Senator ..... moves to amend the delete-everything amendment (SCS2995A-2) to S.F. No. 2995 as follows:

Page 5, line 29, after the first "the" insert "year prior to the"

Page 8, line 20, delete "$....." and insert "$10,000,000. The department shall calculate the aggregate difference in payments for outpatient pharmacy claims for members enrolled with Medical Assistance prepaid health plans reimbursed at the 340B rate as compared to the non-340B rate, as defined in section 256B.0625. The department shall report the results to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance hospital reimbursement no later than January 1 for the previous fiscal year"

Page 9, delete section 8

Page 14, line 17, after "duration" insert "for which" and delete the second "for"

Page 19, delete sections 14 to 16

Page 30, after line 17, insert:

"Sec. 19. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 70. **Coverage and payment for pharmacy services.** (a) Medical assistance coverage for services provided by a licensed physician must include coverage for services provided by a licensed pharmacist to the extent a licensed pharmacist's services are within the pharmacist's scope of practice. This requirement applies to services provided (1) under fee-for-service medical assistance, and (2) by a managed care plan under section 256B.69 or a county-based purchasing plan under section 256B.692.

(b) The commissioner, and managed care and county-based purchasing plans when providing services under sections 256B.69 and 256B.692, must reimburse a participating pharmacist or pharmacy for a service that is also within a physician's scope of practice at an amount no lower than the standard payment rate that would be applied when reimbursing a physician for the service.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained."

Page 33, delete subdivision 7 and insert:

"Subd. 7. **Extended stay.** If a recipient requires care exceeding the 60-day limit described in subdivision 3, the provider may request in a format prescribed by the commissioner an extension to continue payments until the recipient is discharged."

Page 43, line 30, delete "or MinnesotaCare"

Page 43, line 31, reinstate the stricken "section"

Page 44, line 4, delete "chapter and chapter 256L"

Page 44, line 5, after "for" insert "outpatient" and after "drugs" insert "dispensed by a pharmacy and" and delete "medical"

Page 44, line 6, delete "assistance or"

Page 44, line 7, delete "chapter and chapter 256L" and insert "section"

Page 44, line 11, after "to" insert "one-half of"

Page 48, delete lines 16 to 19 and insert:

"(c) The rate described in paragraph (b) shall be increased for hospitals providing high levels of 340B drugs. The rate adjustment shall be based on four percent of each hospital's share of the total reimbursement for 340B drugs to all critical access hospitals, but shall not exceed $3,000,000."

Page 59, delete section 40

Page 60, lines 3 and 5, delete "section … becoming effective" and insert "a deletion of Minnesota Statutes, section 256B.69, subdivision 5a, paragraphs (e) to (g)"

Page 60, line 7, delete "section …"

Page 60, line 8, delete "becoming effective" and insert "a deletion of Minnesota Statutes, section 256B.69, subdivision 5a, paragraphs (e) to (g)"

Page 67, line 5, delete "under it" and insert "pursuant to that section"

Page 70, line 2, delete everything after "charges"

Page 70, line 3, delete everything before "for" and after "services" insert ", as reflected in the medical or dental practice's chargemaster,"

Page 70, line 27, delete "Services(CMS)" and insert "Services (CMS)"

Page 72, lines 26 and 28, before "subject" insert a comma

Page 76, after line 11, insert:

"Sec. 18. Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

Subd. 4. **Network adequacy.** (a) Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

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

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

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

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

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

(b) The commissioner may establish sufficiency by referencing any reasonable criteria, which includes but is not limited to:

(1) ratios of providers to enrollees by specialty;

(2) ratios of primary care professionals to enrollees;

(3) geographic accessibility of providers;

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

(5) hours of operation;

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

(i) low-income persons;

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

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

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

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

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

Page 84, line 4, delete "plan companies" and insert "organizations"

Page 84, line 14, after "available" insert ", for claims incurred on or after January 1, 2023"

Page 85, delete lines 7 and 8

Page 85, line 10, delete "plan companies" and insert "organizations"

Page 96, line 4, delete everything after "by" and insert "Minnesota Statutes, sections 62A.15, subdivisions 3d and 4; and 62D.1071"

Page 131, after line 6, insert:

"Sec. 6. Minnesota Statutes 2022, section 62J.84, subdivision 3, is amended to read:

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 ~~name~~ 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;

(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 introductory price of the prescription drug when it was ~~approved for marketing by the Food and Drug Administration and the net yearly increase, by calendar year, in the price of the prescription drug during the previous five years~~ 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;

(5) 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;

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

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

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

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

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

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

(12) if a brand name prescription drug, the ~~ten~~ highest ~~prices~~ price paid for the prescription drug during the previous calendar year in ~~any country other than~~ the ten

countries, excluding the United States~~.~~, that charged the highest single price for the prescription drug; and

(13) 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.

Sec. 7. Minnesota Statutes 2022, section 62J.84, subdivision 4, is amended to read:

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 less 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 less 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;

(v) the package size;

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

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

~~(3)~~ (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

~~(4)~~ (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.

Sec. 8. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

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 5,~~ to 6 and 9 to 14 and the manufacturers of those prescription drugs; and

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

(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 manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the

information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer 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.

Sec. 9. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

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 ~~manufacturers~~ 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 ~~manufacturers~~ reporting entities.

Sec. 10. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

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

(1) failing to register under subdivision 15;

~~(1)~~ (2) failing to submit timely reports or notices as required by this section;

~~(2)~~ (3) failing to provide information required under this section; or

~~(3)~~ (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.

Sec. 11. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

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 5~~ to 6 and 9 to 14.

Sec. 12. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

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 department determines to represent a substantial public interest and for which the department intends to request data under subdivisions 9 to 14, subject to paragraph (c). The department shall base its inclusion of prescription drugs on any information the department determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state, and the department shall consider drug product families that include prescription drugs:

(1) that triggered reporting under subdivisions 3, 4, or 6 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 period 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 the requirement to report under subdivisions 9 to 14.

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

Sec. 13. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

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 or 6 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 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;

(5) the direct costs incurred during the 12-month period prior to the date of 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;

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

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

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

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

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

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

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

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

(14) 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

(15) if the prescription drug was acquired by the manufacturer within a 12-month period prior to the date of 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.

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

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 included in a notification to report issued to the pharmacy by the department under subdivision 9.

(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 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month period prior to the date of the notification to report;

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

(5) the number of pricing units of the drug dispensed by the pharmacy during the 12-month period prior to the date of 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 12-month period prior to the date of the notification to report;

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

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

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

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 included in a notification to report issued to the PBM by the department under subdivision 9.

(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 for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

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

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

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

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

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

Sec. 16. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

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

(b) For each of the drugs described in paragraph (a), the wholesaler 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 12-month period prior to the date of the notification to report;

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

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

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

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

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

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

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

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

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

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

Page 135, after line 13, insert:

"Sec. 27. **[144.0701] SPECIAL GUERILLA UNIT VETERANS GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health must establish a grant program to offer culturally specific and specialized assistance to support the health and well-being of special guerilla unit veterans.

Subd. 2. **Eligible applicants.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a nongovernmental organization that offers culturally

specific and specialized assistance to support the health and well-being of special guerilla unit veterans.

Subd. 3. **Application.** An organization seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner.

Subd. 4. **Grant activities.** Grant funds must be used to offer programming and culturally specific and specialized assistance to support the health and well-being of special guerilla unit veterans."

Page 168, delete section 42

Page 171, line 6, after "Disability" insert "Minnesota Commission of the Deaf, Deafblind, and Hard of Hearing"

Page 173, line 4, delete "care"

Page 173, line 5, delete "management and costs;"

Page 173, line 10, delete the first comma and insert "and" and delete everything after "detection"

Page 173, line 11, delete everything before the semicolon

Page 178, after line 2, insert:

"Sec. 62. **[145.9011] FETAL AND INFANT DEATH STUDIES.**

Subdivision 1. **Purpose.** (a) The commissioner of health may conduct fetal and infant death studies to assist the planning, implementation, and evaluation of medical, health, and social service systems, and to reduce the number of preventable fetal and infant deaths in Minnesota.

(b) Notwithstanding any other law or policy to the contrary, the fetal and infant mortality review committee must not expire.

Subd. 2. **Access to data.** (a) For purposes of this section, the subject of the data is defined as any of the following:

(1) a live born infant that died within the first year of life;

(2) a fetal death which meets the criteria required for reporting as defined in section 144.222; or

(3) the biological mother of an infant as defined in clause (1) or of a fetal death as defined in clause (2).

