56. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the Minnesota electronic health record incentives program eligibility determination is incorrect.

(f) Regardless of any appeal, the Minnesota electronic health record incentives program eligibility determination must remain in effect until final resolution of the appeal.

(g) The commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

History: *1Sp2005 c 4 art 6 s 1; 2007 c 147 art 15 s 2; 2008 c 358 art 4 s 2; 2009 c 79 art 4 s 1; 2009 c 102 s 1; 2010 c 336 s 1-3; 1Sp2011 c 9 art 6 s 4-12; 2013 c 81 s 1; 2013 c 134 s 30; 2013 c 142 art 3 s 36; 2014 c 275 art 1 s 5; 2014 c 286 art 8 s 5; 2015 c 42 s 1; 2015 c 78 art 5 s 1; 2016 c 189 art 20 s 5; 1Sp2019 c 9 art 11 s 2,3; 2020 c 115 art 4 s 5; 2021 c 30 art 3 s 1; 2021 c 31 art 2 s 16; 1Sp2021 c 7 art 3 s 1-3; 2025 c 38 art 3 s 5*

ELECTRONIC HEALTH RECORD SYSTEM

62J.496 ELECTRONIC HEALTH RECORD SYSTEM REVOLVING ACCOUNT AND LOAN PROGRAM.

Subdivision 1. **Account establishment.** (a) An account is established to:

(1) finance the purchase of certified electronic health records or qualified electronic health records as defined in section 62J.495, subdivision 1a;

(2) enhance the utilization of electronic health record technology, which may include costs associated with upgrading the technology to meet the criteria necessary to be a certified electronic health record or a qualified electronic health record;

(3) train personnel in the use of electronic health record technology; and

(4) improve the secure electronic exchange of health information.

(b) Amounts deposited in the account, including any grant funds obtained through federal or other sources, loan repayments, and interest earned on the amounts shall be used only for awarding loans or loan guarantees, as a source of reserve and security for leveraged loans, for activities authorized in section 62J.495, subdivision 4, or for the administration of the account.

(c) The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any loan issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the loan fund, as well as the amount of the contribution provided;

(3) the commissioner may issue letters of commendation or make other awards that have no financial value to any such entity; and

(4) a contributing entity may not specify that the recipient or recipients of any loan use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

(d) The commissioner may use the loan funds to reimburse private sector entities for any contribution made to the loan fund. Reimbursement to private entities may not exceed the principle amount contributed to the loan fund.

(e) The commissioner may use funds deposited in the account to guarantee, or purchase insurance for, a local obligation if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

(f) The commissioner may use funds deposited in the account as a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the state if the proceeds of the sale of the bonds will be deposited into the loan fund.

(g) The commissioner shall not award new loans or loan guarantees after July 1, 2016.

Subd. 2. **Eligibility.** (a) "Eligible borrower" means one of the following:

(1) federally qualified health centers;

(2) community clinics, as defined under section 145.9268;

(3) nonprofit or local unit of government hospitals licensed under sections 144.50 to 144.56;

(4) individual or small group physician practices that are focused primarily on primary care;

(5) nursing facilities licensed under sections 144A.01 to 144A.27;

(6) local public health departments as defined in chapter 145A; and

(7) other providers of health or health care services approved by the commissioner for which interoperable electronic health record capability would improve quality of care, patient safety, or community health.

(b) The commissioner shall administer the loan fund to prioritize support and assistance to:

(1) critical access hospitals;

(2) federally qualified health centers;

(3) entities that serve uninsured, underinsured, and medically underserved individuals, regardless of whether such area is urban or rural;

(4) individual or small group practices that are primarily focused on primary care;

(5) nursing facilities certified to participate in the medical assistance program; and

(6) providers enrolled in the elderly waiver program of customized living or 24-hour customized living of the medical assistance program, if at least half of their annual operating revenue is paid under the medical assistance program.

(c) An eligible applicant must submit a loan application to the commissioner of health on forms prescribed by the commissioner. The application must include, at a minimum:

(1) the amount of the loan requested and a description of the purpose or project for which the loan proceeds will be used;

(2) a quote from a vendor;

(3) a description of the health care entities and other groups participating in the project;

(4) evidence of financial stability and a demonstrated ability to repay the loan;

(5) a description of how the system to be financed interoperates or plans in the future to interoperate with other health care entities and provider groups located in the same geographical area;

(6) a plan on how the certified electronic health record technology will be maintained and supported over time; and

(7) any other requirements for applications included or developed pursuant to section 3014 of the HITECH Act.

Subd. 3. **Loans.** (a) The commissioner of health may make a no-interest loan or low-interest loan to a provider or provider group who is eligible under subdivision 2 consistent with the priorities established in subdivision 2. The total accumulative loan principal must not exceed $3,000,000 per loan. The interest rate for each loan, if imposed, shall not exceed the current market interest rate. The commissioner of health has discretion over the size, interest rate, and number of loans made. Nothing in this section shall require the commissioner to make a loan to an eligible borrower under subdivision 2.

(b) The commissioner of health may prescribe forms and establish an application process and, notwithstanding section 16A.1283, may impose a reasonable nonrefundable application fee to cover the cost of administering the loan program. Any application fees imposed and collected under the electronic health records system revolving account and loan program in this section are appropriated to the commissioner of health for the duration of the loan program. The commissioner may apply for and use all federal funds available through the HITECH Act to administer the loan program.

(c) For loans approved prior to July 1, 2009, the borrower must begin repaying the principal no later than two years from the date of the loan. Loans must be amortized no later than six years from the date of the loan.

(d) For loans granted on January 1, 2010, or thereafter, the borrower must begin repaying the principal no later than one year from the date of the loan. Loans must be amortized no later than six years after the date of the loan.

(e) All repayments and interest paid on each loan must be credited to the account.

(f) The loan agreement shall include the assurance that the borrower meets the requirements included or developed pursuant to section 3014 of the HITECH Act. The requirements shall include, but are not limited to:

(1) submitting reports on quality measures in compliance with regulations adopted by the federal government;

(2) demonstrating that any certified electronic health record technology purchased, improved, or otherwise financially supported by this loan program is used to exchange health information in a manner that, in accordance with law and standards applicable to the exchange of information, improves the quality of health care;

(3) including a plan on how the borrower intends to maintain and support the certified electronic health record technology over time and the resources expected to be used to maintain and support the technology purchased with the loan; and

(4) complying with other requirements the secretary may require to use loans funds under the HITECH Act.

Subd. 4. **Data classification.** Data collected by the commissioner of health on the application to determine eligibility under subdivision 2 and to monitor borrowers' default risk or collect payments owed under subdivision 3 are (1) private data on individuals as defined in section 13.02, subdivision 12; and (2) nonpublic data as defined in section 13.02, subdivision 9. The names of borrowers and the amounts of the loans granted are public data.

History: *2007 c 147 art 15 s 3; 2009 c 79 art 4 s 2; 2009 c 102 s 2; 2012 c 247 art 4 s 1; 2016 c 189 art 20 s 6*

ELECTRONIC PRESCRIPTION DRUG PROGRAM

62J.497 ELECTRONIC PRESCRIPTION DRUG PROGRAM.

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

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

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

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

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

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

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

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

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

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

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

(l) "NCPDP SCRIPT Standard" means the most recent version of the National Council for Prescription Drug Programs SCRIPT Standard, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the

Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

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

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

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

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

Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish, maintain, and use an electronic prescription drug program. This program must comply with the applicable standards in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

(b) If transactions described in this section are conducted, they must be done electronically using the standards described in this section. Nothing in this section requires providers, group purchasers, prescribers, or dispensers to electronically conduct transactions that are expressly prohibited by other sections or federal law.

(c) Providers, group purchasers, prescribers, and dispensers must use either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the recipient are part of the same legal entity. If an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard or other applicable standards required by this section. Any pharmacy within an entity must be able to receive electronic prescription transmittals from outside the entity using the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health Insurance Portability and Accountability Act (HIPAA) requirement that may require the use of a HIPAA transaction standard within an organization.

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

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

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

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

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

Subd. 4. **Development and use of uniform formulary exception form.** (a) The commissioner of health, in consultation with the Minnesota Administrative Uniformity Committee, shall develop by July 1, 2009, a uniform formulary exception form that allows health care providers to request exceptions from group purchaser formularies using a uniform form. Upon development of the form, all health care providers must

submit requests for formulary exceptions using the uniform form, and all group purchasers must accept this form from health care providers.

(b) No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions.

Subd. 5. **Electronic drug prior authorization standardization and transmission.** (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) No later than January 1, 2016, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

History: *2008 c 358 art 4 s 3; 2009 c 79 art 4 s 3-6; 2009 c 102 s 3,4; 2009 c 173 art 1 s 1; 2010 c 336 s 4,5; 2012 c 253 art 1 s 1; 2014 c 291 art 6 s 1; 2016 c 158 art 1 s 19; 1Sp2021 c 7 art 3 s 4,5*

HEALTH CARE INFORMATION EXCHANGE

62J.498 HEALTH INFORMATION EXCHANGE.

Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to 62J.4982:

(b) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient and is used by a health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(c) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

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

(e) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(f) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This includes but is not limited to health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

(g) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(h) "Health information exchange service provider" means a health data intermediary or health information organization.

(i) "Health information organization" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve coordination of patient care and the efficiency of health care delivery.

(j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

(k) "Master patient index" means an electronic database that holds unique identifiers of patients registered at a care facility and is used by a health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(l) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization has contracts or other agreements for the provision of health information exchange services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

(m) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of clinical transactions.

(n) "State-certified health information organization" means a health information organization that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from health information organizations for certificates of authority to operate in Minnesota;

(2) require information to be provided as needed from health information exchange service providers in order to meet requirements established under sections 62J.498 to 62J.4982;

(3) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

(4) respond to public complaints related to health information exchange services;

(5) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

(6) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

(7) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) make all portions of the application classified as public data available to the public for at least ten days while an application is under consideration. At the request of the commissioner, the applicant shall participate in a public hearing by presenting an overview of their application and responding to questions from interested parties; and

(2) consult with hospitals, physicians, and other providers prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

History: *2010 c 336 s 6; 2015 c 71 art 8 s 2; 2020 c 83 art 2 s 1; 2021 c 30 art 3 s 2*

62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

Subd. 2. MS 2020 [Repealed by amendment, 2021 c 30 art 3 s 3]

Subd. 3. **Certificate of authority for health information organizations.** (a) A health information organization must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, an organization may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans address governance, technical infrastructure, legal and policy issues, finance, and business operations in regard to how the organization will expand to support providers in achieving health information exchange goals over time;

(4) the entity addresses the parameters to be used with participating entities and other health information exchange service providers for clinical transactions, compliance with Minnesota law, and interstate health information exchange trust agreements;

(5) the entity's board of directors or equivalent governing body is composed of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors or equivalent governing body with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with national certification and accreditation programs designated by the commissioner;

(8) the entity maintains the capability to query for patient information based on national standards. The query capability may utilize a master patient index, clinical data repository, or record locator service as defined in section 144.291, subdivision 2, paragraph (j). The entity must be compliant with the requirements of section 144.293, subdivision 8, when conducting clinical transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the National eHealth Exchange;

(2) annually submit strategic and operational plans for review by the commissioner that address:

(i) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

(ii) plans for ensuring the necessary capacity to support clinical transactions;

(iii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

(iv) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

(v) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

(3) enter into reciprocal agreements with all other state-certified health information organizations to enable access to patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements in subdivision 5;

(4) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability; and

(5) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information organizations.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following in addition to information described in the criteria in subdivision 3:

(1) a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors or equivalent governing body, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors or equivalent governing body, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information organization. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

(5) a statement generally describing the health information organization, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

(6) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

(7) a description of the complaint procedures to be used as required under this section;

(8) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

(9) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

(10) a copy of the conflict of interest policy that applies to all members of the board of directors or equivalent governing body and the principal officers of the health information organization; and

(11) other information as the commissioner may reasonably require to be provided.

(b) Within 45 days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Within 90 days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements of subdivision 3. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a state-certified health information organization, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information organizations.** (a) Reciprocal agreements between two health information organizations must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of clinical transactions;

(2) does not charge a fee for the exchange of transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization from entering into contractual agreements for the provision of value-added services.

Subd. 6. [Repealed by amendment, 2015 c 71 art 8 s 3]

History: *2010 c 336 s 7; 2015 c 71 art 8 s 3; 2020 c 83 art 2 s 2; 2021 c 30 art 3 s 3*

62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.

Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation of statute or rule applicable to a health information organization, levy an administrative penalty in an amount up to $25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of participating entities affected by the violation;

(2) the effect of the violation on participating entities' access to health information exchange services;

(3) if only one participating entity is affected, the effect of the violation on the patients of that entity;

(4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information organization;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information organization attempted to correct previous violations;

(11) how the health information organization responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information organization including but not limited to whether the health information organization had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information organization to continue to deliver health information exchange services.

The commissioner shall give reasonable notice in writing to the health information organization of the intent to levy the penalty and the reasons for it. A health information organization may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information organization and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information organization or a representative of a health information organization to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information organization may contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information organization is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information organization is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information organization is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information organization has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information organization would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information organization has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information organization is suspended, the health information organization shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information organization in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information organization may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information organization to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information organization.

(c) If suspension, revocation, or administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information organization written notice of the commissioner's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the nature and amount of the proposed penalty;

(4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the health information organization's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information organizations when implementing sections 62J.498 to 62J.4982.

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information organization subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $7,000; and

(2) annual health information organization certificate fee, $7,000.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

History: *2010 c 336 s 8; 2015 c 71 art 8 s 4,5; 2021 c 30 art 3 s 4*

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT; BILLING AND PURCHASING IMPROVEMENT

62J.50 CITATION AND PURPOSE.

