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ARTICLE 4

HEALTH INSURANCE

Section 1. Minnesota Statutes 2022, section 62A.0411, is amended to read:

62A.0411 MATERNITY CARE.

Subdivision 1. **Minimum inpatient care.** Every health plan ~~as defined in section 62Q.01, subdivision 3, that provides maternity benefits~~ must~~, consistent with other coinsurance, co-payment, deductible, and related contract terms,~~ provide coverage of a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn. The health plan shall not provide any compensation or other nonmedical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified in this section.

Subd. 1a. **Medical facility transfer.** (a) If a health care provider acting within the provider's scope of practice recommends that either the mother or newborn be transferred to a different medical facility, every health plan must provide the coverage required under subdivision 1 for the mother, newborn, and newborn siblings at both medical facilities. The coverage required under this subdivision includes but is not limited to expenses related to transferring all individuals from one medical facility to a different medical facility.

(b) The coverage required under this subdivision must be provided without cost sharing, including but not limited to deductible, co-pay, or coinsurance. The coverage required under this paragraph must be provided without any limitation that is not generally applicable to other coverages under the plan.

(c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in conjunction with a health savings account must include cost-sharing for the coverage required under this subdivision at the minimum level necessary to preserve the enrollee's ability to make tax-exempt contributions and withdrawals from the health savings account as provided in section 223 of the Internal Revenue Code of 1986.

Subd. 2. **Minimum postdelivery outpatient care.** (a) The health plan must also provide coverage for postdelivery outpatient care to a mother and her newborn if the duration of inpatient care is less than the minimums provided in this section.

(b) Postdelivery care consists of a minimum of one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four days following the discharge of the mother and her child.

Subd. 3. **Health plan defined.** For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, and county-based purchasing plans.

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ARTICLE 4

HEALTH INSURANCE

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EFFECTIVE DATE. This section is effective January 1, 2025, and applies to all policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2022, section 62A.15, is amended by adding a subdivision to read:

Subd. 3d. **Pharmacist.** All benefits provided by a policy or contract referred to in subdivision 1 relating to expenses incurred for medical treatment or services provided by a licensed physician must include services provided by a licensed pharmacist, according to the requirements of section 151.01, to the extent a licensed pharmacist's services are within the pharmacist's scope of practice.

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

Sec. 3. Minnesota Statutes 2022, section 62A.15, subdivision 4, is amended to read:

Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor, a licensed optometrist, a registered nurse meeting the requirements of subdivision 3a, a licensed physician assistant, ~~or~~ a licensed acupuncture practitioner, or a licensed pharmacist.

(b) When carriers referred to in subdivision 1 make claim determinations concerning the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any of these determinations that are made by health care professionals must be made by, or under the direction of, or subject to the review of licensed doctors of chiropractic.

(c) When a carrier referred to in subdivision 1 makes a denial of payment claim determination concerning the appropriateness, quality, or utilization of acupuncture services for individuals in this state performed by a licensed acupuncture practitioner, a denial of payment claim determination that is made by a health professional must be made by, under the direction of, or subject to the review of a licensed acupuncture practitioner.

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

Sec. 4. Minnesota Statutes 2022, section 62A.28, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** (a) Every policy, plan, certificate, or contract referred to in subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp hair prostheses, including all equipment and accessories necessary for regular use of scalp hair prostheses, worn for hair loss suffered as a result of a health condition, including but not limited to alopecia areata or the treatment for cancer, unless there is a clinical basis for limitation.

(b) The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items

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Section 1. Minnesota Statutes 2022, section 62A.28, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** (a) Every policy, plan, certificate, or contract referred to in subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp hair prostheses, including all equipment and accessories necessary for regular use of scalp hair prostheses, worn for hair loss suffered as a result of a health condition, including, but not limited to, alopecia areata or the treatment for cancer, unless there is a clinical basis for limitation.

(b) The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items

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under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.

(c) The coverage required by this section for scalp hair prostheses is limited to $1,000 per benefit year.

(d) A scalp hair prosthesis must be prescribed by a doctor to be covered under this section.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to all policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

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under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.

(c) The coverage required by this section for scalp hair prostheses is limited to $1,000 per benefit year.

(d) A scalp hair prostheses must be prescribed by a doctor to be covered under this section.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to all policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

Sec. 2. **[62A.3098] RAPID WHOLE GENOME SEQUENCING; COVERAGE.**

Subdivision 1. **Definition.** For purposes of this section, "rapid whole genome sequencing" or "rWGS" means an investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results in 14 days. Rapid whole genome sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

Subd. 2. **Required coverage.** A health plan that provides coverage to Minnesota residents must cover rWGS testing if the enrollee:

(1) is 21 years of age or younger;

(2) has a complex or acute illness of unknown etiology that is not confirmed to have been caused by an environmental exposure, toxic ingestion, an infection with a normal response to therapy, or trauma; and

(3) is receiving inpatient hospital services in an intensive care unit or a neonatal or high acuity pediatric care unit.

Subd. 3. **Coverage criteria.** Coverage may be based on the following medical necessity criteria:

(1) the enrollee has symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if rWGS testing is not performed;

(2) timely identification of a molecular diagnosis is necessary in order to guide clinical decision making, and the rWGS testing may aid in guiding the treatment or management of the enrollee's condition; and

(3) the enrollee's complex or acute illness of unknown etiology includes at least one of the following conditions:

(i) congenital anomalies involving at least two organ systems, or complex or multiple congenital anomalies in one organ system;

(ii) specific organ malformations that are highly suggestive of a genetic etiology;

(iii) abnormal laboratory tests or abnormal chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism;

(iv) refractory or severe hypoglycemia or hyperglycemia;

(v) abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems;

(vi) severe muscle weakness, rigidity, or spasticity;

(vii) refractory seizures;

(viii) a high-risk stratification on evaluation for a brief resolved unexplained event with any of the following features:

(A) a recurrent event without respiratory infection;

(B) a recurrent seizure-like event; or

(C) a recurrent cardiopulmonary resuscitation;

(ix) abnormal cardiac diagnostic testing results that are suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease;

(x) abnormal diagnostic imaging studies that are suggestive of underlying genetic condition;

(xi) abnormal physiologic function studies that are suggestive of an underlying genetic etiology; or

(xii) family genetic history related to the patient's condition.

Subd. 4. **Cost sharing.** Coverage provided in this section is subject to the enrollee's health plan cost-sharing requirements, including any deductibles, co-payments, or coinsurance requirements that apply to diagnostic testing services.

Subd. 5. **Payment for services provided.** If the enrollee's health plan uses a capitated or bundled payment arrangement to reimburse a provider for services provided in an inpatient setting, reimbursement for services covered under this section must be paid separately and in addition to any reimbursement otherwise payable to the provider under the capitated or bundled payment arrangement, unless the health carrier and the provider have negotiated an increased capitated or bundled payment rate that includes the services covered under this section.

Subd. 6. **Genetic data.** Genetic data generated as a result of performing rWGS and covered under this section: (1) must be used for the primary purpose of assisting the ordering provider and treating care team to diagnose and treat the patient; (2) is protected health information as set forth under the Health Insurance Portability and Accountability Act

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Sec. 5. Minnesota Statutes 2022, section 62D.02, subdivision 4, is amended to read:

Subd. 4. **Health maintenance organization.** "Health maintenance organization" means a ~~foreign or domestic~~ nonprofit corporation organized under chapter 317A, or a local governmental unit as defined in subdivision 11, controlled and operated as provided in sections 62D.01 to 62D.30, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

(HIPAA), the Health Information Technology for Economic and Clinical Health Act, and any promulgated regulations, including but not limited to Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E; and (3) is a protected health record under sections 144.291 to 144.298.

Subd. 7. **Reimbursement.** The commissioner of commerce must reimburse health carriers for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section. Each fiscal year, an amount necessary to make payments to health carriers to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce. Health carriers must report to the commissioner quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. The commissioner must evaluate submissions and make payments to health carriers as provided in Code of Federal Regulations, title 45, section 155.170.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to a health plan offered, issued, or sold on or after that date.

Sec. 3. **[62A.59] COVERAGE OF SERVICE; PRIOR AUTHORIZATION.**

Subdivision 1. **Service for which prior authorization not required.** A health carrier must not retrospectively deny or limit coverage of a health care service for which prior authorization was not required by the health carrier, unless there is evidence that the health care service was provided based on fraud or misinformation.

Subd. 2. **Service for which prior authorization required but not obtained.** A health carrier must not deny or limit coverage of a health care service which the enrollee has already received solely on the basis of lack of prior authorization if the service would otherwise have been covered had the prior authorization been obtained.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 4. **[62C.045] APPLICATION OF OTHER LAW.**

Sections 145D.30 to 145D.37 apply to service plan corporations operating under this chapter.