(b) To conduct fetal and infant death studies, the commissioner of health must have access to:

(1) medical data as defined in section 13.384, subdivision 1, paragraph (b); medical examiner data as defined in section 13.83, subdivision 1; and health records created, maintained, or stored by providers as defined in section 144.291, subdivision 2, paragraph (i), on the subject of the data;

(2) data on health and social support services, such as, but not limited to, family home visiting programs, the women, infants, and children (WIC) program, as well as access to prescription monitoring programs data, and data on behavioral health services, on the subject of the data;

(3) the name of a health care provider that provided prenatal, postpartum, pediatric, and other health services to the subject of the data, which must be provided by a coroner or medical examiner; and

(4) Department of Human Services and other state agency data to identify and receive information on the types and nature of other sources of care and social support received by the subject of the data, and parents and guardians of the subject of the data, to assist with evaluation of social service systems.

(c) When necessary to conduct a fetal and infant death study, the commissioner must have access to:

(1) data described in this subdivision relevant to fetal and infant death studies from before, during, and after pregnancy or birth for the subject of the data; and

(2) law enforcement reports or incident reports related to the subject of the data and must receive the reports when requested from law enforcement.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner must have access to all data described within this section without the consent of the subject of the data and without the consent of the parent, other guardian, or legal representative of the subject of the data. The commissioner has access to the data in this subdivision to study fetal or infant deaths that occur on or after July 1, 2021.

(f) The commissioner must make a good faith reasonable effort to notify the subject of the data, parent, spouse, other guardian, or legal representative of the subject of the data before collecting data on the subject of the data. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last known address of the subject

of the data, parent, spouse, other guardian, or legal representative informing of the data collection and offering a public health nurse support visit if desired.

Subd. 3. **Management of records.** After the commissioner has collected all data about the subject of a fetal or infant death study necessary to perform the study, the data extracted from source records obtained under subdivision 2, other than data identifying the subject of the data, must be transferred to separate records that must be maintained by the commissioner. Notwithstanding section 138.17, after the data have been transferred, all source records obtained under subdivision 2 that are possessed by the commissioner must be destroyed.

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, subjects of the data, their family, or guardians, and data derived by the commissioner under subdivision 3 for the purpose of carrying out fetal or infant death studies, are classified as confidential data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Data classified under subdivision 4, paragraph (a), must not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source must not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out fetal or infant death studies.

(c) Summary data on fetal and infant death studies created by the commissioner, which does not identify individual subjects of the data, their families, guardians, or individual providers, must be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services or other state agency to the commissioner of health under this section retains the same classification as the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Subd. 5. **Fetal and infant mortality reviews.** (a) The commissioner of health must convene case review committees to conduct death study reviews, make recommendations, and publicly share summary information, especially for and about racial and ethnic groups, including American Indians and African Americans, that experience significantly disparate rates of fetal and infant mortality.

(b) The case review committees may include, but are not limited to, medical examiners or coroners, representative from health care institutions that provide care to pregnant people

and infants, obstetric and pediatric practitioners, Medicaid representatives, state agency women and infant program representatives, and individuals from the communities that experience disparate rates of fetal and infant deaths, and other subject matter experts as necessary.

(c) The case review committees will review data from source records obtained under subdivision 2, other than data identifying the subject, the subject's family, or guardians, or the provider involved in the care of the subject.

(d) A person attending a fetal and infant mortality review committee meeting must not disclose what transpired at the meeting, except as necessary to carry out the purposes of the review committee. The proceedings and records of the review committee are protected nonpublic data as defined in section 13.02, subdivision 13. Discovery and introduction into evidence in legal proceedings of case review committee proceedings and records, and testimony in legal proceedings by review committee members and persons presenting information to the review committee, must occur in compliance with the requirements in section 256.01, subdivision 12, paragraph (e).

(e) Every three years beginning December 1, 2024, the case review committees will provide findings and recommendations to the Maternal and Child Health Advisory Task Force and the commissioner from the committee's review of fetal and infant deaths and provide specific recommendations designed to reduce population-based disparities in fetal and infant deaths.

(f) This paragraph must govern case review committee member compensation and expense reimbursement, notwithstanding any other law or policy to the contrary. Members of the case review committee must be compensated by the commissioner of health for actual time spent in work on case reviews at a per diem rate established by the commissioner of health according to funding availability. Compensable time includes preparation for case reviews, time spent on collaborative review, including subcommittee meetings, committee meetings, and other preparation work for the committee review as identified by the commissioner of health. Members must also be reimbursed for expenses in the same manner and amount as provided in the Department of Management and Budget's commissioner's plan under section 43A.18, subdivision 2. To receive compensation or reimbursement, committee members must invoice the Department of Health on an invoice form provided by the commissioner. "

Page 180, delete section 51

Page 180, line 29, delete "HIV/AIDS" and insert "HIV"

Page 189, delete section 56

Page 189, after line 16, insert:

"Sec. 69. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Advisory Committee may recommend a formula to the commissioner to use in distributing funds to community health boards.

(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive an increase equal to ten percent of the grant award to the community health board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for the last six months of the year. For calendar years beginning on or after January 1, 2016, the amount distributed under this paragraph shall be adjusted each year based on available funding and the number of eligible community health boards.

(f) Funding for foundational public health responsibilities will be distributed based on a formula determined by the Commissioner in consultation with the State Community Health Services Advisory Committee. These funds must be used as described in subdivision 5.

Sec. 70. Minnesota Statutes 2022, section 145A.131, subdivision 2, is amended to read:

Subd. 2. **Local match.** (a) A community health board that receives a local public health grant shall provide at least a 75 percent match for the state funds received through the local public health grant described in subdivision 1 and subject to paragraphs (b) to ~~(d)~~ (f).

(b) Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other local funds, and donations or nonfederal grants that are used for community health services described in section 145A.02, subdivision 6.

(c) When the amount of local matching funds for a community health board is less than the amount required under paragraph (a), the local public health grant provided for that community health board under this section shall be reduced proportionally.

(d) A city organized under the provision of sections 145A.03 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Sec. 71. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their local public health grant funds as described in subdivision 1, paragraphs (a) to (e) to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

(b) Except as otherwise provided in this paragraph, funding for foundational public health responsibilities as described in subdivision 1, paragraph (f), must be used to fulfill foundational public health responsibilities as defined by the commissioner in consultation with the state community health service advisory committee. If a community health board can demonstrate foundational public health responsibilities are fulfilled, the board may use funds for local priorities developed through the community health assessment and community health improvement planning process.

Sec. 72. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision to read:

Subd. 2b. **Grants to tribes.** The commissioner must distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government."

Page 191, delete section 57

Page 218, after line 5, insert:

"Sec. 12. **[144.88] MENTAL HEALTH AND SUBSTANCE USE DISORDER EDUCATION CENTER.**

Subdivision 1. **Establishment.** The Mental Health and Substance Use Disorder Education Center is established in the Department of Health. The purpose of the center is to increase the number of professionals, practitioners, and peers working in mental health and substance use disorder treatment; increase the diversity of professionals, practitioners, and peers working in mental health and substance use disorder treatment; and facilitate a culturally informed and responsive mental health and substance use disorder treatment workforce.

Subd. 2. **Activities.** The Mental Health and Substance Use Disorder Education Center must:

(1) analyze the geographic and demographic availability of licensed professionals in the field, identify gaps, and prioritize the need for additional licensed professionals by type, location, and demographics;

(2) create a program that exposes high school and college students to careers in the mental health and substance use disorders field;

(3) create a website for individuals considering becoming a mental health provider that clearly labels the steps necessary to achieve licensure and certification in the various mental health fields and lists resources and links for more information;

(4) create a job board for organizations seeking employees to provide mental health and substance use disorder treatment, services, and supports;

(5) track the number of students at the college and graduate level who are graduating from programs that could facilitate a career as a mental health or substance use disorder treatment practitioner or professional and work with the colleges and universities to support the students in obtaining licensure;

(6) identify barriers to licensure and make recommendations to address the barriers;

(7) establish learning collaborative partnerships with mental health and substance use disorder treatment providers, schools, criminal justice agencies, and others;

(8) promote and expand loan forgiveness programs, funds for professionals to become supervisors, funding to pay for supervision, and funding for pathways to licensure;

(9) identify barriers to using loan forgiveness programs and develop recommendations to address the barriers;

(10) work to expand Medicaid graduate medical education to other mental health professionals;

(11) identify current sites for internships and practicums and assess the need for additional sites;

(12) develop training for other health care professionals to increase their knowledge about mental health and substance use disorders, including but not limited to community health workers, pediatricians, primary care physicians, physician assistants, and nurses; and

(13) support training for integrated mental health and primary care in rural areas.