Subdivision 1. **Citation.** Sections 62J.50 to 62J.61 may be cited as the "Minnesota Health Care Administrative Simplification Act."

Subd. 2. **Purpose.** The legislature finds that significant savings throughout the health care industry can be accomplished by implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange. The legislature finds that initial steps have been taken at the national level by the federal Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services, in its implementation of nationally accepted electronic transaction sets for its Medicare program. The legislature further recognizes the work done by the Workgroup for Electronic Data Interchange and the American National Standards Institute and its accredited standards committee X12, at the national level, and the Minnesota Administrative Uniformity Committee, a statewide, voluntary, public-private group representing payers, hospitals, state programs, physicians, and other health care providers in their work toward administrative simplification in the health care industry.

History: *1994 c 625 art 9 s 1; 2014 c 192 art 1 s 1,2*

62J.51 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 62J.50 to 62J.61, the following definitions apply.

Subd. 2. **ANSI.** "ANSI" means the American National Standards Institute.

Subd. 3. **ASC X12.** "ASC X12" means the American National Standards Institute committee X12.

Subd. 3a. **Card issuer.** "Card issuer" means the group purchaser who is responsible for printing and distributing identification cards to members or insureds.

Subd. 4. [Repealed by amendment, 2014 c 192 art 1 s 3]

Subd. 5. [Repealed by amendment, 2014 c 192 art 1 s 3]

Subd. 6. **Claim payment/advice transaction set (ANSI ASC X12 835).** "Claim payment/advice transaction set (ANSI ASC X12 835)" means the electronic transaction format used for electronic remittance advice and electronic funds transfer as adopted under Code of Federal Regulations, title 45, part 162, subpart P, and any future revisions of the subpart.

Subd. 6a. **Claim status transaction set (ANSI ASC X12 276/277).** "Claim status transaction set (ANSI ASC X12 276/277)" means the electronic transaction format used by providers to request and receive information on the status of a health care claim or encounter that has been submitted to a group purchaser as adopted under Code of Federal Regulations, title 45, part 162, subpart N, and any future revisions of the subpart.

Subd. 6b. **Claim submission address.** "Claim submission address" means the address to which the group purchaser requires health care providers, members, or insureds to send health care claims for processing.

Subd. 6c. **Claim submission number.** "Claim submission number" means the unique identification number to identify group purchasers as described in section 62J.54, with its suffix identifying the claim submission address.

Subd. 7. **Claim submission transaction set (ANSI ASC X12 837).** "Claim submission transaction set (ANSI ASC X12 837)" means the electronic transaction format used to submit all health care claims information as adopted under Code of Federal Regulations, title 45, part 162, subpart K, and any future revisions of the subpart.

Subd. 8. **EDI or electronic data interchange.** "EDI" or "electronic data interchange" means the computer application to computer application exchange of information using nationally accepted standard formats.

Subd. 9. **Eligibility transaction set (ANSI ASC X12 270/271).** "Eligibility transaction set (ANSI ASC X12 270/271)" means the electronic transaction format used by providers to request and receive coverage information on the member or insured as adopted under Code of Federal Regulations, title 45, part 162, subpart L, and any future revisions of the subpart.

Subd. 10. **Enrollment transaction set (ANSI ASC X12 834).** "Enrollment transaction set (ANSI ASC X12 834)" means the electronic transaction format used to transmit enrollment and benefit information from the employer to the payer for the purpose of enrolling in a benefit plan as adopted under Code of Federal Regulations, title 45, part 162, subpart O, and any future revisions of the subpart.

Subd. 11. **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

Subd. 11a. **Health care clearinghouse.** "Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

(1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;

(2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;

(3) acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;

(4) acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and

(5) other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions.

Subd. 12. **ISO.** "ISO" means the International Standardization Organization.

Subd. 13. **NCPDP.** "NCPDP" means the National Council for Prescription Drug Programs, Inc.

Subd. 14. [Repealed by amendment, 2014 c 192 art 1 s 3]

Subd. 15. [Repealed by amendment, 2014 c 192 art 1 s 3]

Subd. 16. **Provider; health care provider.** "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Subd. 16a. **Standard transaction.** "Standard transaction" means a transaction that is defined in Code of Federal Regulations, title 45, part 162.103, and that meets the requirements of the single, uniform companion guides described in section 62J.536.

Subd. 17. **Uniform billing form CMS 1450.** "Uniform billing form CMS 1450" means the most current version of the uniform billing form known as the CMS 1450 developed by the National Uniform Billing Committee.

Subd. 18. **Uniform billing form CMS 1500.** "Uniform billing form CMS 1500" means the most current version of the health insurance claim form, CMS 1500, developed by the National Uniform Claim Committee.

Subd. 19. **Uniform dental billing form.** "Uniform dental billing form" means the most current version of the uniform dental claim form developed by the American Dental Association.

Subd. 19a. **Uniform explanation of benefits.** "Uniform explanation of benefits" means either the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered or its electronic equivalent under section 62J.581, which is sent to a patient.

Subd. 19b. [Repealed by amendment, 2014 c 192 art 1 s 3]

Subd. 20. **Uniform pharmacy billing form.** "Uniform pharmacy billing form" means the National Council for Prescription Drug Programs/universal claim form (NCPDP/UCF).

Subd. 21. **WEDI.** "WEDI" means the national Workgroup for Electronic Data Interchange.

History: *1994 c 625 art 9 s 2; 1996 c 440 art 1 s 22-25; 2000 c 460 s 2,3; 2002 c 307 art 2 s 3; 2002 c 330 s 19; 2005 c 106 s 1,2; 2008 c 305 s 1,2; 2010 c 243 s 1,2; 2014 c 192 art 1 s 3; 1Sp2025 c 3 art 2 s 4*

62J.52 ESTABLISHMENT OF UNIFORM BILLING FORMS.

Subdivision 1. **Uniform billing form CMS 1450.** (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, institutionally owned or operated outpatient services rendered by providers in Minnesota, and institutional or noninstitutional home health services that are not being billed using an equivalent electronic billing format, must be billed using the most current version of the uniform billing form CMS 1450.

(b) The instructions and definitions for the use of the uniform billing form CMS 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the National Uniform Billing Committee.

(c) Services to be billed using the uniform billing form CMS 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, ICFs/DD, and home health (Medicare part B); institutional owned or operated outpatient services such as waivered services, hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, federally qualified health centers, and community mental health centers; home health services such as home health intravenous therapy providers and hospice; and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

(e) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

Subd. 2. **Uniform billing form CMS 1500.** (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the most current version of the health insurance claim form CMS 1500.

(b) The instructions and definitions for the use of the uniform billing form CMS 1500 shall be in accordance with the manual developed by the Administrative Uniformity Committee entitled standards for the use of the CMS 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form CMS 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, advanced practice registered nurse services, chiropractors, physician assistants,

laboratories, medical suppliers, waivered services, personal care attendants, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

(d) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

Subd. 3. **Uniform dental billing form.** (a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the most current version of the American Dental Association uniform dental billing form.

(b) The instructions and definitions for the use of the uniform dental billing form shall be in accordance with the manual developed by the Administrative Uniformity Committee dated February 1994, and as amended or further defined by the commissioner.

Subd. 4. **Uniform pharmacy billing form.** (a) On and after January 1, 1996, all pharmacy services provided by pharmacists in Minnesota that are not currently being billed using an equivalent electronic billing format shall be billed using the most current version of the NCPDP/universal claim form.

(b) The instructions and definitions for the use of the uniform claim form shall be in accordance with instructions specified by the commissioner of health.

Subd. 5. [Repealed, 2008 c 305 s 11]

History: *1994 c 625 art 9 s 3; 2000 c 460 s 4-6; 1Sp2003 c 14 art 7 s 14,15; 2005 c 106 s 3-5; 2007 c 147 art 9 s 6,7; 2008 c 305 s 3-5; 2013 c 125 art 1 s 107; 2014 c 192 art 1 s 4; 2020 c 115 art 4 s 6*

62J.53 ACCEPTANCE OF UNIFORM BILLING FORMS BY GROUP PURCHASERS.

On and after January 1, 1996, all group purchasers in Minnesota shall accept the uniform billing forms prescribed under section 62J.52 as the only nonelectronic billing forms used for payment processing purposes.

History: *1994 c 625 art 9 s 4; 2014 c 192 art 1 s 5*

62J.535 UNIFORM BILLING REQUIREMENTS FOR CLAIM TRANSACTIONS.

Subdivision 1. [Repealed, 2002 c 307 art 2 s 9; 2002 c 330 s 35]

Subd. 1a. **Additional information associated with a claim.** Nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 1b. **Paper claim transactions.** All group purchasers that accept paper claim transactions must accept, and health care providers submitting paper claim transactions must submit, these transactions with use of the applicable medical and nonmedical data code sets specified in the federal electronic claim transaction standards adopted under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. The paper claim transaction must also be conducted using the uniform billing forms as specified in section 62J.52 and the identifiers specified in section 62J.54, on and after the compliance date required by law. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated

under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 2. [Repealed by amendment, 2014 c 192 art 1 s 6]

History: *1999 c 245 art 2 s 8; 2000 c 483 s 16; 2000 c 488 art 11 s 1; 2002 c 307 art 2 s 4-6,8; 2002 c 330 s 20-22,33; 2014 c 192 art 1 s 6*

62J.536 UNIFORM ELECTRONIC TRANSACTIONS AND IMPLEMENTATION GUIDE STANDARDS.

Subdivision 1. **Electronic claims and eligibility transactions required.** (a) Beginning January 15, 2009, all group purchasers must accept from health care providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all group purchasers must accept from health care providers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(b) Beginning January 15, 2009, all group purchasers must transmit to providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 15, 2009, all group purchasers must transmit to providers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(c) Beginning January 15, 2009, all health care providers must submit to group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all health care providers must submit to group purchasers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(d) Beginning January 15, 2009, all health care providers must accept from group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 15, 2009, all health care providers must accept from group purchasers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(e) Beginning January 1, 2012, all health care providers, health care clearinghouses, and group purchasers must provide an appropriate, standard, electronic acknowledgment when receiving the health care claims or equivalent encounter information transaction or the health care payment and remittance advice transaction. The acknowledgment provided must be based on one or more of the following American National Standards Institute, Accredited Standards Committee X12 standard transactions or National Council for Prescription Drug Program (NCPDP) standards:

(1) TA1;

(2) 999;

(3) 277CA; or

(4) the appropriate NCPDP response standard as the electronic acknowledgment.

Health care providers, health care clearinghouses, and group purchasers may send and receive more than one type of standard acknowledgment as mutually agreed upon. The mutually agreed upon acknowledgments must be exchanged electronically. Electronic exchanges of acknowledgments do not include email or facsimile.

(f) Each of the transactions described in paragraphs (a) to (e) shall require the use of a single, uniform companion guide to the implementation guides described under Code of Federal Regulations, title 45, part 162. The companion guides will be developed pursuant to subdivision 2.

(g) Notwithstanding any other provisions in sections 62J.50 to 62J.61, all group purchasers and health care providers must exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines required under this subdivision. Group purchasers may not impose any fee on providers or providers' clearinghouses for the use of the transactions prescribed in this subdivision. Health care providers may not impose a fee on group purchasers or group purchasers' clearinghouses for the use of the transactions prescribed in this subdivision. A clearinghouse may not charge a fee solely to receive a standard transaction from a health care provider, a health care provider's clearinghouse, a group purchaser, or a group purchaser's clearinghouse when it is not an agent of the sending entity. A clearinghouse may not charge a fee solely to send a standard transaction to a health care provider, a health care provider's clearinghouse, a group purchaser, or a group purchaser's clearinghouse when it is not an agent of the receiving entity.

(h) Nothing in this subdivision shall prohibit group purchasers and health care providers from using a direct data entry, web-based methodology for complying with the requirements of this subdivision. Any direct data entry method for conducting the transactions specified in this subdivision must be consistent with the data content component of the single, uniform companion guides required in paragraph (f) and the implementation guides described under Code of Federal Regulations, title 45, part 162.

Subd. 2. **Establishing uniform, standard companion guides.** (a) At least 12 months prior to the timelines required in subdivision 1, the commissioner of health shall promulgate rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides required under subdivision 1, paragraph (f).

(b) The commissioner of health must consult with the Minnesota Administrative Uniformity Committee on the development of the single, uniform companion guides required under subdivision 1, paragraph (f), for each of the transactions in subdivision 1. The single uniform companion guides required under subdivision 1, paragraph (f), must specify uniform billing and coding standards. The commissioner of health shall base the companion guides required under subdivision 1, paragraph (f), billing and coding rules, and standards on the Medicare program, with modifications that the commissioner deems appropriate after consulting the Minnesota Administrative Uniformity Committee.

(c) No group purchaser or health care provider may add to or modify the single, uniform companion guides defined in subdivision 1, paragraph (f), through additional companion guides or other requirements.

(d) In promulgating the rules in paragraph (a), the commissioner shall not require data content that is not essential to accomplish the purpose of the transactions in subdivision 1.

Subd. 2a. **Group purchasers not covered by HIPAA.** For transactions with group purchasers defined in section 62J.03, subdivision 6, that are not covered under United States Code, title 42, sections 1320d to 1320d-8, the requirements of this section are modified as follows:

(1) The group purchasers may be exempt from one or more of the requirements to exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines in subdivision 1 if the commissioner of health determines that:

(i) a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or

(ii) another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.

(2) If group purchasers are exempt from one or more of the requirements to exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines in subdivision 1, providers shall also be exempt from exchanging those transactions with the group purchaser.