Sec. 5. Minnesota Statutes 2022, section 62D.02, subdivision 4, is amended to read:

Subd. 4. **Health maintenance organization.** "Health maintenance organization" means a ~~foreign or domestic~~ nonprofit corporation organized under chapter 317A, ~~or~~ a local governmental unit as defined in subdivision 11, or an entity which is not a nonprofit corporation organized under chapter 317A or a local governmental unit and which holds a certificate of authority under sections 62D.01 to 62D.30 as of June 1, 2024, controlled and operated as provided in sections 62D.01 to 62D.30, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services,

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Sec. 6. Minnesota Statutes 2022, section 62D.02, subdivision 7, is amended to read:

Subd. 7. **Comprehensive health maintenance services.** "Comprehensive health maintenance services" means a set of comprehensive health services which the enrollees might reasonably require to be maintained in good health including as a minimum, but not limited to, emergency care, emergency ground ambulance transportation services, inpatient hospital and physician care, outpatient health services and preventive health services. ~~Elective, induced abortion, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility or the office of a physician, shall not be mandatory for any health maintenance organization.~~

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

Sec. 7. Minnesota Statutes 2022, section 62D.03, subdivision 1, is amended to read:

Subdivision 1. **Certificate of authority required.** Notwithstanding any law of this state to the contrary, any ~~foreign or domestic~~ nonprofit corporation organized to do so or a local governmental unit may apply to the commissioner of health for a certificate of authority to establish and operate a health maintenance organization in compliance with sections 62D.01 to 62D.30. No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization or health maintenance contract unless the organization has a certificate of authority under sections 62D.01 to 62D.30.

Sec. 8. Minnesota Statutes 2022, section 62D.05, subdivision 1, is amended to read:

Subdivision 1. **Authority granted.** Any nonprofit corporation or local governmental unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.30, operate as a health maintenance organization.

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or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

Sec. 6. Minnesota Statutes 2022, section 62D.02, subdivision 7, is amended to read:

Subd. 7. **Comprehensive health maintenance services.** "Comprehensive health maintenance services" means a set of comprehensive health services which the enrollees might reasonably require to be maintained in good health including as a minimum, but not limited to, emergency care, emergency ground ambulance transportation services, inpatient hospital and physician care, outpatient health services and preventive health services. ~~Elective, induced abortion, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility or the office of a physician, shall not be mandatory for any health maintenance organization.~~

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

Sec. 7. Minnesota Statutes 2022, section 62D.03, subdivision 1, is amended to read:

Subdivision 1. **Certificate of authority required.** Notwithstanding any law of this state to the contrary, any ~~foreign or domestic~~ nonprofit corporation organized to do so or a local governmental unit may apply to the commissioner of health for a certificate of authority to establish and operate a health maintenance organization in compliance with sections 62D.01 to 62D.30. No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization or health maintenance contract unless the organization has a certificate of authority under sections 62D.01 to 62D.30.

Sec. 8. Minnesota Statutes 2022, section 62D.03, is amended by adding a subdivision to read:

Subd. 1a. **Certificate of authority; for-profit corporation.** The commissioner of health must not issue a new certificate of authority to an entity to operate a health maintenance organization unless the entity is a nonprofit corporation organized under chapter 317A or a local governmental unit.

Sec. 9. Minnesota Statutes 2022, section 62D.05, subdivision 1, is amended to read:

Subdivision 1. **Authority granted.** Any nonprofit corporation or local governmental unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.30, operate as a health maintenance organization. An entity that: (1) is not a nonprofit corporation organized under chapter 317A or a local governmental unit; and (2) holds a certificate of authority under sections 62D.01 to 62D.30 as of June 1, 2024, may continue to operate as a health maintenance organization for as long as the corporation holds a certificate of authority.

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Sec. 9. Minnesota Statutes 2022, section 62D.06, subdivision 1, is amended to read:

Subdivision 1. **Governing body composition; enrollee advisory body.** The governing body of any health maintenance organization which is a nonprofit corporation may include enrollees, providers, or other individuals; provided, however, that after a health maintenance organization which is a nonprofit corporation has been authorized under sections 62D.01 to 62D.30 for one year, at least 40 percent of the governing body shall be composed of enrollees and members elected by the enrollees and members from among the enrollees and members. For purposes of this section, "member" means a consumer who receives health care services through a self-insured contract that is administered by the health maintenance organization or its related third-party administrator. The number of members elected to the governing body shall not exceed the number of enrollees elected to the governing body. An enrollee or member elected to the governing board may not be a person:

(1) whose occupation involves, or before retirement involved, the administration of health activities or the provision of health services;

(2) who is or was employed by a health care facility as a licensed health professional; or

(3) who has or had a direct substantial financial or managerial interest in the rendering of a health service, other than the payment of a reasonable expense reimbursement or compensation as a member of the board of a health maintenance organization.

After a health maintenance organization which is a local governmental unit has been authorized under sections 62D.01 to 62D.30 for one year, an enrollee advisory body shall be established. The enrollees who make up this advisory body shall be elected by the enrollees from among the enrollees.

Sec. 10. **[62D.085] TRANSACTION OVERSIGHT.**

Subdivision 1. **Insurance provisions applicable to health maintenance organizations.** (a) Health maintenance organizations are subject to sections 60A.135, 60A.136, 60A.137, 60A.16, 60A.161, 60D.17, 60D.18, and 60D.20 and must comply with the provisions of these sections applicable to insurers. For purposes of applying these sections to health maintenance organizations, "commissioner" means the commissioner of health.

(b) Health maintenance organizations are subject to all regulations implementing sections 60D.17, 60D.18, and 60D.20 in Minnesota Rules, chapter 2720, and must comply with the provisions of sections 60D.17, 60D.18, and 60D.20 applicable to insurers, unless the commissioner of health adopts rules to implement this subdivision.

Subd. 2. **Notice on transfers.** No person may acquire all or substantially all of the assets of a domestic nonprofit health maintenance organization through any means unless, at the time the agreement is entered into, the person has filed with the commissioner and has sent to the health maintenance organization a statement containing the information required by section 60D.17, including its implementing regulations, and the agreement and acquisition

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Sec. 15. **[62D.221] OVERSIGHT OF TRANSACTIONS.**

Subdivision 1. **Insurance provisions applicable to health maintenance organizations.** (a) Health maintenance organizations are subject to sections 60A.135, 60A.136, 60A.137, 60A.16, 60A.161, 60D.17, 60D.18, and 60D.20 and must comply with the provisions of these sections applicable to insurers. In applying these sections to health maintenance organizations, "the commissioner" means the commissioner of health. Health maintenance organizations are subject to Minnesota Rules, chapter 2720, as applicable to sections 60D.17, 60D.18, and 60D.20, and must comply with those provisions of the chapter applicable to insurers unless the commissioner of health adopts rules to implement this subdivision.

(b) In addition to the conditions in section 60D.17, subdivision 1, subjecting a health maintenance organization to filing requirements, no person other than the issuer shall acquire all or substantially all of the assets of a domestic nonprofit health maintenance organization through any means unless at the time the offer, request, or invitation is made or the agreement is entered into the person has filed with the commissioner and has sent to the health

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have been approved by the commissioner of health in the manner prescribed for regulatory approval in section 60D.17. The acquisition of assets subject to this subdivision must be treated as an acquisition of control for purposes of applying section 60D.17 and its implementing regulations to this subdivision.

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

Sec. 11. **[62D.1071] COVERAGE OF LICENSED PHARMACIST SERVICES.**

Subdivision 1. **Pharmacist.** All benefits provided by a health maintenance contract relating to expenses incurred for medical treatment or services provided by a licensed physician must include services provided by a licensed pharmacist to the extent a licensed pharmacist's services are within the pharmacist's scope of practice.

Subd. 2. **Denial of benefits.** When paying claims for enrollees in Minnesota, a health maintenance organization must not deny payment for medical services covered by an enrollee's health maintenance contract if the services are lawfully performed by a licensed pharmacist.

Subd. 3. **Medication therapy management.** This section does not apply to or affect the coverage or reimbursement for medication therapy management services under section 62Q.676 or 256B.0625, subdivisions 5, 13h, and 28a.

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

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maintenance organization a statement containing the information required in section 60D.17 and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner of health in the manner prescribed in section 60D.17.

Subd. 2. **Conversion transactions.** If a health maintenance organization must notify or report a transaction to the commissioner under subdivision 1, the health maintenance organization must include information regarding the plan for a conversion benefit entity, in the form and manner determined by the commissioner, if the reportable transaction qualifies as a conversion transaction as defined in section 145D.30, subdivision 5. The commissioner may consider information regarding the conversion transaction and the conversion benefit entity plan in any actions taken under subdivision 1, including in decisions to approve or disapprove transactions, and may extend time frames to a total of 90 days, with notice to the parties to the transaction.