Subd. 3. **Reports.** Beginning January 1, 2024, the commissioner of health shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health summarizing the center's activities and progress in addressing the mental health and substance use disorder treatment workforce shortage.

Sec. 13. **[145.9272] FEDERALLY QUALIFIED HEALTH CENTERS APPRENTICESHIP PROGRAM.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

(b) "Federally qualified health center" has the meaning given in section 145.9269, subdivision 1.

(c) "Nonprofit organization of community health centers" means a nonprofit organization the membership of which consists of federally qualified health centers operating service delivery sites in Minnesota and that provides services to federally qualified health centers in Minnesota to promote the delivery of affordable, quality, primary care services in the state.

Subd. 2. **Apprenticeship program.** The commissioner of health shall distribute a grant to a nonprofit organization of community health centers for an apprenticeship program in federally qualified health centers operating in Minnesota. Grant funds shall be used to establish and fund ongoing costs for apprenticeship programs for medical assistants and dental assistants at federally qualified health center service delivery sites in Minnesota. An apprenticeship program funded under this section shall be a 12-month program led by certified medical assistants and licensed dental assistants. Trainees for an apprenticeship program shall be recruited from federally qualified health center staff and from the population in the geographic area served by the federally qualified health center."

Page 218, after line 14, insert:

"Sec. 15. **[245.4664] MENTAL HEALTH PROFESSIONAL SCHOLARSHIP GRANT PROGRAM.**

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

(b) "Mental health professional" means an individual with a qualification specified in section 245I.04, subdivision 2.

(c) "Underrepresented community" has the meaning given in section 148E.010, subdivision 20.

Subd. 2. **Grant program established.** The mental health professional scholarship program is established in the Department of Human Services to assist mental health providers in funding employee scholarships for master's degree-level education programs in order to create a pathway to becoming a mental health professional.

Subd. 3. **Provision of grants.** The commissioner of human services shall award grants to licensed or certified mental health providers who meet the criteria in subdivision 4 to provide tuition reimbursement for master's degree-level programs and certain related costs for individuals who have worked for the mental health provider for at least the past two years in one or more of the following roles:

(1) a mental health behavioral aide who meets a qualification in section 245I.04, subdivision 16;

(2) a mental health certified family peer specialist who meets the qualifications in section 245I.04, subdivision 12;

(3) a mental health certified peer specialist who meets the qualifications in section 245I.04, subdivision 10;

(4) a mental health practitioner who meets a qualification in section 245I.04, subdivision 4;

(5) a mental health rehabilitation worker who meets the qualifications in section 245I.04, subdivision 14;

(6) an individual employed in a role in which the individual provides face-to-face client services at a mental health center or certified community behavioral health center; or

(7) a staff person who provides care or services to residents of a residential treatment facility.

Subd. 4. **Eligibility.** In order to be eligible for a grant under this section, a mental health provider must:

(1) primarily provide at least 25 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; or

(2) primarily serve people from communities of color or underrepresented communities.

Subd. 5. **Request for proposals.** The commissioner must publish a request for proposals in the State Register specifying provider eligibility requirements, criteria for a qualifying employee scholarship program, provider selection criteria, documentation required for program participation, the maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. **Application requirements.** An eligible provider seeking a grant under this section must submit an application to the commissioner. An application must contain a complete description of the employee scholarship program being proposed by the applicant, including the need for the mental health provider to enhance the education of its workforce, the process the mental health provider will use to determine which employees will be eligible for scholarships, any other funding sources for scholarships, the amount of funding sought for the scholarship program, a proposed budget detailing how funds will be spent, and plans to retain eligible employees after completion of the education program.

Subd. 7. **Selection process.** The commissioner shall determine a maximum award amount for grants and shall select grant recipients based on the information provided in the grant application, including the demonstrated need for the applicant provider to enhance the education of its workforce, the proposed process to select employees for scholarships, the applicant's proposed budget, and other criteria as determined by the commissioner. The commissioner shall give preference to grant applicants who work in rural or culturally specific organizations.

Subd. 8. **Grant agreements.** Notwithstanding any law or rule to the contrary, grant money awarded to a grant recipient in a grant agreement does not lapse until the grant agreement expires.

Subd. 9. **Allowable uses of grant funds.** A mental health provider receiving a grant under this section must use the grant funds for one or more of the following:

(1) to provide employees with tuition reimbursement for a master's degree-level program in a discipline that will allow the employee to qualify as a mental health professional; or

(2) for resources and supports, such as child care and transportation, that allow an employee to attend a master's degree-level program specified in clause (1).

Subd. 10. **Reporting requirements.** A mental health provider receiving a grant under this section must submit an invoice for reimbursement and a report to the commissioner on a schedule determined by the commissioner and using a form supplied by the commissioner. The report must include the amount spent on scholarships; the number of employees who received scholarships; and, for each scholarship recipient, the recipient's name, current position, amount awarded, educational institution attended, name of the educational program, and expected or actual program completion date."

Page 225, after line 31, insert:

"Sec. 5. **[148.635] FEE.**

The fee for verification of licensure is $20. The fee is nonrefundable."

Page 231, after line 6, insert:

"Sec. 14. Minnesota Statutes 2022, section 151.065, subdivision 4, is amended to read:

Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and certificates are as follows:

(1) intern affidavit, ~~$20~~ $30;

(2) duplicate small license, ~~$20~~ $30; and

(3) duplicate large certificate, $30.

Sec. 15. Minnesota Statutes 2022, section 151.065, subdivision 6, is amended to read:

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.

(b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of ~~$90~~ $250.

(c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics provider, or a medical gas dispenser who has allowed the license of the establishment to

lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears.

(d) A controlled substance researcher who has allowed the researcher's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

(e) A pharmacist owner of a professional corporation who has allowed the corporation's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears."

Page 232, delete lines 29 to 31, and insert:

"(1) require payment by the board to the central repository any amount appropriated by the legislature for the operation and administration of the medication repository program;"

Page 233, line 11, delete "transferred" and insert "paid under a contract" and delete "this money" and insert "the amount appropriated"

Page 240, after line 26, insert:

"Sec. 17. Minnesota Statutes 2022, section 151.74, subdivision 3, is amended to read:

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

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

(1) have a valid insulin prescription; and

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

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

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

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

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

(1) applying for medical assistance or MinnesotaCare;

(2) applying for a qualified health plan offered through MNsure, subject to open and special enrollment periods;

(3) accessing information on providers who participate in prescription drug discount programs, including providers who are authorized to participate in the 340B program under section 340b of the federal Public Health Services Act, United States Code, title 42, section 256b; and

(4) accessing insulin manufacturers' patient assistance programs, co-payment assistance programs, and other foundation-based programs.

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

Page 268, line 16, after "private" insert "data"

Page 348, after line 9, insert:

"Sec. 24. Minnesota Statutes 2022, section 245G.03, subdivision 1, is amended to read:

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in section 626.557; chapters 245A, 245C, and 260E; and Minnesota Rules, chapter 9544.

(b) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

(c) If a program is licensed according to this chapter and is part of a certified community behavioral health clinic under sections 245.7351 to 245.7357, the license holder must comply with the requirements in section 245.7355, subdivisions 6 to 9, as part of the licensing requirements under this chapter."

Page 351, after line 11, insert:

"Sec. 32. Minnesota Statutes 2022, section 245I.011, subdivision 3, is amended to read:

Subd. 3. **Certification required.** (a) An individual, organization, or government entity that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause (19), and chooses to be identified as a certified mental health clinic must:

(1) be a mental health clinic that is certified under section 245I.20;

(2) comply with all of the responsibilities assigned to a license holder by this chapter except subdivision 1; and

(3) comply with all of the responsibilities assigned to a certification holder by chapter 245A.

(b) An individual, organization, or government entity described by this subdivision must obtain a criminal background study for each staff person or volunteer who provides direct contact services to clients.

(c) If a program is licensed according to this chapter and is part of a certified community behavioral health clinic under sections 245.7351 to 245.7357, the license holder must comply with the requirements in section 245.7355, subdivisions 6 to 9, as part of the licensing requirements under this chapter."

Page 351, line 33, after "service" insert "or through the provider licensing and reporting hub"

Page 355, line 17, delete "as" and insert "at"

Page 361, line 11, delete "culturally diverse" and insert "racial"

Page 365, line 20, delete "in-person" and insert "face-to-face"

Page 367, after line 7, insert:

"**EFFECTIVE DATE.** This section is effective October 1, 2024."