(3) If the commissioner of health exempts a group purchaser from one or more of the requirements because a transaction is incapable of exchanging data that are currently being exchanged on paper and are necessary to accomplish the purpose of the transaction, the commissioner shall review that exemption annually. If the commissioner determines that the exemption is no longer necessary or appropriate, the commissioner of health shall adopt rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides required under subdivision 1, paragraph (e). Group purchasers and providers shall have 12 months to implement any rules adopted.

(4) If the commissioner of health exempts a group purchaser from one or more of the requirements because another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction, the commissioner shall adopt rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the national electronic transaction standard. Group purchasers and providers shall have 12 months to implement any rules adopted.

(5) The requirement of paper claims attachments shall not indicate that a health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K, is incapable of exchanging data that are currently being exchanged on paper provided that the electronic health care claims transaction has a mechanism to link the paper attachments to the electronic claim.

Subd. 2b. **Compliance and investigations.** (a) The commissioner of health shall, to the extent practicable, seek the cooperation of health care providers, health care clearinghouses, and group purchasers in obtaining compliance with this section and may provide technical assistance to health care providers, health care clearinghouses, and group purchasers.

(b) A person who believes a health care provider, health care clearinghouse, or group purchaser is not complying with the requirements of this section may file a complaint with the commissioner of health. Complaints filed under this section must meet the following requirements:

(1) A complaint must be filed in writing, either on paper or electronically.

(2) A complaint must name the person that is the subject of the complaint and describe the acts or omissions believed to be in violation of this section.

(3) A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred.

(4) The commissioner may prescribe additional procedures for the filing of complaints as required to satisfy the requirements of this section.

(c) The commissioner of health may investigate complaints filed under this section. The investigation may include a review of the pertinent policies, procedures, or practices of the health care provider, health care clearinghouse, or group purchaser and of the circumstances regarding any alleged violation. At the time of initial written communication with the health care provider, health care clearinghouse, or group purchaser

about the complaint, the commissioner of health shall describe the acts or omissions that are the basis of the complaint. The commissioner may conduct compliance reviews to determine whether health care providers, health care clearinghouses, and group purchasers are complying with this section.

(d) Health care providers, health care clearinghouses, and group purchasers must cooperate with the commissioner of health if the commissioner undertakes an investigation or compliance review of the policies, procedures, or practices of the health care provider, health care clearinghouse, or group purchaser to determine compliance with this section. This cooperation includes, but is not limited to:

(1) A health care provider, health care clearinghouse, or group purchaser must permit access by the commissioner of health during normal business hours to its facilities, books, records, accounts, and other sources of information that are pertinent to ascertaining compliance with this section.

(2) If any information required of a health care provider, health care clearinghouse, or group purchaser under this section is in the exclusive possession of any other agency, institution, or person and the other agency, institution, or person fails or refuses to furnish the information, the health care provider, health care clearinghouse, or group purchaser must so certify and set forth what efforts it has made to obtain the information.

(3) Any individually identifiable health information obtained by the commissioner of health in connection with an investigation or compliance review under this section may not be used or disclosed by the commissioner of health, except as necessary for ascertaining or enforcing compliance with this section.

(e) If an investigation of a complaint indicates noncompliance, the commissioner of health shall attempt to reach a resolution of the matter by informal means. Informal means may include demonstrated compliance or a completed corrective action plan or other agreement. If the matter is resolved by informal means, the commissioner of health shall so inform the health care provider, health care clearinghouse, or group purchaser and, if the matter arose from a complaint, the complainant, in writing. If the matter is not resolved by informal means, the commissioner of health shall:

(1) inform the health care provider, health care clearinghouse, or group purchaser and provide an opportunity for the health care provider, health care clearinghouse, or group purchaser to submit written evidence of any mitigating factors or other considerations. The health care provider, health care clearinghouse, or group purchaser must submit any such evidence to the commissioner of health within 30 calendar days of receipt of the notification; and

(2) inform the health care provider, health care clearinghouse, or group purchaser, through a notice of proposed determination according to paragraph (i), that the commissioner of health finds that a civil money penalty should be imposed.

(f) If, after an investigation or a compliance review, the commissioner of health determines that further action is not warranted, the commissioner of health shall so inform the health care provider, health care clearinghouse, or group purchaser and, if the matter arose from a complaint, the complainant, in writing.

(g) A health care provider, health care clearinghouse, or group purchaser may not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against any individual or other person for:

(1) filing of a complaint under this section;

(2) testifying, assisting, or participating in an investigation, compliance review, proceeding, or contested case proceeding under this section; or

(3) opposing any act or practice made unlawful by this section, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve an unauthorized disclosure of a patient's health information.

(h) The commissioner of health may impose a civil money penalty on a health care provider, health care clearinghouse, or group purchaser if the commissioner of health determines that the health care provider, health care clearinghouse, or group purchaser has violated this section. If the commissioner of health determines that more than one health care provider, health care clearinghouse, or group purchaser was responsible for a violation, the commissioner of health may impose a civil money penalty against each health care provider, health care clearinghouse, or group purchaser. The amount of a civil money penalty shall be determined as follows:

(1) The amount of a civil money penalty shall be up to $100 for each violation, but not exceed $25,000 for identical violations during a calendar year.

(2) In the case of continuing violation of this section, a separate violation occurs each business day that the health care provider, health care clearinghouse, or group purchaser is in violation of this section.

(3) In determining the amount of any civil money penalty, the commissioner of health may consider as aggravating or mitigating factors, as appropriate, any of the following:

(i) the nature of the violation, in light of the purpose of the goals of this section;

(ii) the time period during which the violation occurred;

(iii) whether the violation hindered or facilitated an individual's ability to obtain health care;

(iv) whether the violation resulted in financial harm;

(v) whether the violation was intentional;

(vi) whether the violation was beyond the direct control of the health care provider, health care clearinghouse, or group purchaser;

(vii) any history of prior compliance with the provisions of this section, including violations;

(viii) whether and to what extent the provider, health care clearinghouse, or group purchaser has attempted to correct previous violations;

(ix) how the health care provider, health care clearinghouse, or group purchaser has responded to technical assistance from the commissioner of health provided in the context of a compliance effort; or

(x) the financial condition of the health care provider, health care clearinghouse, or group purchaser including, but not limited to, whether the health care provider, health care clearinghouse, or group purchaser had financial difficulties that affected its ability to comply or whether the imposition of a civil money penalty would jeopardize the ability of the health care provider, health care clearinghouse, or group purchaser to continue to provide, or to pay for, health care.

(i) If a penalty is proposed according to this section, the commissioner of health must deliver, or send by certified mail with return receipt requested, to the respondent written notice of the commissioner of health's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the amount of the proposed penalty;

(4) any circumstances described in paragraph (i) that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the respondent's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

(j) A health care provider, health care clearinghouse, or group purchaser may contest whether the finding of facts constitute a violation of this section, according to a contested case proceeding as set forth in sections 14.57 to 14.62, subject to appeal according to sections 14.63 to 14.68.

(k) Any data collected by the commissioner of health as part of an active investigation or active compliance review under this section are classified as protected nonpublic data pursuant to section 13.02, subdivision 13, in the case of data not on individuals and confidential pursuant to section 13.02, subdivision 3, in the case of data on individuals. Data describing the final disposition of an investigation or compliance review are classified as public.

(l) Civil money penalties imposed and collected under this subdivision shall be deposited into a revolving fund and are appropriated to the commissioner of health for the purposes of this subdivision, including the provision of technical assistance.

Subd. 3. **Definition.** Notwithstanding section 62J.03, subdivision 8, for purposes of this section, "health care provider" includes licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Subd. 4. **Health care clearinghouses.** (a) Beginning January 1, 2012, health care clearinghouses must use and make available suitable tracking mechanisms to allow health care providers and group purchasers to determine in a timely fashion that health care claims or equivalent encounter information transactions and health care payment and remittance advice transactions were delivered to their intended final destination. Clearinghouses must provide clear, understandable, accurate information and instructions for tracking claims and remittance advice transactions to all clients, potential clients, or interested parties. Clearinghouses must provide clear, accurate information and instructions for receiving and responding to questions or concerns from health care providers or group purchasers regarding tracking of health care claims and remittance advice transactions. This information must include any designated points of contact and contact information, hours of operation, and other information to assist providers and group purchasers with questions or concerns.

(b) Health care clearinghouses must make or provide electronic connections with other clearinghouses or trading partners requesting such a connection to meet the requirements of this section. A health care clearinghouse must connect electronically in a timely manner with any entity willing and capable of meeting the standard business terms and conditions of the clearinghouse, as well as any applicable laws and regulations. Any connectivity sought or established under this subdivision must be consistent with this section and with other applicable laws and rules. Health care providers and group purchasers may determine which clearinghouses they choose to work with and with which to enter into agent relationships.

(c) Acceptance of a compliant standard transaction may not be contingent on purchase of additional services. A health care clearinghouse may not condition acceptance of a compliant standard transaction from a provider, provider's agent, group purchaser, or group purchaser's agent on the provider's or group purchaser's agreement to pay for an additional service such as transmitting attachments electronically.

(d) The commissioner may:

(1) require information and data from health care clearinghouses, including information regarding clearinghouse operations and performance, to ensure that requirements of this section and related rules are fulfilled;

(2) require that clearinghouses with websites post, maintain, and regularly update on their websites point-of-contact information and other information needed by clients, potential clients, and others to obtain answers to questions or to conduct business;

(3) require that all clearinghouses provide timely, clear, accurate, reliable information to their clients, potential clients, or any interested parties regarding their products or services, pricing, and other business and service information; and

(4) post information from clearinghouses on a Department of Health website and make the information broadly available through other means.

The commissioner shall determine the manner, content, timing, frequency, and other specifications for information to be posted or submitted by health care clearinghouses.

History: *2007 c 147 art 15 s 4; 2008 c 305 s 6-8; 2010 c 243 s 3-5; 2012 c 253 art 1 s 2; 2014 c 192 art 1 s 7*

62J.54 IDENTIFICATION AND IMPLEMENTATION OF UNIQUE IDENTIFIERS.

Subdivision 1. **Unique identification number for health care provider organizations.** (a) All group purchasers and any health care provider organization that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use a national provider identifier to identify health care provider organizations in Minnesota, according to this section.

(b) The national provider identifier for health care providers as adopted and required in Code of Federal Regulations, title 45, part 162, subpart D, and any future modifications to the subpart shall be used as the unique identification number for health care provider organizations in Minnesota under this section.

(c) All health care provider organizations in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier using the process prescribed in Code of Federal Regulations, title 45, part 162, subpart D, and any future modifications to the subpart.

(d) Only the national provider identifier shall be used to identify health care provider organizations when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(e) Health care provider organizations in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 2. **Unique identification number for individual health care providers.** (a) All group purchasers in Minnesota and any individual health care provider that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use the national provider identifier to identify an individual health care provider in Minnesota, according to this section.

(b) The national provider identifier for health care providers adopted in Code of Federal Regulations, title 45, part 162, subpart D, and any future modifications to the subpart shall be used as the unique identification number for individual health care providers.

(c) All individual health care providers in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier using the process prescribed in Code of Federal Regulations, title 45, part 162, subpart D, and any future modifications to the subpart.

(d) Only the national provider identifier shall be used to identify individual health care providers when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(e) Individual health care providers in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 3. **Unique identification number for group purchasers.** (a) All group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers.

(b) The unique health identifier for group purchasers that are health plans under Code of Federal Regulations, title 45, part 160, subpart A, shall be the Standard Unique Health Identifier for Health Plans as adopted in Code of Federal Regulations, title 45, part 162, subpart E, and any future modifications to the subpart, effective as required by the subpart.

(c) Group purchasers that are health plans under Code of Federal Regulations, title 45, part 160, subpart A, shall obtain a unique health identifier using the process prescribed in Code of Federal Regulations, title 45, part 162, subpart E, and any future modifications to the subpart.

(d) The unique group purchaser identifier, as described in this section, shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(e) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 4. **Unique patient identification number.** (a) Not later than 24 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify each patient who receives health care services in Minnesota no later than 36 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for individuals adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique patient identification number, except as provided in paragraphs (e) and (f).

(d) The unique patient identification number shall be used by group purchasers and health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(e) Within the limits of available appropriations, the commissioner shall develop a proposal for an alternate numbering system for patients who do not have or refuse to provide their Social Security numbers, if:

(1) a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments);

(2) the unique health identifier is the Social Security number of the patient;

(3) there is no federal alternate numbering system for patients who do not have or refuse to provide their Social Security numbers; and

(4) federal law or the federal Secretary of Health and Human Services explicitly allows a state to develop an alternate numbering system for patients who do not have or refuse to provide their Social Security numbers.

(f) If an alternate numbering system is developed under paragraph (e), patients who use numbers issued by the alternate numbering system are not required to provide their Social Security numbers and group purchasers or providers may not demand the Social Security numbers of patients who provide numbers issued by the alternate numbering system. If an alternate numbering system is developed under paragraph (e), group purchasers and health care providers shall establish procedures to notify patients that they can elect not to have their Social Security number used as the unique patient identifier.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

History: *1994 c 625 art 9 s 5; 1995 c 234 art 5 s 17; 1996 c 440 art 1 s 26-28; 1997 c 228 s 2; 1Sp1997 c 5 s 16; 2005 c 106 s 6,7; 2014 c 192 art 1 s 8-10*

62J.55 PRIVACY OF UNIQUE IDENTIFIERS.

(a) When the unique identifiers specified in section 62J.54 are used for data collection purposes, the identifiers must be encrypted, as required in section 62J.321, subdivision 1. Encryption must follow encryption standards set by the National Bureau of Standards and approved by the American National Standards Institute as ANSIX3. 92-1982/R 1987 to protect the confidentiality of the data. Social Security numbers must not be maintained in unencrypted form in the database, and the data must never be released in a form that would allow for the identification of individuals. The encryption algorithm and hardware used must not use clipper chip technology.