Sec. 10. Minnesota Statutes 2022, section 62D.12, subdivision 19, is amended to read:

Subd. 19. **Coverage of service.** A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained. This subdivision expires December 31, 2025, for health plans offered, sold, issued, or renewed on or after that date.

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Sec. 12. Minnesota Statutes 2022, section 62D.19, is amended to read:

62D.19 UNREASONABLE EXPENSES.

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner of health shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62D.01 to 62D.30, in order to safeguard the underlying nonprofit status of health maintenance organizations, and in order to ensure that the payment of health maintenance organization money to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense. The commissioner has standing to sue, on behalf of a health maintenance organization, officers or trustees of the health maintenance organization who have breached their fiduciary duty in entering into and performing such contracts.

Sec. 13. Minnesota Statutes 2022, section 62D.20, subdivision 1, is amended to read:

Subdivision 1. **Rulemaking.** The commissioner of health may, pursuant to chapter 14, promulgate such reasonable rules as are necessary or proper to carry out the provisions of sections 62D.01 to 62D.30. Included among such rules shall be those which provide minimum requirements for the provision of comprehensive health maintenance services, as defined in section 62D.02, subdivision 7, and reasonable exclusions therefrom. ~~Nothing in such rules shall force or require a health maintenance organization to provide elective, induced abortions, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility, or the office of a physician; the rules shall provide every health maintenance organization the option of excluding or including elective, induced abortions, except as medically necessary to prevent the death of the mother, as part of its comprehensive health maintenance services.~~

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

Sec. 14. Minnesota Statutes 2022, section 62D.22, subdivision 5, is amended to read:

Subd. 5. **Other state law.** Except as otherwise provided in sections 62A.01 to 62A.42 and 62D.01 to 62D.30, ~~and except as they eliminate elective, induced abortions, wherever performed, from health or maternity benefits,~~ provisions of the insurance laws and provisions of nonprofit health service plan corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under sections 62D.01 to 62D.30.

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Sec. 11. Minnesota Statutes 2022, section 62D.19, is amended to read:

62D.19 UNREASONABLE EXPENSES.

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner of health shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62D.01 to 62D.30, for nonprofit health maintenance organizations, in order to safeguard the underlying nonprofit status of health maintenance organizations; and in order to ensure that the payment of health maintenance organization money to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense. The commissioner has standing to sue, on behalf of a health maintenance organization, officers or trustees of the health maintenance organization who have breached their fiduciary duty in entering into and performing such contracts.

Sec. 12. Minnesota Statutes 2022, section 62D.20, subdivision 1, is amended to read:

Subdivision 1. **Rulemaking.** The commissioner of health may, pursuant to chapter 14, promulgate such reasonable rules as are necessary or proper to carry out the provisions of sections 62D.01 to 62D.30. Included among such rules shall be those which provide minimum requirements for the provision of comprehensive health maintenance services, as defined in section 62D.02, subdivision 7, and reasonable exclusions therefrom. ~~Nothing in such rules shall force or require a health maintenance organization to provide elective, induced abortions, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility, or the office of a physician; the rules shall provide every health maintenance organization the option of excluding or including elective, induced abortions, except as medically necessary to prevent the death of the mother, as part of its comprehensive health maintenance services.~~

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

Sec. 13. Minnesota Statutes 2022, section 62D.22, subdivision 5, is amended to read:

Subd. 5. **Other state law.** Except as otherwise provided in sections 62A.01 to 62A.42 and 62D.01 to 62D.30, ~~and except as they eliminate elective, induced abortions, wherever performed, from health or maternity benefits,~~ provisions of the insurance laws and provisions of nonprofit health service plan corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under sections 62D.01 to 62D.30.

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

Sec. 15. Minnesota Statutes 2022, section 62E.02, subdivision 3, is amended to read:

Subd. 3. **Health maintenance organization.** "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in chapter 62D.

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

Sec. 14. Minnesota Statutes 2022, section 62D.22, is amended by adding a subdivision to read:

Subd. 5a. **Application of other law.** Sections 145D.30 to 145D.37 apply to nonprofit health maintenance organizations operating under this chapter.

HOUSE ARTICLE 4, SECTION 16, WAS MOVED TO MATCH SENATE ARTICLE 2, SECTION 1.

Sec. 17. Minnesota Statutes 2022, section 62M.02, subdivision 1a, is amended to read:

Subd. 1a. **Adverse determination.** "Adverse determination" means a decision by a utilization review organization relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee, including:

(1) a decision to deny an admission, extension of stay, or health care service on the basis that it is not medically necessary; or

(2) an authorization for a health care service that is less intensive than the health care service specified in the original request for authorization.

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

Sec. 18. Minnesota Statutes 2022, section 62M.02, subdivision 5, is amended to read:

Subd. 5. **Authorization.** "Authorization" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and that, based on the information provided, it satisfies the utilization review requirements of the applicable health benefit plan and the health plan company or commissioner will then pay for the covered benefit, provided the preexisting limitation provisions, the general exclusion provisions, and any deductible, co-payment, coinsurance, or other policy requirements have been met.

Sec. 19. Minnesota Statutes 2022, section 62M.02, is amended by adding a subdivision to read:

Subd. 8a. **Commissioner.** "Commissioner" means, effective January 1, 2026, for the sections specified in section 62M.01, subdivision 3, paragraph (c), the commissioner of human services, unless otherwise specified.

Sec. 20. Minnesota Statutes 2022, section 62M.02, subdivision 11, is amended to read:

Subd. 11. **Enrollee.** "Enrollee" means:

(1) an individual covered by a health benefit plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder; or

(2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision 3, paragraph (c), a recipient receiving coverage through fee-for-service under chapters 256B and 256L.

Sec. 21. Minnesota Statutes 2022, section 62M.02, subdivision 12, is amended to read:

Subd. 12. **Health benefit plan.** (a) "Health benefit plan" means:

(1) a policy, contract, or certificate issued by a health plan company for the coverage of medical, dental, or hospital benefits; or

(2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision 3, paragraph (c), coverage of medical, dental, or hospital benefits through fee-for-service under chapters 256B and 256L, as specified by the commissioner on the agency's public website or through other forms of recipient and provider guidance.

(b) A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) blanket accident and sickness insurance as defined in section 62A.11;

(7) accident only coverage issued by a licensed and tested insurance agent; or

(8) workers' compensation.

Sec. 22. Minnesota Statutes 2022, section 62M.02, subdivision 21, is amended to read:

Subd. 21. **Utilization review organization.** "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a prepaid limited health service organization issued a certificate of authority and operating under sections 62A.451 to 62A.4528; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under

chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third-party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and authorizes or makes adverse determinations regarding an admission, extension of stay, or other health care services for a Minnesota resident; effective January 1, 2026, for the sections specified in section 62M.01, subdivision 3, paragraph (c), the commissioner of human services for purposes of delivering services through fee-for-service under chapters 256B and 256L; any other entity that provides, offers, or administers hospital, outpatient, medical, prescription drug, or other health benefits to individuals treated by a health professional under a policy, plan, or contract; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state. Utilization review organization does not include a clinic or health care system acting pursuant to a written delegation agreement with an otherwise regulated utilization review organization that contracts with the clinic or health care system. The regulated utilization review organization is accountable for the delegated utilization review activities of the clinic or health care system.

Sec. 23. Minnesota Statutes 2022, section 62M.04, subdivision 1, is amended to read:

Subdivision 1. **Responsibility for obtaining authorization.** A health benefit plan that includes utilization review requirements must specify the process for notifying the utilization review organization in a timely manner and obtaining authorization for health care services. Each health plan company must provide a clear and concise description of this process to an enrollee as part of the policy, subscriber contract, or certificate of coverage. Effective January 1, 2026, the commissioner must provide a clear and concise description of this process to fee-for-service recipients receiving services under chapters 256B and 256L, through the agency's public website or through other forms of recipient guidance. In addition to the enrollee, the utilization review organization must allow any provider or provider's designee, or responsible patient representative, including a family member, to fulfill the obligations under the health benefit plan.

A claims administrator that contracts directly with providers for the provision of health care services to enrollees may, through contract, require the provider to notify the review organization in a timely manner and obtain authorization for health care services.