Page 384, after line 2, insert:

"**EFFECTIVE DATE.** This section is effective March 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained."

Page 388, line 22, delete "January 1, 2025" and insert "May 1, 2026"

Page 390, line 20, delete "January 1, 2025" and insert "May 1, 2026"

Page 391, line 18, delete "January 1, 2025" and insert "May 1, 2026"

Page 392, line 22, delete "January 1, 2025" and insert "May 1, 2026"

Page 395, lines 6, 8, and 30, delete "January 1, 2025" and insert "May 1, 2026"

Page 396, line 17, delete "January 1, 2025" and insert "May 1, 2026"

Page 397, line 20, delete "January 1, 2025" and insert "May 1, 2026"

Page 398, line 11, delete "4" and insert "5"

Page 400, line 13, strike everything after "(ix)"

Page 400, strike lines 14 to 19

Page 400, line 20, strike everything before "retirement"

Page 400, line 21, strike "(xi)" and insert "(x)"

Page 400, strike line 23

Page 400, line 24, strike "(xiii)" and insert "(xi)"

Page 400, line 26, strike "(xiv)" and insert "(xii)"

Page 400, line 28, strike "(xv)" and insert "(xiii)"

Page 400, line 31, strike "(xvi)" and insert "(xiv)"

Page 401, line 1, strike "(xvii)" and insert "(xv)"

Page 401, line 2, delete "(xviii)" and insert "(xvi)"

Page 409, line 8, delete everything after the first period and insert "Paragraph (c) is effective May 1, 2026."

Page 410, line 12, delete "behavioral health" and insert "homelessness"

Page 446, line 26, delete "256D.61" and insert "256D.60"

Page 477, line 21, after "any" insert "Family First Prevention Services Act"

Page 477, line 23, after "proposed" insert "Family First Prevention Services Act"

Page 477, line 24, after "existing" insert "Family First Prevention Services Act"

Page 479, after line 20, insert:

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

Page 484, delete line 27

Page 486, delete line 10

Page 517, delete section 1

Page 519, line 18, before "EVALUATION" insert "OUTCOMES AND"

Page 519, after line 30, insert:

"ARTICLE 17
HEALTH CARE AFFORDABILITY AND DELIVERY

Section 1. **[62J.86] DEFINITIONS.**

Subdivision 1. **Definitions.** For the purposes of sections 62J.86 to 62J.92, the following terms have the meanings given.

Subd. 2. **Advisory council.** "Advisory council" means the Health Care Affordability Advisory Council established under section 62J.88.

Subd. 3. **Board.** "Board" means the Health Care Affordability Board established under section 62J.87.

Sec. 2. **[62J.87] HEALTH CARE AFFORDABILITY BOARD.**

Subdivision 1. **Establishment.** The Legislative Coordinating Commission shall establish the Health Care 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, and other health care system stakeholders from unaffordable health care costs. The board must be operational by January 1, 2024.

Subd. 2. **Membership.** (a) The Health Care Affordability Board consists of 13 members, appointed as follows:

(1) five members appointed by the governor;

(2) two members appointed by the majority leader of the senate;

(3) two members appointed by the minority leader of the senate;

(4) two members appointed by the speaker of the house; and

(5) two members appointed by the minority leader of the house of representatives.

(b) All appointed members must have knowledge and demonstrated expertise in one or more of the following areas: health care finance, health economics, health care management or administration at a senior level, health care consumer advocacy, representing the health care workforce as a leader in a labor organization, purchasing health care insurance as a health benefits administrator, delivery of primary care, health plan company administration, public or population health, and addressing health disparities and structural inequities.

(c) A member may not participate in board proceedings involving an organization, activity, or transaction in which the member has either a direct or indirect financial interest, other than as an individual consumer of health services.

(d) The Legislative Coordinating Commission shall coordinate appointments under this subdivision to ensure that board members are appointed by August 1, 2023, and that board members as a whole meet all of the criteria related to the knowledge and expertise specified in paragraph (b).

Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms. A board member shall not serve more than three 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 two years.

(c) The board shall elect a vice-chair and other officers from its membership as it deems necessary.

Subd. 5. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time executive director and other staff, who shall serve in the unclassified service. The executive

director must have significant knowledge and expertise in health economics and demonstrated experience in health policy.

(b) The attorney general shall provide legal services to the board.

(c) The Health Economics Division within the Department of Health shall provide technical assistance to the board in analyzing health care trends and costs and in setting health care spending growth targets.

(d) The board may employ or contract for professional and technical assistance, including actuarial assistance, as the board deems necessary to perform the board's duties.

Subd. 6. **Access to information.** (a) The board may request that a state agency provide the board with any publicly available information in a usable format as requested by the board, at no cost to the board.

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

(c) Any information provided to the board by a state agency must be de-identified. For purposes of this subdivision, "de-identification" means the process used to prevent the identity of a person or business from being connected with the information and ensuring all identifiable information has been removed.

(d) Any data submitted to the board shall retain its original classification under the Minnesota Data Practices Act in chapter 13.

Subd. 7. **Compensation.** Board members shall not receive compensation but may receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

Subd. 8. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall meet publicly at least quarterly. The board may meet in closed session when reviewing proprietary information as specified in section 62J.71, subdivision 4.

(b) The board shall announce each public meeting at least two weeks prior to the scheduled date of the meeting. Any materials for the meeting shall be made public at least one week 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.

Sec. 3. **[62J.88] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** The governor shall appoint a Health Care Affordability Advisory Council to provide advice to the board on health care costs and access issues and to represent the views of patients and other stakeholders. Members of the advisory council shall be appointed based on their knowledge and demonstrated expertise in one or more of the following areas: health care delivery, ensuring health care access for diverse populations, public and population health, patient perspectives, health care cost trends and drivers, clinical and health services research, innovation in health care delivery, and health care benefits management.

Subd. 2. **Duties; reports.** (a) The council shall provide technical recommendations to the board on:

(1) the identification of economic indicators and other metrics related to the development and setting of health care spending growth targets;

(2) data sources for measuring health care spending; and

(3) measurement of the impact of health care spending growth targets on diverse communities and populations, including but not limited to those communities and populations adversely affected by health disparities.

(b) The council shall report technical recommendations and a summary of its activities to the board at least annually, and shall submit additional reports on its activities and recommendations to the board, as requested by the board or at the discretion of the council.

Subd. 3. **Terms.** (a) The initial appointed advisory council members shall serve staggered terms of two, three, or four years determined by lot by the secretary of state. Following the initial appointments, advisory council members shall serve four-year terms.

(b) Removal and vacancies of advisory council members shall be governed by section 15.059.

Subd. 4. **Compensation.** Advisory council members may be compensated according to section 15.059.

Subd. 5. **Meetings.** The advisory council shall meet at least quarterly. Meetings of the advisory council are subject to chapter 13D.

Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not expire.

Sec. 4. **[62J.89] DUTIES OF THE BOARD.**

Subdivision 1. **General.** (a) The board shall monitor the administration and reform of the health care delivery and payment systems in the state. The board shall:

(1) set health care spending growth targets for the state, as specified under section 62J.90;

(2) enhance the transparency of provider organizations;

(3) monitor the adoption and effectiveness of alternative payment methodologies;

(4) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care;

(5) monitor and review the impact of changes within the health care marketplace; and

(6) monitor patient access to necessary health care services.

(b) The board shall establish goals to reduce health care disparities in racial and ethnic communities and to ensure access to quality care for persons with disabilities or with chronic or complex health conditions.

Subd. 2. **Market trends.** The board shall monitor efforts to reform the health care delivery and payment system in Minnesota to understand emerging trends in the commercial health insurance market, including large self-insured employers and the state's public health care programs, in order to identify opportunities for state action to achieve:

(1) improved patient experience of care, including quality and satisfaction;

(2) improved health of all populations, including a reduction in health disparities; and

(3) a reduction in the growth of health care costs.

Subd. 3. **Recommendations for reform.** The board shall make recommendations for legislative policy, market, or any other reforms to:

(1) lower the rate of growth in commercial health care costs and public health care program spending in the state;

(2) positively impact the state's rankings in the areas listed in this subdivision and subdivision 2; and

(3) improve the quality and value of care for all Minnesotans, and for specific populations adversely affected by health inequities.

Subd. 4. **Office of Patient Protection.** The board shall establish an Office of Patient Protection, to be operational by January 1, 2025. The office shall assist consumers with

issues related to access and quality of health care, and advise the legislature on ways to reduce consumer health care spending and improve consumer experiences by reducing complexity for consumers.