(b) Providers and group purchasers shall treat medical records, including the Social Security number if it is used as a unique patient identifier, in accordance with sections 144.291 to 144.298. The Social Security number may be disclosed by providers and group purchasers to the commissioner as necessary to allow performance of those duties set forth in section 144.05.

History: *1994 c 625 art 9 s 6; 1995 c 234 art 5 s 18; 2007 c 147 art 10 s 15*

62J.56 IMPLEMENTATION OF ELECTRONIC DATA INTERCHANGE STANDARDS.

Subdivision 1. **General provisions.** (a) The legislature finds that there is a need to advance the use of electronic methods of data interchange among all health care participants in the state in order to achieve significant administrative cost savings. The legislature also finds that in order to advance the use of health care electronic data interchange in a cost-effective manner, the state needs to implement electronic data interchange standards that are nationally accepted, widely recognized, and available for immediate use. The legislature intends to set forth a plan for a systematic phase in of uniform health care electronic data interchange standards in all segments of the health care industry.

(b) The commissioner of health, with the advice of the Minnesota Administrative Uniformity Committee, shall administer the implementation of and monitor compliance with, electronic data interchange standards of health care participants, according to the plan provided in this section.

Subd. 2. **Identification of core transaction sets.** The commissioner, with the advice of the Minnesota Administrative Uniformity Committee, and in coordination with federal efforts, may approve the use of new ASC X12 standards, or new versions of existing standards, as they become available, or other nationally recognized standards, where appropriate ASC X12 standards are not available for use. These alternative standards may be used during a transition period while ASC X12 standards are developed.

Subd. 3. **Implementation guides.** (a) The commissioner, with the advice of the Minnesota Administrative Uniformity Committee, and the Minnesota Center for Health Care Electronic Data Interchange shall review and recommend the use of guides to implement the core transaction sets. Implementation guides must contain the background and technical information required to allow health care participants to implement the transaction set in the most cost-effective way.

(b) The commissioner shall promote the development of implementation guides among health care participants for those business transaction types for which implementation guides are not available, to allow providers and group purchasers to implement electronic data interchange. In promoting the development of these implementation guides, the commissioner shall review the work done by the American Hospital Association through the national Uniform Billing Committee and its state representative organization; the American Medical Association through the National Uniform Claim Committee; the American Dental Association; the National Council of Prescription Drug Programs; and the Workgroup for Electronic Data Interchange.

History: *1994 c 625 art 9 s 7; 1996 c 440 art 1 s 29; 2014 c 192 art 1 s 11-13*

62J.57 MS 2024 [Repealed, 2026 c 127 art 1 s 44]

62J.58 [Repealed, 2008 c 305 s 11]

62J.581 STANDARDS FOR MINNESOTA UNIFORM HEALTH CARE REIMBURSEMENT DOCUMENTS.

Subdivision 1. **Minnesota uniform remittance advice.** All group purchasers shall provide a uniform claim payment/advice transaction to health care providers when a claim is adjudicated. The uniform claim payment/advice transaction shall comply with section 62J.536, subdivision 1, paragraph (b), and rules adopted under section 62J.536, subdivision 2.

Subd. 2. **Minnesota uniform explanation of benefits.** (a) All group purchasers shall provide a uniform explanation of benefits to health care patients when an explanation of benefits is provided as otherwise required or permitted by law. The uniform explanation of benefits shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. **Scope.** For purposes of sections 62J.50 to 62J.61, the uniform explanation of benefits format specified in subdivision 4 shall apply to all health care services delivered by a health care provider or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis, such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in subdivision 2 if they comply with section 62A.01, subdivisions 2 and 3.

Subd. 4. **Specifications.** (a) The uniform explanation of benefits shall be provided by use of a paper document conforming to the specifications in this section or its electronic equivalent under paragraph (b).

(b) Group purchasers may make the uniform explanation of benefits available in a version that can be accessed by health care patients electronically if:

(1) the group purchaser making the uniform explanation of benefits available electronically provides health care patients the ability to choose whether to receive paper, electronic, or both paper and electronic versions of their uniform explanation of benefits;

(2) the group purchaser provides clear, readily accessible information and instructions for the patient to communicate their choice; and

(3) health care patients not responding to the opportunity to make a choice will receive at a minimum a paper uniform explanation of benefits.

(c) The commissioner, after consulting with the Administrative Uniformity Committee, shall specify the data elements and definitions for the paper uniform explanation of benefits. Any electronic version of the uniform explanation of benefits must use the same data elements and definitions as the paper uniform explanation of benefits.

Subd. 5. MS 2024 [Repealed by amendment, 1Sp2025 c 3 art 2 s 5]

History: *2000 c 460 s 7; 2002 c 307 art 2 s 7; 2002 c 330 s 23; 2005 c 106 s 8; 2014 c 192 art 1 s 14-16; 2023 c 25 s 7; 1Sp2025 c 3 art 2 s 5*

62J.59 [Repealed, 2014 c 192 art 1 s 19]

62J.60 MINNESOTA UNIFORM HEALTH CARE IDENTIFICATION CARD.

Subdivision 1. **Requirements for identification card.** All individuals with health care coverage shall be issued Minnesota uniform health care identification cards by group purchasers as of January 1, 1998, unless the requirements of section 62A.01, subdivisions 2 and 3, are met. If a health benefit plan issued by a group purchaser provides coverage for prescription drugs, the group purchaser shall include uniform prescription drug information on the uniform health care identification card issued to its enrollees on or after July 1, 2003. Nothing in this section requires a group purchaser to issue a separate card containing uniform prescription drug information, provided that the Minnesota uniform health care identification card can accommodate the information necessary to process prescription drug claims as required by this section. The Minnesota uniform health care identification cards shall comply with the standards prescribed in this section.

Subd. 1a. **Definition; health benefit plan.** For purposes of this section, "health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a group purchaser for the coverage of medical and hospital benefits. A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile or homeowners medical payment coverage;

(3) liability insurance or supplemental to liability insurance;

(4) accident-only coverage;

(5) credit accident and health insurance issued under chapter 62B;

(6) designed solely to provide dental or vision care;

(7) designed solely to provide coverage for a specified disease or illness;

(8) coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(9) hospital income or indemnity.

Subd. 2. **General characteristics.** (a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements.

(c) Standardized labels are required next to human readable data elements and must come before the human data elements.

Subd. 2a. **Issuance.** A new Minnesota uniform health care identification card must be issued to individuals upon enrollment. Except for the medical assistance and MinnesotaCare programs, a new card must be issued upon any change in an individual's health care coverage that impacts the content or format of the data included on the card or no later than 24 months after adoption of any change in the NCPDP implementation guide or successor document that affects the content or format of the data included on the card. Anytime that a card is issued upon enrollment or replaced by the medical assistance or MinnesotaCare program, the card must conform to the adopted NCPDP standards in effect and to the implementation guide in use at the time of issuance. Newly issued cards must conform to the adopted NCPDP standards in effect at the time of issuance and to the implementation guide in use at the time of issuance. Stickers or other methodologies may be used to update cards temporarily.

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

(3) cardholder (insured) identification number, which is the unique identification number of the individual cardholder established and defined under this section. The standardized label for the data element is "ID";

(4) cardholder (insured) identification name, which is the name of the individual cardholder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

(5) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

(6) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health. The standard label for this data element is "Svc Type"; and

(7) provider/clinic name, which is the name of the primary care clinic the cardholder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the cardholder.

(b) The following human readable data elements shall be present on the back side of the Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69 or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

Subd. 4. **Machine readable data content.** The Minnesota uniform health care identification card may be machine readable or nonmachine readable. If the card is machine readable, the card must contain a magnetic stripe that conforms to ANSI and ISO standards for Tracks 1.

Subd. 5. **Annual reporting.** As part of an annual filing made with the commissioner of health or commerce on or after January 1, 2003, a group purchaser shall certify compliance with this section and shall submit to the commissioner of health or commerce a copy of the Minnesota uniform health care identification card used by the group purchaser.

History: *1994 c 625 art 9 s 11; 1996 c 440 art 1 s 31,32; 1997 c 205 s 17; 1997 c 225 art 2 s 62; 2000 c 460 s 8; 2001 c 110 s 1; 2006 c 255 s 22,23; 2007 c 147 art 9 s 8,9; 2016 c 158 art 2 s 15,16*

62J.61 RULEMAKING; IMPLEMENTATION.

Subdivision 1. **Exemption.** The commissioner of health is exempt from chapter 14, including section 14.386, in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.581.

Subd. 2. **Procedure.** (a) The commissioner shall publish proposed rules in the State Register or, if the commissioner determines that publishing the text of the proposed rules would be unduly cumbersome, shall publish notice of the proposed rules that contains a detailed description of the rules along with a statement that a free copy of the entire set of rules is available upon request to the agency.

(b) Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish notice in the State Register that the rules have been adopted 30 days before they are to take effect.

(c) If the adopted rules are the same as the proposed rules, the notice shall state that the rules have been adopted as proposed and shall cite the prior publication. If the adopted rules differ from the proposed rules, the portions of the adopted rules which differ from the proposed rules shall be included in the notice of adoption together with a citation to the prior State Register that contained the notice of the proposed rules.

(d) The commissioner may use rulemaking to implement sections 62J.54, subdivision 4, 62J.55, and 62J.60.

Subd. 3. **Restrictions.** The commissioner shall not adopt any rules requiring patients to provide their Social Security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter.

Subd. 4. **Patient privacy.** The commissioner shall seek comments from the Ethics and Confidentiality Committee of the Minnesota Health Data Institute and the Department of Administration, Public Information Policy Analysis Division, before adopting or publishing final rules relating to issues of patient privacy and medical records.

Subd. 5. **Opportunity for comment.** The commissioner shall maintain an email address for submission of comments from interested parties to provide input about the effectiveness of and continued need for the rulemaking procedures set out in subdivision 2 and about the quality and effectiveness of rules adopted using these procedures. The commissioner may seek additional input and provide additional opportunities for input as needed.

History: *1994 c 625 art 9 s 12; 1997 c 187 art 4 s 3; 1998 c 254 art 1 s 14; 2014 c 192 art 1 s 17; 2024 c 127 art 59 s 3*

62J.62 ELECTRONIC BILLING ASSISTANCE.

The commissioner of human services shall, out of existing resources, encourage and assist providers to adopt and use electronic billing for state programs, including but not limited to the provision of training.

History: *2006 c 267 art 1 s 1*

62J.63 CENTER FOR HEALTH CARE PURCHASING IMPROVEMENT.

Subdivision 1. **Support for state health care purchasing and performance measurement.** The commissioner of health shall support the state in its efforts to be a more prudent and efficient purchaser of quality health care services, aid the state in developing and using more common strategies and approaches for health care performance measurement and health care purchasing, promote greater transparency of health care costs and quality and greater accountability for health care results and improvement, and identify barriers to more efficient, effective, quality health care and options for overcoming the barriers.

Subd. 2. **Duties; scope.** The commissioner of health may:

(1) require reports or surveys to evaluate the performance of current health care purchasing or administrative simplification strategies;

(2) calculate fiscal impacts, including net savings and return on investment, of health care purchasing strategies and initiatives;

(3) support the Administrative Uniformity Committee under sections 62J.50 and 62J.536 and other relevant groups or activities to advance agreement on health care administrative process streamlining;

(4) contact and participate with other relevant health care task forces, study activities, and similar efforts with regard to health care performance measurement and performance-based purchasing; and

(5) assist in seeking external funding through appropriate grants or other funding opportunities and may administer grants and externally funded projects.

Subd. 3. MS 2020 [Repealed, 1Sp2021 c 7 art 3 s 47]

History: *2006 c 282 art 14 s 10; 2007 c 148 art 2 s 83; 2009 c 157 art 1 s 17; 1Sp2021 c 7 art 3 s 6,7*

62J.65 [Repealed, 1995 c 234 art 8 s 57]

62J.66 [Repealed, 1Sp2003 c 14 art 2 s 57]

62J.68 [Repealed, 1Sp2003 c 14 art 2 s 57]

62J.685 [Repealed, 1998 c 407 art 2 s 109]

62J.69 [Repealed, 1999 c 245 art 2 s 45]

MEDICAL EDUCATION AND RESEARCH

62J.691 PURPOSE.

The legislature finds that medical education and research are important to the health and economic well being of Minnesotans. The legislature further finds that, as a result of competition in the health care marketplace, these teaching and research institutions are facing increased difficulty funding medical education and research. The purpose of section 62J.692 is to help offset lost patient care revenue for those teaching institutions affected by increased competition in the health care marketplace and to help ensure the continued excellence of health care research in Minnesota.

History: *1999 c 245 art 2 s 9; 2014 c 275 art 1 s 6*

62J.692 MEDICAL EDUCATION.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply:

(b) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health.

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

(d) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy students and residents), doctors of chiropractic, dentists (dental students and residents), advanced practice registered nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

(e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(f) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(g) "Trainee" means a student or resident involved in a clinical medical education program.

(h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification (NPI) number where training occurs as part of or under the scope of either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues. Training that occurs in nursing facility settings, rural health clinics, or federally qualified health centers is not eligible for funding under this section.

Subd. 2. [Repealed, 2007 c 133 art 2 s 13]

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, or community health workers is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities, including training hours in settings outside of the hospital or clinic site, as applicable, including but not limited to school, home, and community settings; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program on a timeline determined by the commissioner. An application for funds must contain information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

(d) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the applicable funding cycle.

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute revenue credited or money transferred to the medical education and research costs account under subdivision 8 and section 297F.10, subdivision 1, clause (2), to all qualifying applicants based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision.

Training sites whose training site level grant is less than $5,000, based on the formulas described in this subdivision, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the formulas described in this subdivision.