Sec. 24. Minnesota Statutes 2022, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) ~~Notwithstanding subdivision 3b, a standard review determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within five business days after receiving the request if the request is received electronically, or within six business days if received through nonelectronic means, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization. Effective January 1, 2022,~~ A standard review determination on all

requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within five business days after receiving the request, regardless of how the request was received, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When a determination is made to authorize, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission authorized; and the date of the service, procedure, or admission. If the utilization review organization indicates authorization by use of a number, the number must be called the "authorization number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

(c) When an adverse determination is made, notification must be provided within the time periods specified in paragraph (a) by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox to the attending health care professional and hospital or physician office as applicable. Written notification must also be sent to the hospital or physician office as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include all reasons relied on by the utilization review organization for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for an adverse determination may include, among other things, the lack of adequate information to authorize after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an adverse determination is made, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

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

Sec. 25. Minnesota Statutes 2022, section 62M.07, subdivision 2, is amended to read:

Subd. 2. **Prior authorization of ~~emergency~~ certain services prohibited.** No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of:

(1) emergency confinement or an emergency service. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon as reasonably possible after the beginning of the emergency confinement or emergency service~~.~~;

(2) oral buprenorphine to treat a substance use disorder;

(3) outpatient mental health treatment or outpatient substance use disorder treatment, except for treatment which is: (i) a medication; and (ii) not otherwise listed in this subdivision. Prior authorizations required for medications used for outpatient mental health treatment or outpatient substance use disorder treatment, and not otherwise listed in this subdivision, must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(4) antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network, except for treatment which is: (i) a medication; and (ii) not otherwise listed in this subdivision. Prior authorizations required for medications used for antineoplastic cancer treatment, and not otherwise listed in this subdivision, must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(5) services that currently have a rating of A or B from the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130;

(6) pediatric hospice services provided by a hospice provider licensed under sections 144A.75 to 144A.755; and

(7) treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists.

Clauses (2) to (7) are effective January 1, 2026, and apply to health benefit plans offered, sold, issued, or renewed on or after that date.

Sec. 26. Minnesota Statutes 2022, section 62M.07, subdivision 4, is amended to read:

Subd. 4. **Submission of prior authorization requests.** (a) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or

through an electronic mechanism 24 hours a day, seven days a week. This subdivision does not apply to dental service covered under MinnesotaCare or medical assistance.

(b) Effective January 1, 2027, for health benefit plans offered, sold, issued, or renewed on or after that date, utilization review organizations, health plan companies, and claims administrators must have and maintain a prior authorization application programming interface (API) that automates the prior authorization process for health care services, excluding prescription drugs and medications. The API must allow providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from provider electronic health records or practice management systems. The API must use the Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR) standard in accordance with Code of Federal Regulations, title 45, section 170.215(a)(1), and the most recent standards and guidance adopted by the United States Department of Health and Human Services to implement that section. Prior authorization submission requests for prescription drugs and medications must comply with the requirements of section 62J.497.

Sec. 27. Minnesota Statutes 2022, section 62M.07, is amended by adding a subdivision to read:

Subd. 5. **Treatment of a chronic condition.** This subdivision is effective January 1, 2026, and applies to health benefit plans offered, sold, issued, or renewed on or after that date. An authorization for treatment of a chronic health condition does not expire unless the standard of treatment for that health condition changes. A chronic health condition is a condition that is expected to last one year or more and:

(1) requires ongoing medical attention to effectively manage the condition or prevent an adverse health event; or

(2) limits one or more activities of daily living.

Sec. 28. Minnesota Statutes 2022, section 62M.10, subdivision 7, is amended to read:

Subd. 7. **Availability of criteria.** (a) For utilization review determinations other than prior authorization, a utilization review organization shall, upon request, provide to an enrollee, a provider, and the commissioner of commerce the criteria used to determine the medical necessity, appropriateness, and efficacy of a procedure or service and identify the database, professional treatment guideline, or other basis for the criteria.

(b) For prior authorization determinations, a utilization review organization must submit the organization's current prior authorization requirements and restrictions, including written, evidence-based, clinical criteria used to make an authorization or adverse determination, to all health plan companies for which the organization performs utilization review. A health plan company must post on its public website the prior authorization requirements and restrictions of any utilization review organization that performs utilization review for the health plan company. These prior authorization requirements and restrictions must be detailed

and written in language that is easily understandable to providers. This paragraph does not apply to the commissioner of human services when delivering services through fee-for-service under chapters 256B and 256L.

(c) Effective January 1, 2026, the commissioner of human services must post on the department's public website the prior authorization requirements and restrictions, including written, evidence-based, clinical criteria used to make an authorization or adverse determination, that apply to prior authorization determinations for fee-for-service under chapters 256B and 256L. These prior authorization requirements and restrictions must be detailed and written in language that is easily understandable to providers.

Sec. 29. Minnesota Statutes 2022, section 62M.10, subdivision 8, is amended to read:

Subd. 8. **Notice; new prior authorization requirements or restrictions; change to existing requirement or restriction.** (a) Before a utilization review organization may implement a new prior authorization requirement or restriction or amend an existing prior authorization requirement or restriction, the utilization review organization must submit the new or amended requirement or restriction to all health plan companies for which the organization performs utilization review. A health plan company must post on its website the new or amended requirement or restriction. This paragraph does not apply to the commissioner of human services when delivering services through fee-for-service under chapters 256B and 256L.

(b) At least 45 days before a new prior authorization requirement or restriction or an amended existing prior authorization requirement or restriction is implemented, the utilization review organization, health plan company, or claims administrator must provide written or electronic notice of the new or amended requirement or restriction to all Minnesota-based, in-network attending health care professionals who are subject to the prior authorization requirements and restrictions. This paragraph does not apply to the commissioner of human services when delivering services through fee-for-service under chapters 256B and 256L.

(c) Effective January 1, 2026, before the commissioner of human services may implement a new prior authorization requirement or restriction or amend an existing prior authorization requirement or restriction, the commissioner, at least 45 days before the new or amended requirement or restriction takes effect, must provide written or electronic notice of the new or amended requirement or restriction, to all health care professionals participating as fee-for-service providers under chapters 256B and 256L who are subject to the prior authorization requirements and restrictions.

Sec. 30. Minnesota Statutes 2022, section 62M.17, subdivision 2, is amended to read:

Subd. 2. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan year, a utilization review organization changes coverage terms for a health care service or the clinical criteria used to conduct prior authorizations for a health care service, the change in coverage terms or change in clinical criteria shall not apply until the next plan year for

any enrollee who received prior authorization for a health care service using the coverage terms or clinical criteria in effect before the effective date of the change.

(b) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a drug or device that has been deemed unsafe by the United States Food and Drug Administration (FDA); that has been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug- or device-specific warnings or recommended changes in drug or device usage.

(c) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to patient harm. This paragraph expires December 31, 2025, for health benefit plans offered, sold, issued, or renewed on or after that date.

(d) Effective January 1, 2026, and applicable to health benefit plans offered, sold, issued, or renewed on or after that date, paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to previously unknown and imminent patient harm.

~~(d)~~ (e) Paragraph (a) does not apply if a utilization review organization removes a brand name drug from its formulary or places a brand name drug in a benefit category that increases the enrollee's cost, provided the utilization review organization (1) adds to its formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

Sec. 31. **[62M.19] ANNUAL REPORT TO COMMISSIONER OF HEALTH; PRIOR AUTHORIZATIONS.**

On or before September 1 each year, each utilization review organization must report to the commissioner of health, in a form and manner specified by the commissioner, information on prior authorization requests for the previous calendar year. The report submitted under this subdivision must include the following data:

(1) the total number of prior authorization requests received;

(2) the number of prior authorization requests for which an authorization was issued;

(3) the number of prior authorization requests for which an adverse determination was issued;

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(4) the number of adverse determinations reversed on appeal;

(5) the 25 codes with the highest number of prior authorization requests and the percentage of authorizations for each of these codes;

(6) the 25 codes with the highest percentage of prior authorization requests for which an authorization was issued and the total number of the requests;

(7) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued but which was reversed on appeal and the total number of the requests;

(8) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued and the total number of the requests; and

(9) the reasons an adverse determination to a prior authorization request was issued, expressed as a percentage of all adverse determinations. The reasons listed may include but are not limited to:

(i) the patient did not meet prior authorization criteria;

(ii) incomplete information was submitted by the provider to the utilization review organization;

(iii) the treatment program changed; and

(iv) the patient is no longer covered by the health benefit plan.

Sec. 16. Minnesota Statutes 2022, section 62Q.097, is amended by adding a subdivision to read:

Subd. 3. **Prohibited application questions.** An application for provider credentialing must not:

(1) require the provider to disclose past health conditions;

(2) require the provider to disclose current health conditions, if the provider is being treated so that the condition does not affect the provider's ability to practice medicine; or

(3) require the disclosure of any health conditions that would not affect the provider's ability to practice medicine in a competent, safe, and ethical manner.

EFFECTIVE DATE. This section applies to applications for provider credentialing submitted to a health plan company on or after January 1, 2025.

Sec. 17. Minnesota Statutes 2022, section 62Q.14, is amended to read:

Sec. 32. Minnesota Statutes 2022, section 62Q.14, is amended to read:

62Q.14 RESTRICTIONS ON ENROLLEE SERVICES.

62Q.14 RESTRICTIONS ON ENROLLEE SERVICES.