Sec. 5. **[62J.90] HEALTH CARE SPENDING GROWTH TARGETS.**

Subdivision 1. **Establishment and administration.** The board shall establish and administer the health care spending growth target program to limit health care spending growth in the state, and shall report regularly to the legislature and the public on progress toward these targets.

Subd. 2. **Methodology.** (a) The board shall develop a methodology to establish annual health care spending growth targets and the economic indicators to be used in establishing the initial and subsequent target levels.

(b) The health care spending growth target must:

(1) use a clear and operational definition of total state health care spending;

(2) promote a predictable and sustainable rate of growth for total health care spending as measured by an established economic indicator, such as the rate of increase of the state's economy or of the personal income of residents of this state, or a combination;

(3) define the health care markets and the entities to which the targets apply;

(4) take into consideration the potential for variability in targets across public and private payers;

(5) account for the health status of patients; and

(6) incorporate specific benchmarks related to health equity.

(c) In developing, implementing, and evaluating the growth target program, the board shall:

(1) consider the incorporation of quality of care and primary care spending goals;

(2) ensure that the program does not place a disproportionate burden on communities most impacted by health disparities, the providers who primarily serve communities most impacted by health disparities, or individuals who reside in rural areas or have high health care needs;

(3) explicitly consider payment models that help ensure financial sustainability of rural health care delivery systems and the ability to provide population health;

(4) allow setting growth targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating:

(i) a risk factor adjustment reflecting the health status of the entity's patient mix; and

(ii) an equity adjustment accounting for the social determinants of health and other factors related to health equity for the entity's patient mix;

(5) ensure that growth targets:

(i) do not constrain the Minnesota health care workforce, including the need to provide competitive wages and benefits;

(ii) do not limit the use of collective bargaining or place a floor or ceiling on health care workforce compensation; and

(iii) promote workforce stability and maintain high-quality health care jobs; and

(6) consult with the advisory council and other stakeholders.

Subd. 3. **Data.** The board shall identify data to be used for tracking performance in meeting the growth target and identify methods of data collection necessary for efficient implementation by the board. In identifying data and methods, the board shall:

(1) consider the availability, timeliness, quality, and usefulness of existing data, including the data collected under section 62U.04;

(2) assess the need for additional investments in data collection, data validation, or data analysis capacity to support the board in performing its duties; and

(3) minimize the reporting burden to the extent possible.

Subd. 4. **Setting growth targets; related duties.** (a) The board, by June 15, 2024, and by June 15 of each succeeding calendar year through June 15, 2028, shall establish annual health care spending growth targets for the next calendar year consistent with the requirements of this section. The board shall set annual health care spending growth targets for the five-year period from January 1, 2025, through December 31, 2029.

(b) The board shall periodically review all components of the health care spending growth target program methodology, economic indicators, and other factors. The board may revise the annual spending growth targets after a public hearing, as appropriate. If the board revises a spending growth target, the board must provide public notice at least 60 days before the start of the calendar year to which the revised growth target will apply.

(c) The board, based on an analysis of drivers of health care spending and evidence from public testimony, shall evaluate strategies and new policies, including the establishment of accountability mechanisms, that are able to contribute to meeting growth targets and limiting health care spending growth without increasing disparities in access to health care.

Subd. 5. **Hearings.** At least annually, the board shall hold public hearings to present findings from spending growth target monitoring. The board shall also regularly hold public hearings to take testimony from stakeholders on health care spending growth, setting and revising health care spending growth targets, the impact of spending growth and growth targets on health care access and quality, and as needed to perform the duties assigned under section 62J.89, subdivisions 1, 2, and 3.

Sec. 6. **[62J.91] NOTICE TO HEALTH CARE ENTITIES.**

Subdivision 1. **Notice.** (a) The board shall provide notice to all health care entities that have been identified by the board as exceeding the spending growth target for any given year.

(b) For purposes of this section, "health care entity" shall be defined by the board during the development of the health care spending growth methodology. When developing this methodology, the board shall consider a definition of health care entity that includes clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations, integrated provider and plan systems, and other entities defined by the board, provided that physician organizations with a patient panel of 15,000 or fewer, or which represent providers who collectively receive less than $25,000,000 in annual net patient service revenue from health plan companies and other payers, shall be exempt.

Subd. 2. **Performance improvement plans.** (a) The board shall establish and implement procedures to assist health care entities to improve efficiency and reduce cost growth by requiring some or all health care entities provided notice under subdivision 1 to file and implement a performance improvement plan. The board shall provide written notice of this requirement to health care entities.

(b) Within 45 days of receiving a notice of the requirement to file a performance improvement plan, a health care entity shall:

(1) file a performance improvement plan with the board; or

(2) file an application with the board to waive the requirement to file a performance improvement plan or extend the timeline for filing a performance improvement plan.

(c) The health care entity may file any documentation or supporting evidence with the board to support the health care entity's application to waive or extend the timeline to file a performance improvement plan. The board shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application, provided that this information shall be made public at the discretion of the board. The board may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request in light of all information received from the health care entity, based on a consideration of the following factors:

(1) the costs, price, and utilization trends of the health care entity over time, and any demonstrated improvement in reducing per capita medical expenses adjusted by health status;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth;

(3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity. These factors may include but shall not be limited to age and other health status adjusted factors and other cost inputs such as pharmaceutical expenses and medical device expenses;

(4) the overall financial condition of the health care entity; and

(5) any other factors the board considers relevant. If the board declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the board shall provide written notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan.

(d) A health care entity shall file a performance improvement plan with the board:

(1) within 45 days of receipt of an initial notice;

(2) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or

(3) if the health care entity is granted an extension, on the date given on the extension.

The performance improvement plan shall identify the causes of the entity's cost growth and shall include but not be limited to specific strategies, adjustments, and action steps the entity proposes to implement to improve cost performance. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable

for implementation. The timetable for a performance improvement plan must not exceed 18 months.

(e) The board shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation. If the board determines that the performance improvement plan is unacceptable or incomplete, the board may provide consultation on the criteria that have not been met and may allow an additional time period of up to 30 calendar days for resubmission. Upon approval of the proposed performance improvement plan, the board shall notify the health care entity to begin immediate implementation of the performance improvement plan. Public notice shall be provided by the board on its website, identifying that the health care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the board. The board shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

(f) All health care entities shall in good faith work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan, the health care entity may file amendments to the performance improvement plan, subject to approval of the board. At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the board regarding the outcome of the performance improvement plan. If the board determines the performance improvement plan was not implemented successfully, the board shall:

(1) extend the implementation timetable of the existing performance improvement plan;

(2) approve amendments to the performance improvement plan as proposed by the health care entity;

(3) require the health care entity to submit a new performance improvement plan; or

(4) waive or delay the requirement to file any additional performance improvement plans.

Upon the successful completion of the performance improvement plan, the board shall remove the identity of the health care entity from the board's website. The board may assist health care entities with implementing the performance improvement plans or otherwise ensure compliance with this subdivision.

(g) If the board determines that a health care entity has:

(1) willfully neglected to file a performance improvement plan with the board within 45 days as required;

(2) failed to file an acceptable performance improvement plan in good faith with the board;

(3) failed to implement the performance improvement plan in good faith; or

(4) knowingly failed to provide information required by this subdivision to the board or knowingly provided false information, the board may assess a civil penalty to the health care entity of not more than $500,000. The board may only impose a civil penalty if the board determines that the health care entity is unlikely to voluntarily comply with all applicable provisions of this subdivision.

Sec. 7. **[62J.92] REPORTING REQUIREMENTS.**

Subdivision 1. **General requirement.** (a) The board shall present the reports required by this section to the chairs and ranking members of the legislative committees with primary jurisdiction over health care finance and policy. The board shall also make these reports available to the public on the board's website.

(b) The board may contract with a third-party vendor for technical assistance in preparing the reports.

Subd. 2. **Progress reports.** The board shall submit written progress updates about the development and implementation of the health care spending growth target program by February 15, 2025, and February 15, 2026. The updates must include reporting on board membership and activities, program design decisions, planned timelines for implementation of the program, and the progress of implementation. The reports must include the methodological details underlying program design decisions.