(b) Money appropriated through the state general fund, the health care access fund, and any additional fund for the purpose of funding medical education and research costs and that does not require federal approval must be awarded only to eligible training sites that do not qualify for a medical education and research cost rate factor under sections 256.969, subdivision 2b, paragraph (k), or 256B.75, paragraph (b). The commissioner shall distribute the available medical education money appropriated to eligible training sites that do not qualify for a medical education and research cost rate factor based on a distribution formula determined by the commissioner. The distribution formula under this paragraph must consider clinical training costs, public program revenues, and other factors identified by the commissioner that address the objective of supporting clinical training.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraphs (a) and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include disqualifying the training site under this section or the removal of students from the site.

(e) Use of funds is limited to expenses related to eligible clinical training costs. The commissioner shall develop a methodology for determining eligible costs.

(f) Any funds that cannot be distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. When appropriate, the commissioner shall include the undistributed money in the subsequent distribution cycle using the applicable methodology described in this subdivision.

Subd. 4a. MS 2022 [Repealed, 2023 c 70 art 5 s 16]

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site.

(b) The reports must provide verification of the distribution of the funds and must include:

(1) documentation of any discrepancies between the grant distribution notice included in the commissioner's approval letter and the actual distribution;

(2) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

(3) other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

Subd. 6. **Other available funds.** The commissioner is authorized to distribute, in accordance with subdivision 4, funds made available through:

(1) voluntary contributions by employers or other entities;

(2) allocations for the commissioner of human services to support medical education and research; and

(3) other sources as identified and deemed appropriate by the legislature for inclusion in the fund.

Subd. 7. MS 2022 [Repealed, 2023 c 70 art 5 s 16]

Subd. 7a. MS 2022 [Repealed, 2023 c 70 art 5 s 16]

Subd. 8. **Federal financial participation.** The commissioner of human services shall seek federal financial participation for the dedicated revenue for medical education and research costs provided under section 297F.10, subdivision 1, clause (2).

Subd. 9. **Review of eligible providers.** The commissioner may review provider groups included in the definition of a clinical medical education program to assure that the distribution of the funds continue to be consistent with the purpose of this section. The results of any such reviews must be reported to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance.

Subd. 10. [Repealed, 2007 c 147 art 15 s 22]

History: *1999 c 245 art 2 s 10; 2000 c 494 s 1-3; 2001 c 161 s 14; 1Sp2001 c 9 art 2 s 2,3; 2002 c 220 art 15 s 1,2; 2002 c 277 s 32; 2002 c 375 art 3 s 1; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 7 s 16-19; art 12 s 1; 1Sp2003 c 21 art 9 s 1,2; 2004 c 228 art 1 s 16; 2005 c 10 art 1 s 81; 2005 c 84 s 1-3; 1Sp2005 c 4 art 2 s 1; 2007 c 147 art 15 s 5-8; 2009 c 79 art 5 s 4; 1Sp2010 c 1 art 21 s 1; 1Sp2011 c 9 art 2 s 3; art 6 s 13; 2013 c 108 art 12 s 4-9; 2015 c 71 art 8 s 6; 2016 c 158 art 2 s 17; 2022 c 58 s 170; 2022 c 98 art 14 s 1; 2023 c 70 art 5 s 1-5*

62J.693 [Repealed, 2013 c 108 art 12 s 109]

62J.694 [Repealed, 2006 c 282 art 14 s 15]

PATIENT PROTECTION ACT

62J.695 CITATION.

Sections 62J.695 to 62J.76 may be cited as the "Patient Protection Act."

History: *1997 c 237 s 1*

62J.70 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62J.70 to 62J.76, the terms defined in this section have the meanings given them.

Subd. 2. **Health care provider or provider.** "Health care provider" or "provider" means:

(1) a physician, nurse, or other provider as defined under section 62J.03;

(2) a hospital as defined under section 144.696, subdivision 3;

(3) an individual or entity that provides health care services under the medical assistance, MinnesotaCare, or state employee group insurance program; and

(4) an association, partnership, corporation, limited liability corporation, or other organization of persons or entities described in clause (1) or (2) organized for the purposes of providing, arranging, or administering health care services or treatment.

This section does not apply to trade associations, membership associations of health care professionals, or other organizations that do not directly provide, arrange, or administer health care services or treatment.

Subd. 3. **Health plan company.** "Health plan company" means health plan company as defined in section 62Q.01, subdivision 4.

Subd. 4. **Enrollee.** "Enrollee" means an individual covered by a health plan company or health insurance or health coverage plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder.

History: *1997 c 237 s 2; 2016 c 158 art 2 s 18*

62J.701 GOVERNMENTAL PROGRAMS.

(a) Beginning January 1, 1999, the provisions in paragraphs (b) to (e) apply.

(b) For purposes of sections 62J.695 to 62J.80, the requirements and other provisions that apply to health plan companies also apply to governmental programs.

(c) For purposes of this section, "governmental programs" means the medical assistance program, the MinnesotaCare program, the state employee group insurance program, the public employees insurance program under section 43A.316, and coverage provided by political subdivisions under section 471.617.

(d) Notwithstanding paragraph (b), section 62J.72 does not apply to the fee-for-service programs under medical assistance and MinnesotaCare.

(e) If a state commissioner or local unit of government contracts with a health plan company or a third-party administrator, the contract may assign any obligations under paragraph (b) to the health plan company or third-party administrator. Nothing in this paragraph shall be construed to remove or diminish

any enforcement responsibilities of the commissioners of health or commerce provided in sections 62J.695 to 62J.80.

History: *1998 c 407 art 2 s 9; 2016 c 158 art 2 s 19*

62J.71 PROHIBITED PROVIDER CONTRACTS.

Subdivision 1. **Prohibited agreements and directives.** The following types of agreements and directives are contrary to state public policy, are prohibited under this section, and are null and void:

(1) any agreement or directive that prohibits a health care provider from communicating with an enrollee with respect to the enrollee's health status, health care, or treatment options, if the health care provider is acting in good faith and within the provider's scope of practice as defined by law;

(2) any agreement or directive that prohibits a health care provider from making a recommendation regarding the suitability or desirability of a health plan company, health insurer, or health coverage plan for an enrollee, unless the provider has a financial conflict of interest in the enrollee's choice of health plan company, health insurer, or health coverage plan;

(3) any agreement or directive that prohibits a provider from providing testimony, supporting or opposing legislation, or making any other contact with state or federal legislators or legislative staff or with state and federal executive branch officers or staff;

(4) any agreement or directive that prohibits a health care provider from disclosing accurate information about whether services or treatment will be paid for by a patient's health plan company or health insurer or health coverage plan; and

(5) any agreement or directive that prohibits a health care provider from informing an enrollee about the nature of the reimbursement methodology used by an enrollee's health plan company, health insurer, or health coverage plan to pay the provider.

Subd. 2. **Persons and entities affected.** The following persons and entities shall not enter into any agreement or directive that is prohibited under this section:

(1) a health plan company;

(2) a health care network cooperative as defined under section 62R.04, subdivision 3; or

(3) a health care provider as defined in section 62J.70, subdivision 2.

Subd. 3. **Retaliation prohibited.** No person, health plan company, or other organization may take retaliatory action against a health care provider solely on the grounds that the provider:

(1) refused to enter into an agreement or provide services or information in a manner that is prohibited under this section or took any of the actions listed in subdivision 1;

(2) disclosed accurate information about whether a health care service or treatment is covered by an enrollee's health plan company, health insurer, or health coverage plan;

(3) discussed diagnostic, treatment, or referral options that are not covered or are limited by the enrollee's health plan company, health insurer, or health coverage plan;

(4) criticized coverage of the enrollee's health plan company, health insurer, or health coverage plan; or

(5) expressed personal disagreement with a decision made by a person, organization, or health care provider regarding treatment or coverage provided to a patient of the provider, or assisted or advocated for the patient in seeking reconsideration of such a decision, provided the health care provider makes it clear that the provider is acting in a personal capacity and not as a representative of or on behalf of the entity that made the decision.

Subd. 4. **Exclusion.** (a) Nothing in this section prohibits an entity that is subject to this section from taking action against a provider if the entity has evidence that the provider's actions are illegal, constitute medical malpractice, or are contrary to accepted medical practices.

(b) Nothing in this section prohibits a contract provision or directive that requires any contracting party to keep confidential or to not use or disclose the specific amounts paid to a provider, provider fee schedules, provider salaries, and other proprietary information of a specific entity that is subject to this section.

History: *1997 c 237 s 3; 1998 c 407 art 2 s 10-12*

62J.72 DISCLOSURE OF HEALTH CARE PROVIDER INFORMATION.

Subdivision 1. **Written disclosure.** (a) A health plan company, as defined under section 62J.70, subdivision 3, a health care network cooperative as defined under section 62R.04, subdivision 3, and a health care provider as defined under section 62J.70, subdivision 2, shall, during open enrollment, upon enrollment, and annually thereafter, provide enrollees with a description of the general nature of the reimbursement methodologies used by the health plan company, health insurer, or health coverage plan to pay providers. The description must explain clearly any aspect of the reimbursement methodology that creates a financial incentive for the health care provider to limit or restrict the health care provided to enrollees. An entity required to disclose shall also disclose if no reimbursement methodology is used that creates a financial incentive for the health care provider to limit or restrict the health care provided to enrollees. This description may be incorporated into the member handbook, subscriber contract, certificate of coverage, or other written enrollee communication. The general reimbursement methodology shall be made available to employers at the time of open enrollment.

(b) Health plan companies, health care network cooperatives, and providers must, upon request, provide an enrollee with specific information regarding the reimbursement methodology, including, but not limited to, the following information:

(1) a concise written description of the provider payment plan, including any incentive plan applicable to the enrollee;

(2) a written description of any incentive to the provider relating to the provision of health care services to enrollees, including any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee, or the number of referrals to or utilization of specialists; and

(3) a written description of any incentive plan that involves the transfer of financial risk to the health care provider.

(c) The disclosure statement describing the general nature of the reimbursement methodologies must comply with the Readability of Insurance Policies Act in chapter 72C and must be filed with and approved by the commissioner prior to its use.

(d) A disclosure statement that has been filed with the commissioner for approval under paragraph (c) is deemed approved 30 days after the date of filing, unless approved or disapproved by the commissioner on or before the end of that 30-day period.

(e) The disclosure statement describing the general nature of the reimbursement methodologies must be provided upon request in English, Spanish, Vietnamese, and Hmong. In addition, reasonable efforts must be made to provide information contained in the disclosure statement to other non-English-speaking enrollees.

(f) Health plan companies and providers may enter into agreements to determine how to respond to enrollee requests received by either the provider or the health plan company. This subdivision does not require disclosure of specific amounts paid to a provider, provider fee schedules, provider salaries, or other proprietary information of a specific health plan company or health insurer or health coverage plan or provider.

Subd. 2. **Additional written disclosure of provider information.** In the event a health plan company prepares a written disclosure as specified in subdivision 1, in a manner that explicitly makes a comparison of the financial incentives between the providers with whom it contracts, it must describe the incentives that occur at the provider level.

Subd. 3. **Information on patients' medical bills.** A health plan company and health care provider shall provide patients and enrollees with a copy of an explicit and intelligible bill whenever the patient or enrollee is sent a bill and is responsible for paying any portion of that bill. The bills must contain descriptive language sufficient to be understood by the average patient or enrollee. This subdivision does not apply to a flat co-pay paid by the patient or enrollee at the time the service is required.

Subd. 4. **Nonapplicability.** Health care providers as defined in section 62J.70, subdivision 2, clause (1), need not individually provide information required under this section if it has been provided by another individual or entity that is subject to this section.

History: *1997 c 237 s 4; 1998 c 407 art 2 s 13*

62J.73 PROHIBITION ON EXCLUSIVE ARRANGEMENTS.

Subdivision 1. **Prohibition on exclusive relationships.** No provider, group of providers, or health plan company shall restrict a person's right to provide health services or procedures to another provider, group of providers, or health plan company, unless the person is an employee.

Subd. 2. **Prohibition on restrictive contract terms.** No provider, group of providers, or person providing goods or health services to a provider shall enter into a contract or subcontract with a health plan company or group of providers on terms that require the provider, group of providers, or person not to contract with another health plan company, unless the provider or person is an employee.

Subd. 3. **Prohibition regarding essential facilities and services.** (a) No health plan company, provider, or group of providers may withhold from its competitors health care services, which are essential for competition between health care providers within the meaning of the essential facilities doctrine as interpreted by the federal courts.

(b) This subdivision should be construed as an instruction to state court in interpreting federal law.

Subd. 4. **Violations.** Any provider or other individual who believes provisions of this section may have been violated may file a complaint with the attorney general's office regarding a possible violation of this section.

History: *1997 c 237 s 5*

62J.74 ENFORCEMENT.

Subdivision 1. **Authority.** The commissioners of health and commerce shall each periodically review contracts and arrangements among health care providing entities and health plan companies they regulate to determine compliance with sections 62J.70 to 62J.73. Any person may submit a contract or arrangement to the relevant commissioner for review if the person believes sections 62J.70 to 62J.73 have been violated. Any provision of a contract or arrangement found by the relevant commissioner to violate this section is null and void, and the relevant commissioner may assess civil penalties against the health plan company in an amount not to exceed $2,500 for each day the contract or arrangement is in effect, and may use the enforcement procedures otherwise available to the commissioner. All due process rights afforded under chapter 14 apply to this section.

Subd. 2. **Assistance to licensing boards.** A health-related licensing board as defined under section 214.01, subdivision 2, shall submit a contract or arrangement to the relevant commissioner for review if the board believes sections 62J.70 to 62J.73 have been violated. If the commissioner determines that any provision of a contract or arrangement violates those sections, the board may take disciplinary action against any person who is licensed or regulated by the board who entered into the contract arrangement.