No health plan company may restrict the choice of an enrollee as to where the enrollee receives services related to:

No health plan company may restrict the choice of an enrollee as to where the enrollee receives services related to:

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(1) the voluntary planning of the conception and bearing of children~~, provided that this clause does not refer to abortion services~~;

(2) the diagnosis of infertility;

(3) the testing and treatment of a sexually transmitted disease; and

(4) the testing for AIDS or other HIV-related conditions.

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

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(1) the voluntary planning of the conception and bearing of children~~, provided that this clause does not refer to abortion services~~;

(2) the diagnosis of infertility;

(3) the testing and treatment of a sexually transmitted disease; and

(4) the testing for AIDS or other HIV-related conditions.

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

Sec. 33. Minnesota Statutes 2022, section 62Q.19, subdivision 3, is amended to read:

Subd. 3. **Health plan company affiliation.** A health plan company must offer a provider contract to ~~any~~ all designated essential community ~~provider~~ providers located within the area served by the health plan company. A health plan company must include all essential community providers that have accepted a contract in each of the company's provider networks. A health plan company shall not restrict enrollee access to services designated to be provided by the essential community provider for the population that the essential community provider is certified to serve. A health plan company may also make other providers available for these services. A health plan company may require an essential community provider to meet all data requirements, utilization review, and quality assurance requirements on the same basis as other health plan providers.

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

Sec. 34. Minnesota Statutes 2022, section 62Q.19, is amended by adding a subdivision to read:

Subd. 4a. **Contract payment rates; private.** An essential community provider and a health plan company may negotiate the payment rate for covered services provided by the essential community provider. This rate must be at least the same rate per unit of service as is paid by the health plan company to the essential community provider under the provider contract between the two with the highest number of enrollees receiving health care services from the provider or, if there is no provider contract between the health plan company and the essential community provider, the rate must be at least the same rate per unit of service as is paid to other plan providers for the same or similar services. The provider contract used to set the rate under this subdivision must be in relation to an individual, small group, or large group health plan. This subdivision applies only to provider contracts in relation to individual, small employer, and large group health plans.

Sec. 35. Minnesota Statutes 2022, section 62Q.19, subdivision 5, is amended to read:

Subd. 5. **Contract payment rates; public.** An essential community provider and a health plan company may negotiate the payment rate for covered services provided by the essential community provider. This rate must be at least the same rate per unit of service

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Sec. 18. Minnesota Statutes 2023 Supplement, section 62Q.473, is amended by adding a subdivision to read:

Subd. 3. **Reimbursement.** (a) The commissioner of commerce must reimburse health plans for coverage under this section. This subdivision does not apply to coverage provided by health plans to public health care program enrollees under chapters 256B and 256L. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments and services covered by the health plan as of January 1, 2023, are ineligible for payment under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2023, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plans as provided in Code of Federal Regulations, title 45, section 155.170.

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

Sec. 19. Minnesota Statutes 2023 Supplement, section 62Q.473, is amended by adding a subdivision to read:

Subd. 4. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plans to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

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

Sec. 20. Minnesota Statutes 2023 Supplement, section 62Q.522, subdivision 1, is amended to read:

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

~~(b) "Closely held for-profit entity" means an entity that:~~

~~(1) is not a nonprofit entity;~~

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as is paid to other health plan providers for the same or similar services. This subdivision applies only to provider contracts in relation to health plans offered through the State Employee Group Insurance Program, medical assistance, and MinnesotaCare.

Sec. 36. Minnesota Statutes 2023 Supplement, section 62Q.473, is amended by adding a subdivision to read:

Subd. 3. **Reimbursement.** The commissioner of commerce must reimburse health plan companies for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan company without the requirements of this section. Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce. Health plan companies must report to the commissioner quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. The commissioner must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

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

Sec. 37. Minnesota Statutes 2023 Supplement, section 62Q.522, subdivision 1, is amended to read:

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

~~(b) "Closely held for-profit entity" means an entity that:~~

~~(1) is not a nonprofit entity;~~

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~~(2) has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer owners; and~~

~~(3) has no publicly traded ownership interest.~~

~~For purposes of this paragraph:~~

~~(i) ownership interests owned by a corporation, partnership, limited liability company, estate, trust, or similar entity are considered owned by that entity's shareholders, partners, members, or beneficiaries in proportion to their interest held in the corporation, partnership, limited liability company, estate, trust, or similar entity;~~

~~(ii) ownership interests owned by a nonprofit entity are considered owned by a single owner;~~

~~(iii) ownership interests owned by all individuals in a family are considered held by a single owner. For purposes of this item, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and~~

~~(iv) if an individual or entity holds an option, warrant, or similar right to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.~~

~~(c)~~ (b) "Contraceptive method" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

~~(d)~~ (c) "Contraceptive service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy, excluding vasectomies. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptive methods or services, management of side effects, counseling for continued adherence, and device insertion or removal.

~~(e) "Eligible organization" means an organization that opposes providing coverage for some or all contraceptive methods or services on account of religious objections and that is:~~

~~(1) organized as a nonprofit entity and holds itself out to be religious; or~~

~~(2) organized and operates as a closely held for-profit entity, and the organization's owners or highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that the organization objects to covering some or all contraceptive methods or services on account of the owners' sincerely held religious beliefs.~~

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~~(2) has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer owners; and~~

~~(3) has no publicly traded ownership interest.~~

~~For purposes of this paragraph:~~

~~(i) ownership interests owned by a corporation, partnership, limited liability company, estate, trust, or similar entity are considered owned by that entity's shareholders, partners, members, or beneficiaries in proportion to their interest held in the corporation, partnership, limited liability company, estate, trust, or similar entity;~~

~~(ii) ownership interests owned by a nonprofit entity are considered owned by a single owner;~~

~~(iii) ownership interests owned by all individuals in a family are considered held by a single owner. For purposes of this item, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and~~

~~(iv) if an individual or entity holds an option, warrant, or similar right to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.~~

~~(c)~~ (b) "Contraceptive method" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

~~(d)~~ (c) "Contraceptive service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy, excluding vasectomies. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptive methods or services, management of side effects, counseling for continued adherence, and device insertion or removal.

~~(e) "Eligible organization" means an organization that opposes providing coverage for some or all contraceptive methods or services on account of religious objections and that is:~~

~~(1) organized as a nonprofit entity and holds itself out to be religious; or~~

~~(2) organized and operates as a closely held for-profit entity, and the organization's owners or highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that the organization objects to covering some or all contraceptive methods or services on account of the owners' sincerely held religious beliefs.~~

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~~(f) "Exempt organization" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.~~

~~(g)~~ (d) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive method or service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

~~(h)~~ (e) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent: (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration; and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

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

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~~(f) "Exempt organization" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.~~

~~(g)~~ (d) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive method or service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

~~(h)~~ (e) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent: (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration; and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

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

Sec. 38. Minnesota Statutes 2023 Supplement, section 62Q.523, subdivision 1, is amended to read:

Subdivision 1. **Scope of coverage.** Except as otherwise provided in section ~~62Q.522~~ 62Q.679, subdivisions 2 and 3 ~~and 4~~, all health plans that provide prescription coverage must comply with the requirements of this section.

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

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Sec. 21. **[62Q.524] COVERAGE OF ABORTIONS AND ABORTION-RELATED SERVICES.**

Subdivision 1. **Definition.** For purposes of this section, "abortion" means any medical treatment intended to induce the termination of a pregnancy with a purpose other than producing a live birth.

Subd. 2. **Required coverage.** (a) A health plan must provide coverage for abortions and abortion-related services, including preabortion services and follow-up services.

(b) A health plan must not impose on the coverage under this section any co-payment, coinsurance, deductible, or other enrollee cost-sharing that is greater than the cost-sharing that applies to similar services covered under the health plan.

(c) A health plan must not impose any limitation on the coverage under this section, including but not limited to any utilization review, prior authorization, referral requirements, restrictions, or delays, that is not generally applicable to other coverages under the plan.

Subd. 3. **Exclusion.** This section does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

Subd. 4. **Reimbursement.** (a) The commissioner of commerce must reimburse health plans for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments and services covered by the health plan as of January 1, 2024, are ineligible for payment under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2024, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plans as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plans to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

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

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Sec. 39. **[62Q.524] COVERAGE OF ABORTIONS AND ABORTION-RELATED SERVICES.**

Subdivision 1. **Definition.** For purposes of this section, "abortion" means any medical treatment intended to induce the termination of a pregnancy with a purpose other than producing a live birth.

Subd. 2. **Required coverage; cost-sharing.** (a) A health plan must provide coverage for abortions and abortion-related services, including preabortion services and follow-up services.

(b) A health plan must not impose on the coverage under this section any co-payment, coinsurance, deductible, or other enrollee cost-sharing that is greater than the cost-sharing that applies to similar services covered under the health plan.

(c) A health plan must not impose any limitation on the coverage under this section, including but not limited to any utilization review, prior authorization, referral requirements, restrictions, or delays, that is not generally applicable to other coverages under the plan.