Subd. 3. **Health care spending trends.** By December 15, 2025, and every December 15 thereafter, the board shall submit a report on health care spending trends and the health care spending growth target program that includes:

(1) spending growth in aggregate and for entities subject to health care spending growth targets relative to established target levels;

(2) findings from analyses of drivers of health care spending growth;

(3) estimates of the impact of health care spending growth on Minnesota residents, including for communities most impacted by health disparities, related to their access to insurance and care, value of health care, and the ability to pursue other spending priorities;

(4) the potential and observed impact of the health care growth targets on the financial viability of the rural delivery system;

(5) changes under consideration for revising the methodology to monitor or set growth targets;

(6) recommendations for initiatives to assist health care entities in meeting health care spending growth targets, including broader and more transparent adoption of value-based payment arrangements; and

(7) the number of health care entities whose spending growth exceeded growth targets, information on performance improvement plans and the extent to which the plans were completed, and any civil penalties imposed on health care entities related to noncompliance with performance improvement plans and related requirements.

Sec. 8. Minnesota Statutes 2022, section 62K.15, is amended to read:

62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT PERIODS.

(a) Health carriers offering individual health plans must limit annual enrollment in the individual market to the annual open enrollment periods for MNsure. Nothing in this section limits the application of special or limited open enrollment periods as defined under the Affordable Care Act.

(b) Health carriers offering individual health plans must inform all applicants at the time of application and enrollees at least annually of the open and special enrollment periods as defined under the Affordable Care Act.

(c) Health carriers offering individual health plans must provide a special enrollment period for enrollment in the individual market by employees of a small employer that offers a qualified small employer health reimbursement arrangement in accordance with United States Code, title 26, section 9831(d). The special enrollment period shall be available only to employees newly hired by a small employer offering a qualified small employer health reimbursement arrangement, and to employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement. For employees newly hired by the small employer, the special enrollment period shall last for 30 days after the employee's first day of employment. For employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement, the special enrollment period shall last for 30 days after the date the arrangement is initially offered to employees.

(d) The commissioner of commerce shall enforce this section.

(e) Health carriers offering individual health plans through MNsure must provide a special enrollment period as required under the easy enrollment health insurance outreach program under section 62V.13.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

Sec. 9. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for the following purposes:

(1) to evaluate the performance of the health care home program as authorized under section 62U.03, subdivision 7;

(2) to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations;

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities; ~~and~~

(5) to compile one or more public use files of summary data or tables that must:

(i) be available to the public for no or minimal cost by March 1, 2016, and available by web-based electronic data download by June 30, 2019;

(ii) not identify individual patients, payers, or providers;

(iii) be updated by the commissioner, at least annually, with the most current data available;

(iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

(v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015~~.~~; and

(6) to provide technical assistance to the Health Care Affordability Board to implement sections 62J.86 to 62J.92.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, 2023.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

Sec. 10. **[62V.12] STATE-FUNDED COST-SHARING REDUCTIONS.**

Subdivision 1. **Establishment.** (a) The board must develop and administer a state-funded cost-sharing reduction program for eligible persons who enroll in a silver level qualified health plan through MNsure. The board must implement the cost-sharing reduction program for plan years beginning on or after January 1, 2024.

(b) For purposes of this section, an "eligible person" is an individual who meets the eligibility criteria to receive a cost-sharing reduction under Code of Federal Regulations, title 45, section 155.305(g).

Subd. 2. **Reduction in cost-sharing.** (a) The cost-sharing reduction program must use state funds to reduce enrollee cost-sharing by increasing the actuarial value of silver level health plans for eligible persons beyond the 73 percent value established in Code of Federal Regulations, title 45, section 156.420(a)(3)(ii), to an actuarial value of 87 percent.

(b) Paragraph (a) applies beginning for plan year 2024 for eligible individuals expected to have a household income above 200 percent of the federal poverty level but that does not exceed 250 percent of the federal poverty level, for the benefit year for which coverage is requested.

(c) Beginning for plan year 2026, the cost-sharing reduction program applies for eligible individuals expected to have a household income above 250 percent of the federal poverty

level but that does not exceed 300 percent of the federal poverty level, for the benefit year for which coverage is requested. Under this paragraph, the cost-sharing reduction program applies by increasing the actuarial value of silver level health plans for eligible persons to the 73 percent actuarial value established in Code of Federal Regulations, title 45, section 156.420(a)(3)(ii).

Subd. 3. **Administration.** The board, when administering the program, must:

(1) allow eligible persons to enroll in a silver level health plan with a state-funded cost-sharing reduction;

(2) modify the MNsure shopping tool to display the total cost-sharing reduction benefit available to individuals eligible under this section; and

(3) reimburse health carriers on a quarterly basis for the cost to the health plan providing the state-funded cost-sharing reductions.

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

Sec. 11. **[62V.13] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM.**

Subdivision 1. **Establishment.** The board, in cooperation with the commissioner of revenue, must establish the easy enrollment health insurance outreach program to:

(1) reduce the number of uninsured Minnesotans and increase access to affordable health insurance coverage;

(2) allow the commissioner of revenue to provide return information, at the request of the taxpayer, to MNsure to provide the taxpayer with information about the potential eligibility for financial assistance and health insurance enrollment options through MNsure;

(3) allow MNsure to estimate taxpayer potential eligibility for financial assistance for health insurance coverage; and

(4) allow MNsure to conduct targeted outreach to assist interested taxpayer households in applying for and enrolling in affordable health insurance options through MNsure, including connecting interested taxpayer households with a navigator or broker for free enrollment assistance.

Subd. 2. **Screening for eligibility for insurance assistance.** Upon receipt of and based on return information received from the commissioner of revenue under section 270B.14, subdivision 22, MNsure may make a projected assessment on whether the interested

taxpayer's household may qualify for a financial assistance program for health insurance coverage.

Subd. 3. **Outreach letter and special enrollment period.** (a) MNsure must provide a written letter of the projected assessment under subdivision 2 to a taxpayer who indicates to the commissioner of revenue that the taxpayer is interested in obtaining information on access to health insurance.

(b) MNsure must allow a special enrollment period for taxpayers who receive the outreach letter in paragraph (a) and are determined eligible to enroll in a qualified health plan through MNsure. The triggering event for the special enrollment period is the day the outreach letter under this subdivision is mailed to the taxpayer. An eligible individual, and their dependents, have 65 days from the triggering event to select a qualifying health plan and coverage for the qualifying health plan is effective the first day of the month after plan selection.

(c) Taxpayers who have a member of the taxpayer's household currently enrolled in a qualified health plan through MNsure are not eligible for the special enrollment under paragraph (b).

(d) MNsure must provide information about the easy enrollment health insurance outreach program and the special enrollment period described in this subdivision to the general public.

Subd. 4. **Appeals.** (a) Projected eligibility assessments for financial assistance under this section are not appealable.

(b) Qualification for the special enrollment period under this section is appealable to MNsure under this chapter and Minnesota Rules, chapter 7700.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

Sec. 12. Minnesota Statutes 2022, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations and licensed insurance producers under chapter 60K that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare or medical assistance, the commissioner, within the available appropriation, shall pay the organization or licensed insurance producer a ~~$70~~ $100 application assistance bonus. The organization or licensed insurance producer may provide an applicant a gift certificate or other incentive upon enrollment.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 13. Minnesota Statutes 2022, section 256B.04, is amended by adding a subdivision to read:

Subd. 26. **Disenrollment under medical assistance and MinnesotaCare.** (a) The commissioner shall regularly update mailing addresses and other contact information for medical assistance and MinnesotaCare enrollees in cases of returned mail and nonresponse using information available through managed care and county-based purchasing plans, state health and human services programs, and other sources.

(b) The commissioner shall not disenroll an individual from medical assistance or MinnesotaCare in cases of returned mail until the commissioner makes at least two attempts by phone, email, or other methods to contact the individual. The commissioner may disenroll the individual after providing no less than 30 days for the individual to respond to the most recent contact attempt.

Sec. 14. Minnesota Statutes 2022, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

(b) Notwithstanding any other law to the contrary:

(1) a child under 21 years of age who is determined eligible for medical assistance must remain eligible for a period of 12 months; and

(2) a child under six years of age who is determined eligible for medical assistance must remain eligible through the month in which the child reaches six years of age.

(c) A child's eligibility under paragraph (b) may be terminated earlier if:

(i) the child or the child's representative requests voluntary termination of eligibility;

(ii) the child ceases to be a resident of this state;

(iii) the child dies;

(iv) the child attains the maximum age; or

(v) the agency determines eligibility was erroneously granted at the most recent eligibility determination due to agency error or fraud, abuse, or perjury attributed to the child or the child's representative.

~~(b)~~ (d) For a person eligible for an insurance affordability program as defined in section 256B.02, subdivision 19, who reports a change that makes the person eligible for medical assistance, eligibility is available for the month the change was reported and for three months prior to the month the change was reported, if the person was eligible in those prior months.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval and the implementation of required administrative and systems changes, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2022, section 256B.0631, is amended by adding a subdivision to read:

Subd. 1a. **Prohibition on cost-sharing and deductibles.** The medical assistance benefit plan must not include cost-sharing or deductibles for any medical assistance recipient or benefit.