History: *1997 c 237 s 6*

62J.75 [Expired]

62J.76 NONPREEMPTION.

Nothing in the Patient Protection Act preempts or replaces requirements related to patient protections that are more protective of patient rights than the requirements established by the Patient Protection Act.

History: *1997 c 237 s 8*

62J.77 [Repealed, 1999 c 245 art 2 s 45]

62J.78 [Repealed, 1999 c 245 art 2 s 45]

62J.79 [Repealed, 1999 c 245 art 2 s 45]

62J.80 RETALIATION.

A health plan company or health care provider shall not retaliate or take adverse action against an enrollee or patient who, in good faith, makes a complaint against a health plan company or health care provider. If retaliation is suspected, the executive director may report it to the appropriate regulatory authority.

History: *1998 c 407 art 2 s 18*

62J.805 DEFINITIONS.

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

Subd. 2. **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 (1) miscoding a health treatment or service, (2) an error in determining whether a health treatment or service is covered under the patient's health plan, or (3) an error in determining the cost-sharing owed by the patient.

Subd. 3. **Group practice.** "Group practice" has the meaning given to health care provider group practice in section 145D.01, subdivision 1.

Subd. 4. **Health care provider.** "Health care provider" means:

(1) a health professional who is licensed or registered by the state to provide health treatment and services within the professional's scope of practice and in accordance with state law;

(2) a group practice; or

(3) a hospital.

Subd. 5. **Health plan.** "Health plan" has the meaning given in section 62A.011, subdivision 3.

Subd. 6. **Hospital.** "Hospital" means a health care facility licensed as a hospital under sections 144.50 to 144.56.

Subd. 7. **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 to diagnose or treat 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. 8. **Payment.** "Payment" includes co-payments and coinsurance and deductible payments made by a patient.

History: *2024 c 114 art 3 s 25*

62J.806 POLICY FOR COLLECTION OF MEDICAL DEBT.

Subdivision 1. **Requirement.** A health care provider must make available to the public the health care provider's policy for collecting medical debt from patients. The policy must be made available by:

(1) clearly posting the policy 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 the policy.

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

(1) communicate with patients about the medical debt owed and collecting medical debt;

(2) refer medical debt to a collection agency or law firm for collection; and

(3) identify medical debt as uncollectible or satisfied, and ending collection activities.

History: *2024 c 114 art 3 s 26*

62J.807 DENIAL OF HEALTH TREATMENT OR SERVICES DUE TO OUTSTANDING MEDICAL DEBT.

(a) A health care provider must not deny medically necessary health treatment or services to a patient or any member of the patient's family or household because of current or previous 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 treatment 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.

History: *2024 c 114 art 3 s 27*

62J.808 BILLING ERRORS; HEALTH TREATMENT OR SERVICES.

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.

(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 the bill, the health care provider must, within 30 days after completing the review, refund to the patient the amount the patient overpaid under the bill.

Subd. 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:

(1) of the potential billing error;

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

(3) that 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.

(b) The notice required under this subdivision must be transmitted to the patient within 30 days after the date 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 (1) notify the patient that the review is complete, (2) 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 (3) 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 date the health care provider or health plan company completes the review.

History: *2024 c 114 art 3 s 28*

PRICE TRANSPARENCY; INFORMATION REPORTING

62J.81 DISCLOSURE OF PAYMENTS FOR HEALTH CARE SERVICES.

Subdivision 1. **Required disclosure by provider.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay.

(b) In addition to the information required to be disclosed under paragraph (a), a provider must also provide the consumer with information regarding other types of fees or charges that the consumer may be required to pay in conjunction with a visit to the provider, including but not limited to any applicable facility fees.

(c) The information required under this subdivision must be provided to a consumer within ten business days from the day a complete request was received by the health care provider. For purposes of this section, "complete request" includes all the patient and service information the health care provider requires to provide a good faith estimate, including a completed good faith estimate form if required by the health care provider.

(d) Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(e) No contract between a health plan company and a provider shall prohibit a provider from disclosing the pricing information required under this subdivision.

Subd. 1a. **Required disclosure by health plan company.** (a) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee intending to receive specific health care services or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the

enrollee and the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.

(b) The information required under this subdivision must be provided by the health plan company to an enrollee within ten business days from the day a complete request was received by the health plan company. For purposes of this section, "complete request" includes all the patient and service information the health plan company requires to provide a good faith estimate, including a completed good faith estimate form if required by the health plan company.

Subd. 2. **Applicability.** (a) For purposes of this section, "consumer" does not include a medical assistance or MinnesotaCare enrollee, for services covered under those programs.

(b) For purposes of this section, a good faith estimate is not:

(1) a guarantee of final costs for services received from a health care provider; or

(2) a final determination of eligibility for coverage of benefits or provider network participation under a health plan.

History: *2004 c 288 art 7 s 3; 2006 c 255 s 24; 2007 c 147 art 15 s 9; 2011 c 108 s 36; 2016 c 158 art 2 s 20; 2018 c 168 s 1*

62J.811 PROVIDER BALANCE BILLING REQUIREMENTS.

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

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

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

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

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

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

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

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

(g) Any data collected by the commissioner as part of an active investigation or active compliance review under this section are classified (1) if the data is not on individuals, it is classified as protected nonpublic data pursuant to section 13.02 subdivision 13; or (2) if the data is on individuals, it is classified as confidential pursuant to section 13.02, subdivision 3. Data describing the final disposition of an investigative or compliance review are classified as public.

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

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

History: *2023 c 70 art 2 s 5*

62J.812 PRIMARY CARE PRICE TRANSPARENCY.

(a) Each provider shall maintain a list of the services over $25 that correspond with the provider's 25 most frequently billed current procedural terminology (CPT) codes, including the provider's ten most commonly billed evaluation and management codes, and of the ten most frequently billed CPT codes for preventive services. If the provider is associated with a health care system, the health care system may develop the list of services required under this paragraph for the providers within the health care system.

(b) For each service listed in paragraph (a), the provider shall disclose the provider's charge, the average reimbursement rate received for the service from the provider's health plan payers in the commercial insurance market, and, if applicable, the Medicare allowable payment rate and the medical assistance fee-for-service payment rate. For purposes of this paragraph, "provider's charge" means the dollar amount the provider charges to a patient who has received the service and who is not covered by private or public health care coverage.

(c) The list described in this subdivision must be updated annually and must be posted in the provider's reception area of the clinic or office and made available on the provider's website, if the provider maintains a website.

(d) For purposes of this section, "provider" means a primary care provider or clinic that specializes in family medicine, general internal medicine, gynecology, or general pediatrics.

(e) No contract between a health plan company and a provider shall prohibit a provider from disclosing the pricing information required under this section.

History: *2018 c 168 s 2; 2020 c 83 art 1 s 10*

62J.82 HOSPITAL INFORMATION REPORTING DISCLOSURE.

Subdivision 1. **Required information.** The Minnesota Hospital Association shall develop a web-based system, available to the public free of charge, for reporting the following, for Minnesota residents:

(1) hospital-specific performance on the measures of care developed under section 256B.072 for acute myocardial infarction, heart failure, and pneumonia;

(2) by January 1, 2009, hospital-specific performance on the public reporting measures for hospital-acquired infections as published by the National Quality Forum and collected by the Minnesota Hospital Association and Stratis Health in collaboration with infection control practitioners; and

(3) charge information, including, but not limited to, number of discharges, average length of stay, average charge, average charge per day, and median charge, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association.

Subd. 2. **Website.** The website must provide information that compares hospital-specific data to hospital statewide data. The website must be updated annually. The commissioner shall provide a link to this reporting information on the department's website.

Subd. 3. **Enforcement.** The commissioner shall provide a link to this information on the department's website. If a hospital does not provide this information to the Minnesota Hospital Association, the commissioner of health may require the hospital to do so in accordance with section 144.55, subdivision 6.

History: *1Sp2005 c 4 art 8 s 2; 2007 c 147 art 14 s 1*

62J.823 HOSPITAL PRICING TRANSPARENCY.

Subdivision 1. **Short title.** This section may be cited as the "Hospital Pricing Transparency Act."

Subd. 2. **Definition.** For the purposes of this section, "estimate" means the actual price expected to be billed to the individual or to the individual's health plan company based on the specific diagnostic-related group code or specific procedure code or codes, reflecting any known discounts the individual would receive.

Subd. 3. **Applicability and scope.** Any hospital, as defined in section 144.696, subdivision 3, and outpatient surgical center, as defined in section 144.696, subdivision 4, shall provide a written estimate of the cost of a specific service or stay upon the request of a patient, a doctor, an advanced practice registered nurse, a physician assistant, or the patient's representative. The request must include:

(1) the health coverage status of the patient, including the specific health plan or other health coverage under which the patient is enrolled, if any; and

(2) at least one of the following:

(i) the specific diagnostic-related group code;

(ii) the name of the procedure or procedures to be performed;

(iii) the type of treatment to be received; or

(iv) any other information that will allow the hospital or outpatient surgical center to determine the specific diagnostic-related group or procedure code or codes.

Subd. 4. **Estimate.** (a) An estimate provided by the hospital or outpatient surgical center must contain:

(1) the method used to calculate the estimate;

(2) the specific diagnostic-related group or procedure code or codes used to calculate the estimate, and a description of the diagnostic-related group or procedure code or codes that is reasonably understandable to a patient; and

(3) a statement indicating that the estimate, while accurate, may not reflect the actual billed charges and that the final bill may be higher or lower depending on the patient's specific circumstances.

(b) The estimate may be provided in any method that meets the needs of the patient and the hospital or outpatient surgical center, including electronically; however, a paper copy must be provided if specifically requested.

History: *2006 c 255 s 25; 2020 c 115 art 4 s 7; 2022 c 58 s 10*

62J.824 FACILITY FEE DISCLOSURE.

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

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

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

(d) For purposes of this section:

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

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

History: *2019 c 7 s 1; 2023 c 70 art 2 s 6*

62J.826 MEDICAL AND DENTAL PRACTICES; CURRENT STANDARD CHARGES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) hospitals;

(2) outpatient surgical centers; and

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

(i) diagnostic radiology services;

(ii) diagnostic laboratory testing;

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

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

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

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

(vii) dental services.

Subd. 3. **Required file format and content.** (a) A medical or dental practice that is subject to this section must make available to the public current standard charges using the format and data elements specified in the currently effective version of the Hospital Price Transparency Sample Format (Tall) (CSV) and related data dictionary recommended for hospitals by the Centers for Medicare and Medicaid Services (CMS). If CMS modifies or replaces the specifications for this format, the form of this file must be modified or replaced to conform with the new CMS specifications by the date specified by CMS for compliance with its new specifications. All prices included in the file must be expressed as dollar amounts. The data must be in the form of a comma separated values file which can be directly imported, without further editing or remediation, into a relational database table which has been designed to receive these files. The medical or dental practice must make the file available to the public in a manner specified by the commissioner.

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

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

History: *2023 c 70 art 2 s 7*

62J.83 REDUCED PAYMENT AMOUNTS PERMITTED.

(a) Notwithstanding any provision of chapter 148 or any other provision of law to the contrary, a health care provider may provide care to a patient at a discounted payment amount, including care provided for free.

(b) This section does not apply in a situation in which the discounted payment amount is not permitted under federal law.

History: *2006 c 255 s 26; 2008 c 344 s 56; 2009 c 86 art 1 s 88*

62J.84 PRESCRIPTION DRUG PRICE TRANSPARENCY.

Subdivision 1. **Short title.** This section may be cited as the "Prescription Drug Price Transparency Act."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

containing less than the specified number of digits such that each segment contains the specified number of digits.

(o) "Pharmacy" or "pharmacy provider" means a community/outpatient pharmacy as defined in Minnesota Rules, part 6800.0100, subpart 2, that is also licensed as a pharmacy by the Board of Pharmacy under section 151.19.

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

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

(r) "Rebate" means a discount, chargeback, or other price concession that affects the price of a prescription drug product, regardless of whether conferred through regular aggregate payments, on a claim-by-claim basis at the point of sale, as part of retrospective financial reconciliations, including reconciliations that also reflect other contractual arrangements, or by any other method. Rebate does not mean a bona fide service fee as defined in Code of Federal Regulations, title 42, section 447.502.

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

(t) "Wholesale drug distributor" or "wholesaler" means an entity that is licensed to act as a wholesale drug distributor under section 151.47.

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

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

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

(4) the year the prescription drug was introduced for sale in the United States;

(5) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the price increase;

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

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug;

(7) the number of units of the prescription drug sold during the previous 12-month period;

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

(9) the total rebate payable amount accrued for the prescription drug during the previous 12-month period;

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

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

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

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

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

(15) if a brand name prescription drug, the highest price paid for the prescription drug during the previous calendar year in the ten countries, excluding the United States, that charged the highest single price for the prescription drug; and

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

(i) price at acquisition;

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

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

(iv) date of acquisition; and

(v) acquisition price.

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

Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no later than 60 days after a manufacturer introduces a new prescription drug for sale in the United States that is a new brand name drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than 30 days and is not at least 15 percent lower than the referenced brand name drug when the generic or biosimilar drug is launched, the manufacturer must submit to the commissioner, in the form and manner prescribed by the commissioner, the following information, if applicable:

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the price of the prescription drug;

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

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

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug; and

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

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

Subd. 5. MS 2022 [Repealed, 2023 c 70 art 2 s 43]

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

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

(2) a list of reporting entities that reported prescription drug price information under subdivisions 3, 4, and 11 to 14; and

(3) information reported to the commissioner under subdivisions 3, 4, and 11 to 14, aggregated on a per-drug basis in a manner that does not allow the identification of a reporting entity that is not the manufacturer of the drug.