Subd. 3. **Exclusion.** This section does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

Subd. 4. **Reimbursement.** The commissioner of commerce must reimburse health plan companies for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan company without the requirements of this section. Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce. Health plan companies must report to the commissioner quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. The commissioner must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

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

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Sec. 22. **[62Q.585] GENDER-AFFIRMING CARE COVERAGE; MEDICALLY NECESSARY CARE.**

Subdivision 1. **Requirement.** No health plan that covers physical or mental health services may be offered, sold, issued, or renewed in this state that:

(1) excludes coverage for medically necessary gender-affirming care; or

(2) requires gender-affirming treatments to satisfy a definition of "medically necessary care," "medical necessity," or any similar term that is more restrictive than the definition provided in subdivision 2.

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

(b) "Gender-affirming care" means all medical, surgical, counseling, or referral services, including telehealth services, that an individual may receive to support and affirm the

Sec. 40. **[62Q.531] AMINO ACID-BASED FORMULA COVERAGE.**

Subdivision 1. **Definition.** (a) For purposes of this section, the following term has the meaning given.

(b) "Formula" means an amino acid-based elemental formula.

Subd. 2. **Required coverage.** A health plan company must provide coverage for formula when formula is medically necessary.

Subd. 3. **Covered conditions.** Conditions for which formula is medically necessary include but are not limited to:

(1) cystic fibrosis;

(2) amino acid, organic acid, and fatty acid metabolic and malabsorption disorders;

(3) IgE mediated allergies to food proteins;

(4) food protein-induced enterocolitis syndrome;

(5) eosinophilic esophagitis;

(6) eosinophilic gastroenteritis;

(7) eosinophilic colitis; and

(8) mast cell activation syndrome.

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

Sec. 41. **[62Q.585] GENDER-AFFIRMING CARE COVERAGE; MEDICALLY NECESSARY CARE.**

Subdivision 1. **Requirement.** No health plan that covers physical or mental health services may be offered, sold, issued, or renewed in this state that:

(1) excludes coverage for medically necessary gender-affirming care; or

(2) requires gender-affirming treatments to satisfy a definition of "medically necessary care," "medical necessity," or any similar term that is more restrictive than the definition provided in subdivision 2.

Subd. 3. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Gender-affirming care" means all medical, surgical, counseling, or referral services, including telehealth services, that an individual may receive to support and affirm the

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individual's gender identity or gender expression and that are legal under the laws of this state.

(c) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages listed in section 62A.011, subdivision 3, clauses (7) and (10).

(d) "Medically necessary care" means health care services appropriate in terms of type, frequency, level, setting, and duration to the enrollee's diagnosis or condition and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the enrollee's health; or

(2) prevent deterioration of the enrollee's condition.

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

Sec. 23. **[62Q.665] COVERAGE FOR ORTHOTIC AND PROSTHETIC DEVICES.**

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

(b) "Accredited facility" means any entity that is accredited to provide comprehensive orthotic or prosthetic devices or services by a Centers for Medicare and Medicaid Services approved accrediting agency.

(c) "Orthosis" means:

(1) an external medical device that is:

(i) custom-fabricated or custom-fitted to a specific patient based on the patient's unique physical condition;

(ii) applied to a part of the body to correct a deformity, provide support and protection, restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or postoperative condition; and

(iii) deemed medically necessary by a prescribing physician or licensed health care provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services; and

(2) any provision, repair, or replacement of a device that is furnished or performed by:

(i) an accredited facility in comprehensive orthotic services; or

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individual's gender identity or gender expression and that are legal under the laws of this state.

(c) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages listed in section 62A.011, subdivision 3, clauses (7) and (10).

Subd. 2. **Minimum definition.** "Medically necessary care" means health care services appropriate in terms of type, frequency, level, setting, and duration to the enrollee's diagnosis or condition and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the enrollee's health; or

(2) prevent deterioration of the enrollee's condition.

Sec. 42. **[62Q.665] COVERAGE FOR ORTHOTIC AND PROSTHETIC DEVICES.**

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

(b) "Accredited facility" means any entity that is accredited to provide comprehensive orthotic or prosthetic devices or services by a Centers for Medicare and Medicaid Services approved accrediting agency.

(c) "Orthosis" means:

(1) an external medical device that is:

(i) custom-fabricated or custom-fitted to a specific patient based on the patient's unique physical condition;

(ii) applied to a part of the body to correct a deformity, provide support and protection, restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or postoperative condition; and

(iii) deemed medically necessary by a prescribing physician or licensed health care provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services; and

(2) any provision, repair, or replacement of a device that is furnished or performed by:

(i) an accredited facility in comprehensive orthotic services; or

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(ii) a health care provider licensed in Minnesota and operating within the provider's scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies, or services.

(d) "Orthotics" means:

(1) the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing and providing the initial training necessary to accomplish the fitting of an orthotic device for the support, correction, or alleviation of a neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity;

(2) evaluation, treatment, and consultation related to an orthotic device;

(3) basic observation of gait and postural analysis;

(4) assessing and designing orthosis to maximize function and provide support and alignment necessary to prevent or correct a deformity or to improve the safety and efficiency of mobility and locomotion;

(5) continuing patient care to assess the effect of an orthotic device on the patient's tissues; and

(6) proper fit and function of the orthotic device by periodic evaluation.

(e) "Prosthesis" means:

(1) an external medical device that is:

(i) used to replace or restore a missing limb, appendage, or other external human body part; and

(ii) deemed medically necessary by a prescribing physician or licensed health care provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services; and

(2) any provision, repair, or replacement of a device that is furnished or performed by:

(i) an accredited facility in comprehensive prosthetic services; or

(ii) a health care provider licensed in Minnesota and operating within the provider's scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies, or services.

(f) "Prosthetics" means:

(1) the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities or absences;

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(ii) a health care provider licensed in Minnesota and operating within the provider's scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies, or services.

(d) "Orthotics" means:

(1) the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing and providing the initial training necessary to accomplish the fitting of an orthotic device for the support, correction, or alleviation of a neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity;

(2) evaluation, treatment, and consultation related to an orthotic device;

(3) basic observation of gait and postural analysis;

(4) assessing and designing orthosis to maximize function and provide support and alignment necessary to prevent or correct a deformity or to improve the safety and efficiency of mobility and locomotion;

(5) continuing patient care to assess the effect of an orthotic device on the patient's tissues; and

(6) proper fit and function of the orthotic device by periodic evaluation.

(e) "Prosthesis" means:

(1) an external medical device that is:

(i) used to replace or restore a missing limb, appendage, or other external human body part; and

(ii) deemed medically necessary by a prescribing physician or licensed health care provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services; and

(2) any provision, repair, or replacement of a device that is furnished or performed by:

(i) an accredited facility in comprehensive prosthetic services; or

(ii) a health care provider licensed in Minnesota and operating within the provider's scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies, or services.

(f) "Prosthetics" means:

(1) the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities or absences;

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(2) the generation of an image, form, or mold that replicates the patient's body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial appendage that is designed either to support body weight or to improve or restore function or anatomical appearance, or both;

(3) observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the prosthesis to maximize function, stability, and safety of the patient;

(4) providing and continuing patient care in order to assess the prosthetic device's effect on the patient's tissues; and

(5) assuring proper fit and function of the prosthetic device by periodic evaluation.

Subd. 2. **Coverage.** (a) A health plan must provide coverage for orthotic and prosthetic devices, supplies, and services, including repair and replacement, at least equal to the coverage provided under federal law for health insurance for the aged and disabled under sections 1832, 1833, and 1834 of the Social Security Act, United States Code, title 42, sections 1395k, 1395l, and 1395m, but only to the extent consistent with this section.

(b) A health plan must not subject orthotic and prosthetic benefits to separate financial requirements that apply only with respect to those benefits. A health plan may impose co-payment and coinsurance amounts on those benefits, except that any financial requirements that apply to such benefits must not be more restrictive than the financial requirements that apply to the health plan's medical and surgical benefits, including those for internal restorative devices.

(c) A health plan may limit the benefits for, or alter the financial requirements for, out-of-network coverage of prosthetic and orthotic devices, except that the restrictions and requirements that apply to those benefits must not be more restrictive than the financial requirements that apply to the out-of-network coverage for the health plan's medical and surgical benefits.

(d) A health plan must cover orthoses and prostheses when furnished under an order by a prescribing physician or licensed health care prescriber who has authority in Minnesota to prescribe orthoses and prostheses, and that coverage for orthotic and prosthetic devices, supplies, accessories, and services must include those devices or device systems, supplies, accessories, and services that are customized to the covered individual's needs.

(e) A health plan must cover orthoses and prostheses determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for purposes of performing physical activities, as applicable, including but not limited to running, biking, and swimming, and maximizing the enrollee's limb function.

(f) A health plan must cover orthoses and prostheses for showering or bathing.