EFFECTIVE DATE. This section is effective July 1, 2025, and applies to all medical assistance benefit plans offered, issued, or renewed on or after that date.

Sec. 16. Minnesota Statutes 2022, section 256L.04, subdivision 7a, is amended to read:

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program, except as provided in subdivision 15.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 30. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2022, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens, with the exception of children under 19 years of age, are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality

according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 18. Minnesota Statutes 2022, section 256L.04, is amended by adding a subdivision to read:

Subd. 15. **Persons eligible for public option.** (a) Families and individuals with income above the maximum income eligibility limit specified in subdivision 1 or 7 but who meet all other MinnesotaCare eligibility requirements are eligible for MinnesotaCare. All other provisions of this chapter apply unless otherwise specified.

(b) Families and individuals may enroll in MinnesotaCare under this subdivision only during an annual open enrollment period or special enrollment period, as designated by MNsure in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 30. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2022, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines~~,~~ are no longer eligible for the program and ~~shall~~ must be disenrolled by the commissioner, unless the individuals continue MinnesotaCare enrollment through the public option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month in which the commissioner sends advance notice according to Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 30. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2022, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

~~(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).~~

~~(c)~~ (b) Paragraph ~~(b)~~ (a) does not apply to~~:~~

~~(1)~~ children 20 years of age or younger~~; and~~

~~(2) individuals with household incomes below 35 percent of the federal poverty guidelines~~.

~~(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:~~

~~**Federal Poverty Guideline Greater than or Equal to**~~	~~**Less than**~~	~~**Individual Premium Amount**~~
~~35%~~	~~55%~~	~~$4~~
~~55%~~	~~80%~~	~~$6~~
~~80%~~	~~90%~~	~~$8~~
~~90%~~	~~100%~~	~~$10~~
~~100%~~	~~110%~~	~~$12~~
~~110%~~	~~120%~~	~~$14~~
~~120%~~	~~130%~~	~~$15~~
~~130%~~	~~140%~~	~~$16~~
~~140%~~	~~150%~~	~~$25~~
~~150%~~	~~160%~~	~~$37~~
~~160%~~	~~170%~~	~~$44~~
~~170%~~	~~180%~~	~~$52~~
~~180%~~	~~190%~~	~~$61~~
~~190%~~	~~200%~~	~~$71~~
~~200%~~		~~$80~~

~~(c)~~ (c) Beginning January 1, ~~2021~~ 2024, the commissioner shall continue to charge premiums in accordance with the simplified premium scale established to comply with the American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31, 2025, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The commissioner shall adjust the premium scale ~~established under paragraph (d)~~ as needed to ensure that premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with the Code of Federal Regulations, title 42, section 600.505 (a)(1).

(d) The commissioner shall establish a sliding premium scale for persons eligible through the public option under section 256L.04, subdivision 15. Beginning January 1, 2027, persons eligible through the public option shall pay premiums according to this premium scale. Persons eligible through the public option who are 20 years of age or younger are exempt from paying premiums.

EFFECTIVE DATE. This section is effective January 1, 2024, and certification under section 30 is not required, except that paragraph (d) is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 30. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2022, section 270B.14, is amended by adding a subdivision to read:

Subd. 22. **Disclosure to MNsure board.** The commissioner may disclose a return or return information to the MNsure board if a taxpayer makes the designation under section 290.433 on an income tax return filed with the commissioner. The commissioner must only disclose data necessary to provide the taxpayer with information about the potential eligibility for financial assistance and health insurance enrollment options under section 62V.13.

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

Sec. 22. **[290.433] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM CHECKOFF.**

Subdivision 1. **Taxpayer designation.** Any individual who files an income tax return may designate on their original return a request that the commissioner provide their return information to the MNsure board for purposes of providing the individual with information about potential eligibility for financial assistance and health insurance enrollment options

under section 62V.13, to the extent necessary to administer the easy enrollment health insurance outreach program.

Subd. 2. **Form.** The commissioner shall notify filers of their ability to make the designation in subdivision 1 on their income tax return.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023.

Sec. 23. **DIRECTION TO MNSURE BOARD AND COMMISSIONER.**

The MNsure board and the commissioner of the Department of Revenue must develop and implement systems, policies, and procedures that encourage, facilitate, and streamline data sharing, projected eligibility assessments, and notice to taxpayers to achieve the purpose of the easy enrollment health insurance outreach program under Minnesota Statutes, section 62V.13, for operation beginning with tax year 2023.

Sec. 24. **RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

(a) The commissioners of human services, health, and commerce and the MNsure board shall submit to the health care affordability board and the chairs and ranking minority members of the legislative committees with primary jurisdiction over health and human services finance and policy and commerce by January 15, 2024, a report on the organization and duties of the Office of Patient Protection, to be established under Minnesota Statutes, section 62J.89, subdivision 4. The report must include recommendations on how the office shall:

(1) coordinate or consolidate within the office existing state agency patient protection activities, including but not limited to the activities of ombudsman offices and the MNsure board;

(2) enforce standards and procedures under Minnesota Statutes, chapter 62M, for utilization review organizations;

(3) work with private sector and state agency consumer assistance programs to assist consumers with questions or concerns relating to public programs and private insurance coverage;

(4) establish and implement procedures to assist consumers aggrieved by restrictions on patient choice, denials of services, and reductions in quality of care resulting from any final action by a payer or provider; and

(5) make health plan company quality of care and patient satisfaction information and other information collected by the office readily accessible to consumers on the board's website.

(b) The commissioners and the MNsure board shall consult with stakeholders as they develop the recommendations. The stakeholders consulted must include but are not limited to organizations and individuals representing: underserved communities; persons with disabilities; low-income Minnesotans; senior citizens; and public and private sector health plan enrollees, including persons who purchase coverage through MNsure, health plan companies, and public and private sector purchasers of health coverage.

(c) The commissioners and the MNsure board may contract with a third party to develop the report and recommendations.

Sec. 25. **TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

(a) The commissioner of human services must continue to administer MinnesotaCare as a basic health program in accordance with Minnesota Statutes, section 256L.02, subdivision 5, and must seek federal waivers, approvals, and law changes as required under section 26.

(b) The commissioner must present an implementation plan for the MinnesotaCare public option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by December 15, 2024. The plan must include:

(1) recommendations for any changes to the MinnesotaCare public option necessary to continue federal basic health program funding or to receive other federal funding;

(2) recommendations for ensuring sufficient provider participation in MinnesotaCare;

(3) estimates of state costs related to the MinnesotaCare public option;

(4) a description of the proposed premium scale for persons eligible through the public option, including an analysis of the extent to which the proposed premium scale:

(i) ensures affordable premiums for persons across the income spectrum enrolled under the public option; and

(ii) avoids premium cliffs for persons transitioning to and enrolled under the public option; and

(5) draft legislation that includes any additional policy and conforming changes necessary to implement the MinnesotaCare public option and the implementation plan recommendations.

(c) The commissioner shall present to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, by January 15, 2025, a report comparing service delivery and payment system models for delivering services to MinnesotaCare enrollees eligible under Minnesota Statutes, section 256L.04, subdivisions 1, 7, and 15. The report must compare the current delivery model with at least two alternative models. The alternative models must include a state-based model in which the state holds the plan risk as the insurer and may contract with a third-party administrator for claims processing and plan administration. The alternative models may include but are not limited to:

(1) expanding the use of integrated health partnerships under Minnesota Statutes, section 256B.0755;

(2) delivering care under fee-for-service through a primary care case management system; and

(3) continuing to contract with managed care and county-based purchasing plans for some or all enrollees under modified contracts.

(d) The report must also include:

(1) a description of how each model would address:

(i) racial inequities in the delivery of health care and health care outcomes;

(ii) geographic inequities in the delivery of health care;

(iii) incentives for preventive care and other best practices; and

(iv) reimbursement of providers for high-quality, value-based care at levels sufficient to sustain or increase enrollee access to care;

(2) a comparison of the projected cost of each model; and

(3) an implementation timeline for each model that includes the earliest date by which each model could be implemented if authorized during the 2025 legislative session.