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

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

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

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

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section.

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

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

(1) failing to register under subdivision 15;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Not sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via email, reporting entities registered with the department of:

(1) the requirement to report under subdivisions 11 to 14; and

(2) the reporting period for which data must be provided.

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

(d) Notwithstanding subdivision 16, the commissioner is exempt from chapter 14, including section 14.386, in implementing this subdivision.

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

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

(2) which the manufacturer manufactures or repackages;

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

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

(ii) the introduced to market date; or

(iii) the acquisition date;

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

(4) the year the prescription drug was introduced for sale in the United States;

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

(6) the direct costs incurred during the reporting period specified in the notification to report by the manufacturers that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug;

(7) the number of units of the prescription drug sold during the reporting period specified in the notification to report;

(8) the total sales revenue for the prescription drug during the reporting period specified in the notification to report;

(9) the total rebate payable amount accrued for the prescription drug during the reporting period specified in the notification to report;

(10) the manufacturer's net profit attributable to the prescription drug during the reporting period specified in the notification to report;

(11) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the reporting period specified in the notification to report, if applicable;

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

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

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

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

(16) if the prescription drug was acquired by the manufacturer within the reporting period specified in the notification to report, all of the following information:

(i) the price at acquisition;

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

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

(iv) the date of acquisition; and

(v) the acquisition price.

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

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug:

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

(2) that the pharmacy dispensed in Minnesota or mailed to a Minnesota address.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug acquired during the reporting period specified in the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the reporting period specified in the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the reporting period specified in the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the reporting period specified in the notification to report;

(6) the total payment receivable by the pharmacy for dispensing the drug including ingredient cost, dispensing fee, and administrative fees during the reporting period specified in the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the reporting period specified in the notification to report; and

(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the reporting period specified in the notification to report.

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

(d) The commissioner may grant extensions, exemptions, or both to compliance with the requirements of paragraphs (a) and (b) by small or independent pharmacies, if compliance with paragraphs (a) and (b) would represent a hardship or undue burden to the pharmacy. The commissioner may establish procedures for small or independent pharmacies to request extensions or exemptions under this paragraph.

Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a PBM must submit to the commissioner the information described in paragraph (b) for any prescription drug:

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

(2) for which the PBM fulfilled pharmacy benefit management duties for Minnesota residents.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of pricing units of the drug product filled during the reporting period specified in the notification to report;

(3) the total reimbursement amount accrued and payable to pharmacies for pricing units of the drug product filled during the reporting period specified in the notification to report;

(4) the total reimbursement amount accrued and receivable from payers for pricing units of the drug product filled during the reporting period specified in the notification to report;

(5) the total administrative fee amount accrued and receivable from payers for pricing units of the drug product filled during the reporting period specified in the notification to report;

(6) the total rebate receivable amount accrued by the PBM for the drug product during the reporting period specified in the notification to report; and

(7) the total rebate payable amount accrued by the PBM for the drug product during the reporting period specified in the notification to report.

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

Subd. 14. **Wholesale drug distributor prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a wholesale drug distributor that distributes prescription drugs, for which it is not the manufacturer, to persons or entities, or both, other than a consumer or patient in the state, must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the wholesale drug distributor by the department under subdivision 10; and

(2) that the wholesale drug distributor distributed within or into Minnesota.

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug product acquired by the wholesale drug distributor during the reporting period specified in the notification to report;

(3) the total spent before rebates by the wholesale drug distributor to acquire the drug product during the reporting period specified in the notification to report;

(4) the total rebate receivable amount accrued by the wholesale drug distributor for the drug product during the reporting period specified in the notification to report;

(5) the number of units of the drug product sold by the wholesale drug distributor during the reporting period specified in the notification to report;

(6) gross revenue from sales in the United States generated by the wholesale drug distributor for the drug product during the reporting period specified in the notification to report; and

(7) total rebate payable amount accrued by the wholesale drug distributor for the drug product during the reporting period specified in the notification to report.

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

Subd. 15. **Registration requirements.** A reporting entity subject to this chapter shall register, or update existing registration information, with the department in a form and manner prescribed by the commissioner by January 30 each year.

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

History: *2020 c 78 s 1; 2021 c 30 art 3 s 5-9; 2023 c 70 art 2 s 8-21; 2024 c 127 art 59 s 4; 1Sp2025 c 3 art 2 s 6-14*

62J.841 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 62J.841 to 62J.845, the following definitions apply.

Subd. 2. **Consumer Price Index.** "Consumer Price Index" means the Consumer Price Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items, reported by the United States Department of Labor, Bureau of Labor Statistics, or its successor or, if the index is discontinued, an equivalent index reported by a federal authority or, if no such index is reported, "Consumer Price Index" means a comparable index chosen by the Bureau of Labor Statistics.

Subd. 3. **Generic or off-patent drug.** "Generic or off-patent drug" means any prescription drug for which any exclusive marketing rights granted under the Federal Food, Drug, and Cosmetic Act, section 351 of the federal Public Health Service Act, and federal patent law have expired, including any drug-device combination product for the delivery of a generic drug.

Subd. 4. **Manufacturer.** "Manufacturer" has the meaning given in section 151.01, subdivision 14a, but does not include an entity that must be licensed solely because the entity repackages or relabels drugs.

Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject to United States Code, title 21, section 353(b)(1).

Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning provided in United States Code, title 42, section 1395w-3a.

Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in section 151.441, subdivision 14.

History: *2023 c 57 art 2 s 22*

NOTE: This section was found to be unconstitutional in violation of the interstate dormant Commerce Clause of the United States Constitution as applied to certain sales of generic or off-patent drugs occurring in *Association for Accessible Medicines v. Ellison*, 704 F.Supp.3d 947 (D. Minn. 2023), *affirmed*, 140 F.4th 957 (8th Cir. 2025).

62J.842 EXCESSIVE PRICE INCREASES PROHIBITED.

Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an excessive price increase, whether directly or through a wholesale distributor, pharmacy, or similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or delivered to any consumer in the state.

Subd. 2. **Excessive price increase.** A price increase is excessive for purposes of this section when:

(1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

(i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar year; or

(ii) 40 percent of the wholesale acquisition cost over the immediately preceding three calendar years; and

(2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds $30 for:

(i) a 30-day supply of the drug; or

(ii) a course of treatment lasting less than 30 days.

Subd. 3. **Exemption.** It is not a violation of this section for a wholesale distributor or pharmacy to increase the price of a generic or off-patent drug if the price increase is directly attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy by the manufacturer of the drug.

History: *2023 c 57 art 2 s 23*

NOTE: This section was found to be unconstitutional in violation of the interstate dormant Commerce Clause of the United States Constitution as applied to certain sales of generic or off-patent drugs occurring in *Association for Accessible Medicines v. Ellison*, 704 F.Supp.3d 947 (D. Minn. 2023), *affirmed*, 140 F.4th 957 (8th Cir. 2025).

62J.843 REGISTERED AGENT AND OFFICE WITHIN THE STATE.

Any manufacturer that sells, distributes, delivers, or offers for sale any generic or off-patent drug in the state must maintain a registered agent and office within the state.

History: *2023 c 57 art 2 s 24*

62J.844 ENFORCEMENT.

Subdivision 1. **Notification.** (a) The commissioner of health shall notify the manufacturer of a generic or off-patent drug and the attorney general of any price increase that the commissioner believes may violate section 62J.842.

(b) The commissioner of management and budget and any other state agency that provides or purchases a pharmacy benefit except the Department of Human Services, and any entity under contract with a state agency to provide a pharmacy benefit other than an entity under contract with the Department of Human Services, may notify the manufacturer of a generic or off-patent drug and the attorney general of any price increase that the commissioner or entity believes may violate section 62J.842.

Subd. 2. **Submission of drug cost statement and other information by manufacturer; investigation by attorney general.** (a) Within 45 days of receiving a notice under subdivision 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to the attorney general. The statement must:

(1) itemize the cost components related to production of the drug;

(2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any increase during the preceding calendar year, or preceding three calendar years as applicable, in the price of the drug; and

(3) provide any other information that the manufacturer believes to be relevant to a determination of whether a violation of section 62J.842 has occurred.

(b) The attorney general may investigate whether a violation of section 62J.842 has occurred, in accordance with section 8.31, subdivision 2.

Subd. 3. **Petition to court.** (a) On petition of the attorney general, a court may issue an order:

(1) compelling the manufacturer of a generic or off-patent drug to:

(i) provide the drug cost statement required under subdivision 2, paragraph (a); and

(ii) answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general under subdivision 2, paragraph (b);

(2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing an order requiring that drug prices be restored to levels that comply with section 62J.842;

(3) requiring the manufacturer to provide an accounting to the attorney general of all revenues resulting from a violation of section 62J.842;

(4) requiring the manufacturer to repay to all Minnesota consumers, including any third-party payers, any money acquired as a result of a price increase that violates section 62J.842;

(5) notwithstanding section 16A.151, requiring that all revenues generated from a violation of section 62J.842 be remitted to the state and deposited into a special fund, to be used for initiatives to reduce the cost to consumers of acquiring prescription drugs, if a manufacturer is unable to determine the individual transactions necessary to provide the repayments described in clause (4);

(6) imposing a civil penalty of up to $10,000 per day for each violation of section 62J.842;

(7) providing for the attorney general's recovery of costs and disbursements incurred in bringing an action against a manufacturer found in violation of section 62J.842, including the costs of investigation and reasonable attorney's fees; and

(8) providing any other appropriate relief, including any other equitable relief as determined by the court.

(b) For purposes of paragraph (a), clause (6), every individual transaction in violation of section 62J.842 is considered a separate violation.

Subd. 4. **Private right of action.** Any action brought pursuant to section 8.31, subdivision 3a, by a person injured by a violation of section 62J.842 is for the benefit of the public.

History: *2023 c 57 art 2 s 25*

NOTE: This section was found to be unconstitutional in violation of the interstate dormant Commerce Clause of the United States Constitution as applied to certain sales of generic or off-patent drugs occurring in *Association for Accessible Medicines v. Ellison*, 704 F.Supp.3d 947 (D. Minn. 2023), *affirmed*, 140 F.4th 957 (8th Cir. 2025).

62J.845 PROHIBITION ON WITHDRAWAL OF GENERIC OR OFF-PATENT DRUGS FOR SALE.

Subdivision 1. **Prohibition.** A manufacturer of a generic or off-patent drug is prohibited from withdrawing that drug from sale or distribution within this state for the purpose of avoiding the prohibition on excessive price increases under section 62J.842.

Subd. 2. **Notice to board and attorney general.** Any manufacturer that intends to withdraw a generic or off-patent drug from sale or distribution within the state shall provide a written notice of withdrawal to the attorney general at least 90 days prior to the withdrawal.

Subd. 3. **Financial penalty.** The attorney general shall assess a penalty of $500,000 on any manufacturer of a generic or off-patent drug that the attorney general determines has failed to comply with the requirements of this section.

History: *2023 c 57 art 2 s 26*

NOTE: This section was found to be unconstitutional in violation of the interstate dormant Commerce Clause of the United States Constitution as applied to certain sales of generic or off-patent drugs occurring in *Association for Accessible Medicines v. Ellison*, 704 F.Supp.3d 947 (D. Minn. 2023), *affirmed*, 140 F.4th 957 (8th Cir. 2025).

62J.846 SEVERABILITY.

If any provision of sections 62J.841 to 62J.845 or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of sections 62J.841 to 62J.845 that can be given effect without the invalid provision or application.

History: *2023 c 57 art 2 s 27*

62J.85 CITATION.

Sections 62J.85 to 62J.95 may be cited as the "Prescription Drug Affordability Act."

History: *2023 c 57 art 2 s 28*

62J.86 DEFINITIONS.

Subdivision 1. **Definitions.** For the purposes of sections 62J.85 to 62J.95, the following terms have the meanings given.

Subd. 2. MS 2024 [Repealed, 2026 c 124 art 5 s 4]

Subd. 3. **Biologic.** "Biologic" means a drug that is produced or distributed in accordance with a biologics license application approved under Code of Federal Regulations, title 42, section 447.502.

Subd. 4. **Biosimilar.** "Biosimilar" has the meaning provided in section 62J.84, subdivision 2, paragraph (b).

Subd. 5. **Board.** "Board" means the Prescription Drug Affordability Board established under section 62J.87.

Subd. 6. **Brand name drug.** "Brand name drug" means a drug that is produced or distributed pursuant to:

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

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

Subd. 7. **Generic drug.** "Generic drug" has the meaning provided in section 62J.84, subdivision 2, paragraph (e).

Subd. 8. **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03, subdivision 6, and includes pharmacy benefit managers, as defined in section 62W.02, subdivision 15.

Subd. 9. **Manufacturer.** "Manufacturer" means an entity that:

(1) engages in the manufacture of a prescription drug product or enters into a lease with another manufacturer to market and distribute a prescription drug product under the entity's own name; and

(2) sets or changes the wholesale acquisition cost of the prescription drug product it manufacturers or markets.

Subd. 10. **Prescription drug product.** "Prescription drug product" means a brand name drug, a generic drug, a biologic, or a biosimilar.

Subd. 11. **Wholesale acquisition cost or WAC.** "Wholesale acquisition cost" or "WAC" has the meaning given in United States Code, title 42, section 1395W-3a(c)(6)(B).

History: *2023 c 57 art 2 s 29*

62J.87 PRESCRIPTION DRUG AFFORDABILITY BOARD.

Subdivision 1. **Establishment.** The commissioner of commerce shall establish the Prescription Drug Affordability Board, which shall be governed as a board under section 15.012, paragraph (a), to protect consumers, state and local governments, health plan companies, providers, pharmacies, and other health care system stakeholders from unaffordable costs of certain prescription drugs.