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(2) the generation of an image, form, or mold that replicates the patient's body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial appendage that is designed either to support body weight or to improve or restore function or anatomical appearance, or both;

(3) observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the prosthesis to maximize function, stability, and safety of the patient;

(4) providing and continuing patient care in order to assess the prosthetic device's effect on the patient's tissues; and

(5) assuring proper fit and function of the prosthetic device by periodic evaluation.

Subd. 2. **Coverage.** (a) A health plan must provide coverage for orthotic and prosthetic devices, supplies, and services, including repair and replacement, at least equal to the coverage provided under federal law for health insurance for the aged and disabled under sections 1832, 1833, and 1834 of the Social Security Act, United States Code, title 42, sections 1395k, 1395l, and 1395m, but only to the extent consistent with this section.

(b) A health plan must not subject orthotic and prosthetic benefits to separate financial requirements that apply only with respect to those benefits. A health plan may impose co-payment and coinsurance amounts on those benefits, except that any financial requirements that apply to such benefits must not be more restrictive than the financial requirements that apply to the health plan's medical and surgical benefits, including those for internal restorative devices.

(c) A health plan may limit the benefits for, or alter the financial requirements for, out-of-network coverage of prosthetic and orthotic devices, except that the restrictions and requirements that apply to those benefits must not be more restrictive than the financial requirements that apply to the out-of-network coverage for the health plan's medical and surgical benefits.

(d) A health plan must cover orthoses and prostheses when furnished under an order by a prescribing physician or licensed health care prescriber who has authority in Minnesota to prescribe orthoses and prostheses, and that coverage for orthotic and prosthetic devices, supplies, accessories, and services must include those devices or device systems, supplies, accessories, and services that are customized to the covered individual's needs.

(e) A health plan must cover orthoses and prostheses determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for purposes of performing physical activities, as applicable, including but not limited to running, biking, and swimming, and maximizing the enrollee's limb function.

(f) A health plan must cover orthoses and prostheses for showering or bathing.

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Subd. 3. **Prior authorization.** A health plan may require prior authorization for orthotic and prosthetic devices, supplies, and services in the same manner and to the same extent as prior authorization is required for any other covered benefit.

Subd. 4. **Reimbursement.** (a) The commissioner of commerce must reimburse health plans for coverage under this section. This subdivision does not apply to coverage provided by health plans to public health care program enrollees under chapters 256B and 256L. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments and services covered by the health plan as of January 1, 2024, are ineligible for payment under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2024, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plans as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plans to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

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

Sec. 24. **[62Q.6651] MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR COVERAGE OF PROSTHETICS OR ORTHOTICS.**

(a) When performing a utilization review for a request for coverage of prosthetic or orthotic benefits, a health plan company shall apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists.

(b) A health plan company shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely on the basis of an enrollee's actual or perceived disability.

(c) A health plan company shall not deny a prosthetic or orthotic benefit for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

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Subd. 3. **Prior authorization.** A health plan may require prior authorization for orthotic and prosthetic devices, supplies, and services in the same manner and to the same extent as prior authorization is required for any other covered benefit.

Subd. 4. **Reimbursement.** The commissioner of commerce must reimburse health plan companies for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan company without the requirements of this section. Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce. Health plan companies must report to the commissioner quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. The commissioner must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

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

Sec. 43. **[62Q.666] MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR COVERAGE OF PROSTHETICS OR ORTHOTICS.**

(a) When performing a utilization review for a request for coverage of prosthetic or orthotic benefits, a health plan company shall apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists.

(b) A health plan company shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely on the basis of an enrollee's actual or perceived disability.

(c) A health plan company shall not deny a prosthetic or orthotic benefit for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

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(d) A health plan offered, issued, or renewed in Minnesota that offers coverage for prosthetics and custom orthotic devices shall include language describing an enrollee's rights pursuant to paragraphs (b) and (c) in its evidence of coverage and any benefit denial letters.

(e) A health plan that provides coverage for prosthetic or orthotic services shall ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two distinct prosthetic and custom orthotic providers in the plan's provider network located in Minnesota. In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider, the health plan company shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

(f) If coverage for prosthetic or custom orthotic devices is provided, payment shall be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of the devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of a device, is necessary because:

(1) of a change in the physiological condition of the patient;

(2) of an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

(g) Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

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

Sec. 25. **[62Q.666] INTERMITTENT CATHETERS.**

Subdivision 1. **Required coverage.** A health plan must provide coverage for intermittent urinary catheters and insertion supplies if intermittent catheterization is recommended by the enrollee's health care provider. At least 180 intermittent catheters per month with insertion supplies must be covered unless a lesser amount is prescribed by the enrollee's health care provider. A health plan providing coverage under the medical assistance program may be required to provide coverage for more than 180 intermittent catheters per month with insertion supplies.

Subd. 2. **Cost-sharing requirements.** A health plan is prohibited from imposing a deductible, co-payment, coinsurance, or other restriction on intermittent catheters and insertion supplies that the health plan does not apply to durable medical equipment in general.

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(d) A health plan offered, issued, or renewed in Minnesota that offers coverage for prosthetics and custom orthotic devices shall include language describing an enrollee's rights pursuant to paragraphs (b) and (c) in its evidence of coverage and any benefit denial letters.

(e) A health plan that provides coverage for prosthetic or orthotic services shall ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two distinct prosthetic and custom orthotic providers in the plan's provider network located in Minnesota. In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider, the health plan company shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

(f) If coverage for prosthetic or custom orthotic devices is provided, payment shall be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of the devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of a device, is necessary because:

(1) of a change in the physiological condition of the patient;

(2) of an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

(g) Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

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

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EFFECTIVE DATE. This section is effective for any health plan issued or renewed on or after January 1, 2025.

Sec. 26. **[62Q.679] RELIGIONS OBJECTIONS.**

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

(b) "Closely held for-profit entity" means an entity that is not a nonprofit entity, has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer owners, and has no publicly traded ownership interest. For purposes of this paragraph:

(1) ownership interests owned by a corporation, partnership, limited liability company, estate, trust, or similar entity are considered owned by that entity's shareholders, partners, members, or beneficiaries in proportion to their interest held in the corporation, partnership, limited liability company, estate, trust, or similar entity;

(2) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(3) ownership interests owned by all individuals in a family are considered held by a single owner. For purposes of this item, "family" means brothers and sisters including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(4) if an individual or entity holds an option, warrant, or similar right to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Eligible organization" means an organization that opposes providing coverage under section 62Q.522, 62Q.524, or 62Q.585 on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself out to be religious; or

(2) organized and operates as a closely held for-profit entity, and the organization's owners or highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that the organization objects to covering some or all health benefits under section 62Q.522, 62Q.524, or 62Q.585 on account of the owners' sincerely held religious beliefs.

(d) "Exempt organization" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

Subd. 2. **Exemption.** (a) An exempt organization is not required to provide coverage under section 62Q.522, 62Q.524, or 62Q.585 if the exempt organization has religious objections to the coverage. An exempt organization that chooses to not provide coverage

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Sec. 44. **[62Q.679] RELIGIOUS OBJECTIONS.**

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

(b) "Closely held for-profit entity" means an entity that is not a nonprofit entity, has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer owners, and has no publicly traded ownership interest. For purposes of this paragraph:

(1) ownership interests owned by a corporation, partnership, limited liability company, estate, trust, or similar entity are considered owned by that entity's shareholders, partners, members, or beneficiaries in proportion to their interest held in the corporation, partnership, limited liability company, estate, trust, or similar entity;

(2) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(3) ownership interests owned by all individuals in a family are considered held by a single owner. For purposes of this clause, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(4) if an individual or entity holds an option, warrant, or similar right to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Eligible organization" means an organization that opposes covering some or all health benefits under section 62Q.522, 62Q.524, or 62Q.585 on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself out to be religious; or

(2) organized and operates as a closely held for-profit entity, and the organization's owners or highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that the organization objects to covering some or all health benefits under section 62Q.522, 62Q.524, or 62Q.585 on account of the owners' sincerely held religious beliefs.

(d) "Exempt organization" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

Subd. 2. **Exemption.** (a) An exempt organization is not required to provide coverage under section 62Q.522, 62Q.524, or 62Q.585 if the exempt organization has religious objections to the coverage. An exempt organization that chooses to not provide coverage

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pursuant to this paragraph must notify employees as part of the hiring process and to all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(b) If the exempt organization provides partial coverage under section 62Q.522, 62Q.524, or 62Q.585, the notice required under paragraph (a) must provide a list of the portions of the coverage that the organization refuses to cover.