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

Sec. 26. **REQUEST FOR FEDERAL APPROVAL.**

(a) The commissioner of human services must seek all federal waivers, approvals, and law changes necessary to implement a MinnesotaCare public option and any related changes to state law, including but not limited to those waivers, approvals, and law changes necessary to allow the state to:

(1) continue receiving federal basic health program payments for basic health program-eligible MinnesotaCare enrollees and to receive other federal funding for the MinnesotaCare public option;

(2) receive federal payments equal to the value of premium tax credits and cost-sharing reductions that MinnesotaCare enrollees with household incomes greater than 200 percent of the federal poverty guidelines would otherwise have received; and

(3) receive federal payments equal to the value of emergency medical assistance that would otherwise have been paid to the state for covered services provided to eligible enrollees.

(b) In implementing this section, the commissioner of human services must contract with one or more independent entities to conduct an actuarial analysis of the implementation, administration, and effects of the provisions of a MinnesotaCare public option and any related changes to state law, including but not limited to benefits, costs, impacts on coverage, and affordability to the state and eligible enrollees, impacts on the state's individual market, and compliance with federal law, at a minimum as necessary to obtain any waivers, approvals, and law changes sought under this section.

(c) In implementing this section, the commissioner of human services must consult with the commissioner of commerce and the Board of Directors of MNsure and may contract for technical assistance.

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

Sec. 27. **ANALYSIS OF BENEFITS AND COSTS OF A UNIVERSAL HEALTH CARE SYSTEM.**

Subdivision 1. **Definitions.** (a) "Total public and private health care spending" means:

(1) spending on all medical care including but not limited to dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care, whether paid through premiums, co-pays and

deductibles, other out-of-pocket payments, or other funding from government, employers, or other sources; and

(2) the costs associated with administering, delivering, and paying for the care. The costs of administering, delivering, and paying for the care includes all expenses by insurers, providers, employers, individuals, and government to select, negotiate, purchase, and administer insurance and care including but not limited to coverage for health care, dental, long-term care, prescription drugs, medical expense portions of workers compensation and automobile insurance, and the cost of administering and paying for all health care products and services that are not covered by insurance.

(b) "All necessary care" means the full range of services listed in the proposed Minnesota Health Plan legislation, including medical, dental, vision and hearing, mental health, chemical dependency treatment, reproductive and sexual health, prescription drugs, medical equipment and supplies, long-term care, home care, and coordination of care.

Subd. 2. **Initial assumptions.** (a) When calculating administrative savings under the universal health proposal, the analysts shall recognize that simple, direct payment of medical services avoids the need for provider networks, eliminates prior authorization requirements, and eliminates administrative complexity of other payment schemes along with the need for creating risk adjustment mechanisms, and measuring, tracking, and paying under those risk adjusted or nonrisk adjusted payment schemes by both providers and payors.

(b) The analysts shall assume that, while gross provider payments may be reduced to reflect reduced administrative costs, net provider income would remain similar to the current system. However, they shall not assume that payment rate negotiations will track current Medicaid, Medicare, or market payment rates or a combination of those rates, because provider compensation, after adjusting for reduced administrative costs, would not be universally raised or lowered but would be negotiated based on market needs, so provider compensation might be raised in an underserved area such as mental health but lowered in other areas.

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

Sec. 28. **BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM PROPOSAL.**

Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall contract with one or more independent entities to conduct an analysis of the benefits and costs of a legislative proposal for a universal health care financing system and a similar

analysis of the current health care financing system to assist the state in comparing the proposal to the current system. The contract must strive to produce estimates for all elements in subdivision 3.

Subd. 2. **Proposal.** The commissioner of health, with input from the commissioners of human services and commerce, shall submit to the contractor for analysis the legislative proposal known as the Minnesota Health Plan, proposed in 2023 Senate File No. 2740; House File No. 2798, if enacted, that would offer a universal health care plan designed to meet a set of principles, including:

(1) ensure all Minnesotans are covered;

(2) cover all necessary care; and

(3) allow patients to choose their doctors, hospitals, and other providers.

Subd. 3. **Proposal analysis.** (a) The analysis must measure the performance of both the proposed Minnesota Health Plan and the current public and private health care financing system over a ten-year period to contrast the impact on:

(1) coverage: the number of people who are uninsured versus the number of people who are insured;

(2) benefit completeness: adequacy of coverage measured by the completeness of the coverage and the number of people lacking coverage for key necessary care elements such as dental, long-term care, medical equipment or supplies, vision and hearing, or other health services that are not covered, if any. The analysis must take into account the vast variety of benefit designs in the commercial market and report the extent of coverage in each area;

(3) underinsurance: whether people with coverage can afford the care they need or whether cost prevents them from accessing care. This includes affordability in terms of premiums, deductibles, and out-of-pocket expenses;

(4) system capacity: the timeliness and appropriateness of the care received and whether people turn to inappropriate care such as emergency rooms because of a lack of proper care in accordance with clinical guidelines; and

(5) health care spending: total public and private health care spending in Minnesota under the current system versus under the Minnesota Health Plan legislative proposal, including all spending by individuals, businesses, and government. Where relevant, the analysis shall be broken out by key necessary care areas, such as medical, dental, and mental health. The analysis of total health care spending shall examine whether there are savings or additional costs under the legislative proposal compared to the existing system due to:

(i) changes in cost of insurance, billing, underwriting, marketing, evaluation, and other administrative functions for all entities involved in the health care system, including savings from global budgeting for hospitals and institutional care instead of billing for individual services provided;

(ii) changed prices on medical services and products, including pharmaceuticals, due to price negotiations under the proposal;

(iii) impact on utilization, health outcomes, and workplace absenteeism due to prevention, early intervention, and health-promoting activities;

(iv) shortages or excess capacity of medical facilities, equipment, and personnel, including caregivers and staff, under either the current system or the proposal, including capacity of clinics, hospitals, and other appropriate care sites versus inappropriate emergency room usage. The analysis shall break down capacity by geographic differences such as rural versus metro, and disparate access by population group;

(v) the impact on state, local, and federal government non-health-care expenditures. This may include areas such as reduced crime and out-of-home placement costs due to mental health or chemical dependency coverage. Additional definition may further develop hypotheses for other impacts that warrant analysis;

(vi) job losses or gains within the health care system; specifically, in health care delivery, health billing, and insurance administration;

(vii) job losses or gains elsewhere in the economy under the proposal due to implementation of the resulting reduction of insurance and administrative burdens on businesses; and

(viii) impact on disparities in health care access and outcomes.

(b) The contractor or contractors shall propose an iterative process for designing and conducting the analysis. Steps shall be reviewed with and approved by the commissioner of health and lead house and senate authors of the legislative proposal, and shall include but not be limited to:

(1) clarification of the specifics of the proposal. The analysis shall assume that the provisions in the proposal are not preempted by federal law or that the federal government gives a waiver to the preemptions;

(2) additional data elements needed to accomplish goals of the analysis;

(3) assumptions analysts are using in their analysis and the quality of the evidence behind those assumptions;

(4) timing of each stage of the project with agreed upon decision points;

(5) approaches to address any services currently provided in the existing health care system that may not be provided for within the Minnesota Health Plan as proposed; and

(6) optional scenarios provided by contractor or contractors with minor alterations in the proposed plan related to services covered or cost-sharing if those scenarios might be helpful to the legislature.

(c) The commissioner shall issue a final report by January 15, 2026, and may provide interim reports and status updates to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance aligned with the iterative process defined above.

(d) The contractor may offer a modeling tool as deliverable with a line-item cost provided.

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

Sec. 29. **REPEALER.**

Minnesota Statutes 2022, section 256B.0631, subdivisions 1, 2, and 3, are repealed.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 30. **CONTINGENT EFFECTIVE DATE.**

Sections 16, 18, and 19, and the specified portion of section 20, are effective January 1, 2027, or upon federal approval, whichever is later, but only if the commissioner of human services certifies to the legislature the following:

(1) that implementation of those sections will not result in substantial reduction in federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of the federal poverty guidelines;

(2) premiums necessary to operationalize the program are deemed affordable in accordance with applicable federal law;

(3) the actuarial value of benefit does not fall below 94 percent and the benefit set is equal to or greater than that historically available in MinnesotaCare;

(4) the 1332 waiver was approved consistent, or without substantial deviation, from the implementation plan;

(5) the commissioner of commerce certifies that the public option would expand plan options available for individuals purchasing coverage;

(6) the state receives a substantially similar pass-through funding amount from the federal government that would have otherwise gone to enrollees' advanced premium tax credits;

(7) individuals currently served by the MinnesotaCare program are not disproportionally or substantively negatively impacted in order to make the public option affordable or implementable; and

(8) individuals currently served by the Medical Assistance program are not disproportionally or substantively negatively impacted in order to make the public option affordable or implementable.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. "

Renumber the sections in sequence and correct the internal references