Subd. 2. **Membership.** (a) The Prescription Drug Affordability Board consists of nine members appointed as follows:

(1) seven voting members appointed by the governor;

(2) one nonvoting member appointed by the majority leader of the senate; and

(3) one nonvoting member appointed by the speaker of the house.

(b) All members appointed must have knowledge and demonstrated expertise in pharmaceutical economics and finance or health care economics and finance. A member must not be an employee of, a board member of, or a consultant to a manufacturer or trade association for manufacturers, or a pharmacy benefit manager or trade association for pharmacy benefit managers.

(c) Initial appointments must be made by January 1, 2024.

Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms, except that initial appointees shall serve staggered terms of two, three, or four years as determined by lot by the secretary of state. A board member shall serve no more than two consecutive terms.

(b) A board member may resign at any time by giving written notice to the board.

Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from the members appointed by the governor.

(b) The board shall elect a chair to replace the acting chair at the first meeting of the board by a majority of the members. The chair shall serve for one year.

(c) The board shall elect a vice-chair and other officers from its membership as it deems necessary.

Subd. 5. **Staff; technical assistance.** (a) The board shall hire an executive director and other staff, who shall serve in the unclassified service. The executive director must have knowledge and demonstrated expertise in pharmacoeconomics, pharmacology, health policy, health services research, medicine, or a related field or discipline.

(b) The commissioner of health shall provide technical assistance to the board. The board may also employ or contract for professional and technical assistance as the board deems necessary to perform the board's duties.

(c) The attorney general shall provide legal services to the board.

Subd. 6. **Compensation.** The board members shall not receive compensation but may receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

Subd. 7. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall meet publicly at least every three months to review prescription drug product information submitted to the board under section 62J.90. If there are no pending submissions, the chair of the board may cancel or postpone the required meeting. The board may meet in closed session when reviewing proprietary information, as determined under the standards developed in accordance with section 62J.91, subdivision 3.

(b) The board shall announce each public meeting at least three weeks prior to the scheduled date of the meeting. Any materials for the meeting shall be made public at least two weeks prior to the scheduled date of the meeting.

(c) At each public meeting, the board shall provide the opportunity for comments from the public, including the opportunity for written comments to be submitted to the board prior to a decision by the board.

History: *2023 c 57 art 2 s 30*

62J.88 MS 2024 [Repealed, 2026 c 124 art 5 s 4]

62J.89 CONFLICTS OF INTEREST.

Subdivision 1. **Definition.** For purposes of this section, "conflict of interest" means a financial or personal association that has the potential to bias or have the appearance of biasing a person's decisions in matters related to the board or in the conduct of the board's activities. A conflict of interest includes any instance in which a person, a person's immediate family member, including a spouse, parent, child, or other legal dependent, or an in-law of any of the preceding individuals, has received or could receive a direct or indirect financial benefit of any amount deriving from the result or findings of a decision or determination of the

board. For purposes of this section, a financial benefit includes honoraria, fees, stock, the value of the member's, immediate family member's, or in-law's stock holdings, and any direct financial benefit deriving from the finding of a review conducted under sections 62J.85 to 62J.95. Ownership of securities is not a conflict of interest if the securities are: (1) part of a diversified mutual or exchange traded fund; or (2) in a tax-deferred or tax-exempt retirement account that is administered by an independent trustee.

Subd. 2. **General.** (a) Prior to the acceptance of an appointment or employment, or prior to entering into a contractual agreement, a board member, board staff member, or third-party contractor must disclose to the appointing authority or the board any conflicts of interest. The information disclosed must include the type, nature, and magnitude of the interests involved.

(b) A board member, board staff member, or third-party contractor with a conflict of interest with regard to any prescription drug product under review must recuse themselves from any discussion, review, decision, or determination made by the board relating to the prescription drug product.

(c) Any conflict of interest must be disclosed in advance of the first meeting after the conflict is identified or within five days after the conflict is identified, whichever is earlier.

Subd. 3. **Prohibitions.** Board members, board staff, or third-party contractors are prohibited from accepting gifts, bequeaths, or donations of services or property that raise the specter of a conflict of interest or have the appearance of injecting bias into the activities of the board.

History: *2023 c 57 art 2 s 32; 2026 c 124 art 5 s 1,2*

62J.90 PRESCRIPTION DRUG PRICE INFORMATION; DECISION TO CONDUCT COST REVIEW.

Subdivision 1. **Drug price information from the commissioner of health and other sources.** (a) The commissioner of health shall provide to the board the information reported to the commissioner by drug manufacturers under section 62J.84, subdivisions 3, 4, and 5. The commissioner shall provide this information to the board within 30 days of the date the information is received from drug manufacturers.

(b) The board may subscribe to one or more prescription drug pricing files, such as Medispan or FirstDatabank, or as otherwise determined by the board.

Subd. 2. **Identification of certain prescription drug products.** (a) The board must identify selected prescription drug products based on the following criteria:

(1) brand name drugs or biologics for which the WAC increases by more than 15 percent or by more than $3,000 during any 12-month period or course of treatment if less than 12 months, after adjusting for changes in the consumer price index (CPI);

(2) brand name drugs or biologics with a WAC of $60,000 or more per calendar year or per course of treatment;

(3) biosimilar drugs that have a WAC that is not at least 20 percent lower than the referenced brand name biologic at the time the biosimilar is introduced; and

(4) generic drugs for which the WAC:

(i) is $100 or more, after adjusting for changes in the CPI, for:

(A) a 30-day supply;

(B) a course of treatment lasting less than 30 days; or

(C) one unit of the drug, if the labeling approved by the Food and Drug Administration does not recommend a finite dosage; and

(ii) increased by 200 percent or more during the immediate preceding 12-month period, as determined by the difference between the resulting WAC and the average WAC reported over the preceding 12 months, after adjusting for changes in the CPI.

The board is not required to identify all prescription drug products that meet the criteria in this paragraph.

(b) The board, in consultation with the commissioner of health, may identify prescription drug products not described in paragraph (a) that may impose costs that create significant affordability challenges for the state health care system or for patients, including but not limited to drugs to address public health emergencies.

(c) The board shall make available to the public the names and related price information of the prescription drug products identified under this subdivision, with the exception of information determined by the board to be proprietary under the standards developed by the board under section 62J.91, subdivision 3, and information provided by the commissioner of health classified as not public data under section 13.02, subdivision 8a, or as trade secret information under section 13.37, subdivision 1, paragraph (b), or as trade secret information under the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended.

Subd. 3. **Determination to proceed with review.** (a) The board may initiate a cost review of a prescription drug product identified by the board under this section.

(b) The board shall consider requests by the public for the board to proceed with a cost review of any prescription drug product identified under this section.

(c) If there is no consensus among the members of the board on whether to initiate a cost review of a prescription drug product, any member of the board may request a vote to determine whether to review the cost of the prescription drug product.

History: *2023 c 57 art 2 s 33; 2026 c 124 art 5 s 3*

62J.91 PRESCRIPTION DRUG PRODUCT REVIEWS.

Subdivision 1. **General.** Once a decision by the board has been made to proceed with a cost review of a prescription drug product, the board shall conduct the review and make a determination as to whether appropriate utilization of the prescription drug under review, based on utilization that is consistent with the United States Food and Drug Administration (FDA) label or standard medical practice, has led or will lead to affordability challenges for the state health care system or for patients.

Subd. 2. **Review considerations.** In reviewing the cost of a prescription drug product, the board may consider the following factors:

(1) the price at which the prescription drug product has been and will be sold in the state;

(2) manufacturer monetary price concessions, discounts, or rebates, and drug-specific patient assistance;

(3) the price of therapeutic alternatives;

(4) the cost to group purchasers based on patient access consistent with the FDA-labeled indications and standard medical practice;

(5) measures of patient access, including cost-sharing and other metrics;

(6) the extent to which the attorney general or a court has determined that a price increase for a generic or off-patent prescription drug product was excessive under sections 62J.842 and 62J.844;

(7) any information a manufacturer chooses to provide; and

(8) any other factors as determined by the board.

Subd. 3. **Public data; proprietary information.** (a) Any submission made to the board related to a drug cost review must be made available to the public with the exception of information determined by the board to be proprietary and information provided by the commissioner of health classified as not public data under section 13.02, subdivision 8a, or as trade secret information under section 13.37, subdivision 1, paragraph (b), or as trade secret information under the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended.

(b) The board shall establish the standards for the information to be considered proprietary under paragraph (a) and section 62J.90, subdivision 2, including standards for heightened consideration of proprietary information for submissions for a cost review of a drug that is not yet approved by the FDA.

(c) Prior to the board establishing the standards under paragraph (b), the public shall be provided notice and the opportunity to submit comments.

(d) The establishment of standards under this subdivision is exempt from the rulemaking requirements under chapter 14, and section 14.386 does not apply.

History: *2023 c 57 art 2 s 34*

62J.92 DETERMINATIONS; COMPLIANCE; REMEDIES.

Subdivision 1. **Upper payment limit.** (a) In the event the board finds that the spending on a prescription drug product reviewed under section 62J.91 creates an affordability challenge for the state health care system or for patients, the board shall establish an upper payment limit after considering:

(1) extraordinary supply costs, if applicable;

(2) the range of prices at which the drug is sold in the United States according to one or more pricing files accessed under section 62J.90, subdivision 1, and the range at which pharmacies are reimbursed in Canada; and

(3) any other relevant pricing and administrative cost information for the drug.

(b) An upper payment limit applies to all purchases of, and payer reimbursements for, a prescription drug that is dispensed or administered to individuals in the state in person, by mail, or by other means, and for which an upper payment limit has been established.

(c) In determining whether a drug creates an affordability challenge or determining an upper payment limit amount, the board may not use cost-effectiveness analyses that include the cost-per-quality adjusted life year or similar measure to identify subpopulations for which a treatment would be less cost-effective due to severity of illness, age, or pre-existing disability. For any treatment that extends life, if the board uses cost-effectiveness results, it must use results that weigh the value of all additional lifetime gained equally for all patients no matter their severity of illness, age, or pre-existing disability.

Subd. 2. **Implementation and administration of the upper payment limit.** (a) An upper payment limit may take effect no sooner than 120 days following the date of its public release by the board.

(b) When setting an upper payment limit for a drug subject to the Medicare maximum fair price under United States Code, title 42, section 1191(c), the board shall set the upper payment limit at the Medicare maximum fair price.

(c) Health plan companies and pharmacy benefit managers shall report annually to the board, in the form and manner specified by the board, on how cost savings resulting from the establishment of an upper payment limit have been used by the health plan company or pharmacy benefit manager to benefit enrollees, including but not limited to reducing enrollee cost-sharing.

Subd. 3. **Noncompliance.** (a) The board shall, and other persons may, notify the Office of the Attorney General of a potential failure by an entity subject to an upper payment limit to comply with that limit.

(b) If the Office of the Attorney General finds that an entity was noncompliant with the upper payment limit requirements, the attorney general may pursue remedies consistent with chapter 8 or appropriate criminal charges if there is evidence of intentional profiteering.

(c) An entity who obtains price concessions from a drug manufacturer that result in a lower net cost to the stakeholder than the upper payment limit established by the board is not considered noncompliant.

(d) The Office of the Attorney General may provide guidance to stakeholders concerning activities that could be considered noncompliant.

Subd. 4. **Appeals.** (a) Persons affected by a decision of the board may request an appeal of the board's decision within 30 days of the date of the decision. The board shall hear the appeal and render a decision within 60 days of the hearing.

(b) All appeal decisions are subject to judicial review in accordance with chapter 14.

History: *2023 c 57 art 2 s 35*

62J.93 REPORTS.

Beginning March 1, 2024, and each March 1 thereafter, the board shall submit a report to the governor and legislature on general price trends for prescription drug products and the number of prescription drug products that were subject to the board's cost review and analysis, including the result of any analysis as well as the number and disposition of appeals and judicial reviews.

History: *2023 c 57 art 2 s 36*

62J.94 ERISA PLANS AND MEDICARE DRUG PLANS.

(a) Nothing in sections 62J.85 to 62J.95 shall be construed to require ERISA plans or Medicare Part D plans to comply with decisions of the board. ERISA plans or Medicare Part D plans are free to choose to exceed the upper payment limit established by the board under section 62J.92.

(b) Providers who dispense and administer drugs in the state must bill all payers no more than the upper payment limit without regard to whether an ERISA plan or Medicare Part D plan chooses to reimburse the provider in an amount greater than the upper payment limit established by the board.

(c) For purposes of this section, an ERISA plan or group health plan is an employee welfare benefit plan established by or maintained by an employer or an employee organization, or both, that provides employer

sponsored health coverage to employees and the employee's dependents and is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

History: *2023 c 57 art 2 s 37*

62J.95 SEVERABILITY.

If any provision of sections 62J.85 to 62J.94 or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of sections 62J.85 to 62J.94 that can be given effect without the invalid provision or application.

History: *2023 c 57 art 2 s 38*

62J.96 ACCESS TO 340B DRUGS.

Subdivision 1. **Manufacturers.** A manufacturer must not directly or indirectly restrict, prohibit, or otherwise interfere with the delivery of a covered outpatient drug to a pharmacy that is under contract with a 340B covered entity to receive and dispense covered outpatient drugs on behalf of the covered entity, unless the delivery of the drug to the pharmacy is prohibited under the 340B Drug Pricing Program.

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

(b) "340B covered entity" has the meaning provided in section 340B(a)(4) of the Public Health Service Act.

(c) "Covered outpatient drug" has the meaning provided in section 1927(k) of the Social Security Act.

(d) "Manufacturer" has the meaning provided in section 151.01, subdivision 14a.

Subd. 3. **Expiration.** This section expires July 1, 2027.

History: *2024 c 121 art 4 s 3*