Subd. 3. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the coverage requirements of sections 62Q.522, 62Q.524, and 62Q.585, with respect to the health benefits identified in the notice under this paragraph, if the eligible organization provides notice to any health plan company the eligible organization contracts with that it is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of the health benefits under sections 62Q.522, 62Q.524, and 62Q.585.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include: (1) the name of the eligible organization; (2) a statement that the eligible organization objects to coverage for some or all of the health benefits under sections 62Q.522, 62Q.524, and 62Q.585, including a list of the health benefits the eligible organization objects to, if applicable; and (3) the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (a) to prospective employees as part of the hiring process and to all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must, for all future enrollments in the health plan:

(1) expressly exclude coverage for those health benefits identified in the notice under paragraph (a) from the health plan; and

(2) provide separate payments for any health benefits required to be covered under sections 62Q.522, 62Q.524, and 62Q.585 for an enrollee as long as the enrollee remains enrolled in the health plan.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or other charge for the health benefits under section 62Q.522 on the enrollee. The health plan

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pursuant to this paragraph must notify employees as part of the hiring process and must notify all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(b) If the exempt organization provides partial coverage under section 62Q.522, 62Q.524, or 62Q.585, the notice required under paragraph (a) must provide a list of the portions of such coverage which the organization refuses to cover.

Subd. 3. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the coverage requirements of section 62Q.522, 62Q.524, or 62Q.585, with respect to the health benefits identified in the notice under this paragraph, if the eligible organization provides notice to any health plan company with which the eligible organization contracts that it is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of the health benefits under section 62Q.522, 62Q.524, or 62Q.585.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to coverage for some or all of the health benefits under section 62Q.522, 62Q.524, or 62Q.585, including a list of the health benefits to which the eligible organization objects, if applicable; and (3) the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (a) to prospective employees as part of the hiring process and to all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must, for all future enrollments in the health plan:

(1) expressly exclude coverage for those health benefits identified in the notice under paragraph (a) from the health plan; and

(2) provide separate payments for any health benefits required to be covered under section 62Q.522, 62Q.524, or 62Q.585 for enrollees as long as the enrollee remains enrolled in the health plan.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or other charge for the health benefits under section 62Q.522 on the enrollee. The health plan

company must not directly or indirectly impose any premium, fee, or other charge for the health benefits under section 62Q.522, 62Q.524, or 62Q.585 on the eligible organization or health plan.

(f) On January 1, 2025, and every year thereafter a health plan company must notify the commissioner, in a manner determined by the commissioner, of the number of eligible organizations granted an accommodation under this subdivision.

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

company must not directly or indirectly impose any premium, fee, or other charge for the health benefits under section 62Q.522, 62Q.524, or 62Q.585 on the eligible organization or health plan.

(f) On January 1, 2024, and every year thereafter a health plan company must notify the commissioner, in a manner determined by the commissioner, of the number of eligible organizations granted an accommodation under this subdivision.

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

Sec. 45. Minnesota Statutes 2022, section 62Q.73, subdivision 2, is amended to read:

Subd. 2. **Exception.** (a) This section does not apply to governmental programs except as permitted under paragraph (b). For purposes of this subdivision, "governmental programs" means the prepaid medical assistance program~~,~~; effective January 1, 2026, the medical assistance fee-for-service program; the MinnesotaCare program~~,~~; the demonstration project for people with disabilities~~,~~; and the federal Medicare program.

(b) In the course of a recipient's appeal of a medical determination to the commissioner of human services under section 256.045, the recipient may request an expert medical opinion be arranged by the external review entity under contract to provide independent external reviews under this section. If such a request is made, the cost of the review shall be paid by the commissioner of human services. Any medical opinion obtained under this paragraph shall only be used by a state human services judge as evidence in the recipient's appeal to the commissioner of human services under section 256.045.

(c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights provided in section 256.045 for governmental program recipients.

HOUSE ARTICLE 4, SECTIONS 46 TO 48, HAVE BEEN MOVED TO MATCH SENATE ARTICLE 3, SECTIONS 5 TO 7.

Sec. 49. Minnesota Statutes 2023 Supplement, section 145D.01, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this ~~chapter~~ section and section 145D.02, the following terms have the meanings given.

(b) "Captive professional entity" means a professional corporation, limited liability company, or other entity formed to render professional services in which a beneficial owner is a health care provider employed by, controlled by, or subject to the direction of a hospital or hospital system.

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

(d) "Control," including the terms "controlling," "controlled by," and "under common control with," means the possession, direct or indirect, of the power to direct or cause the

direction of the management and policies of a health care entity, whether through the ownership of voting securities, membership in an entity formed under chapter 317A, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with, corporate office held by, or court appointment of, the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 40 percent or more of the voting securities of any other person, or if any person, directly or indirectly, constitutes 40 percent or more of the membership of an entity formed under chapter 317A. The attorney general may determine that control exists in fact, notwithstanding the absence of a presumption to that effect.

(e) "Health care entity" means:

(1) a hospital;

(2) a hospital system;

(3) a captive professional entity;

(4) a medical foundation;

(5) a health care provider group practice;

(6) an entity organized or controlled by an entity listed in clauses (1) to (5); or

(7) an entity that owns or exercises control over an entity listed in clauses (1) to (5).

(f) "Health care provider" means a physician licensed under chapter 147, a physician assistant licensed under chapter 147A, or an advanced practice registered nurse as defined in section 148.171, subdivision 3, who provides health care services, including but not limited to medical care, consultation, diagnosis, or treatment.

(g) "Health care provider group practice" means two or more health care providers legally organized in a partnership, professional corporation, limited liability company, medical foundation, nonprofit corporation, faculty practice plan, or other similar entity:

(1) in which each health care provider who is a member of the group provides services that a health care provider routinely provides, including but not limited to medical care, consultation, diagnosis, and treatment, through the joint use of shared office space, facilities, equipment, or personnel;

(2) for which substantially all services of the health care providers who are group members are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or

(3) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group.

An entity that otherwise meets the definition of health care provider group practice in this paragraph shall be considered a health care provider group practice even if its shareholders, partners, members, or owners include a professional corporation, limited liability company, or other entity in which any beneficial owner is a health care provider and that is formed to render professional services.

(h) "Hospital" means a health care facility licensed as a hospital under sections 144.50 to 144.56.

(i) "Medical foundation" means a nonprofit legal entity through which health care providers perform research or provide medical services.

(j) "Transaction" means a single action, or a series of actions within a five-year period, which occurs in part within the state of Minnesota or involves a health care entity formed or licensed in Minnesota, that constitutes:

(1) a merger or exchange of a health care entity with another entity;

(2) the sale, lease, or transfer of 40 percent or more of the assets of a health care entity to another entity;

(3) the granting of a security interest of 40 percent or more of the property and assets of a health care entity to another entity;

(4) the transfer of 40 percent or more of the shares or other ownership of a health care entity to another entity;

(5) an addition, removal, withdrawal, substitution, or other modification of one or more members of the health care entity's governing body that transfers control, responsibility for, or governance of the health care entity to another entity;

(6) the creation of a new health care entity;

(7) an agreement or series of agreements that results in the sharing of 40 percent or more of the health care entity's revenues with another entity, including affiliates of such other entity;

(8) an addition, removal, withdrawal, substitution, or other modification of the members of a health care entity formed under chapter 317A that results in a change of 40 percent or more of the membership of the health care entity; or

(9) any other transfer of control of a health care entity to, or acquisition of control of a health care entity by, another entity.

(k) A transaction as defined in paragraph (j) does not include:

(1) an action or series of actions that meets one or more of the criteria set forth in paragraph (j), clauses (1) to (9), if, immediately prior to all such actions, the health care

entity directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, all other parties to the action or series of actions;

(2) a mortgage or other secured loan for business improvement purposes entered into by a health care entity that does not directly affect delivery of health care or governance of the health care entity;

(3) a clinical affiliation of health care entities formed solely for the purpose of collaborating on clinical trials or providing graduate medical education;

(4) the mere offer of employment to, or hiring of, a health care provider by a health care entity;

(5) contracts between a health care entity and a health care provider primarily for clinical services; or

(6) a single action or series of actions within a five-year period involving only entities that operate solely as a nursing home licensed under chapter 144A; a boarding care home licensed under sections 144.50 to 144.56; a supervised living facility licensed under sections 144.50 to 144.56; an assisted living facility licensed under chapter 144G; a foster care setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, for a physical location that is not the primary residence of the license holder; a community residential setting as defined in section 245D.02, subdivision 4a; or a home care provider licensed under sections 144A.471 to 144A.483.

Sec. 50. **[145D.30] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of sections 145D.30 to 145D.37, the following terms have the meanings given unless the context clearly indicates otherwise.

Subd. 2. **Commissioner** "Commissioner" means the commissioner of commerce for a nonprofit health coverage entity that is a nonprofit health service plan corporation operating under chapter 62C or the commissioner of health for a nonprofit health coverage entity that is a nonprofit health maintenance organization operating under chapter 62D.

Subd. 3. **Control.** "Control," including the terms "controlling," "controlled by," and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a nonprofit health coverage entity, whether through the ownership of voting securities, through membership in an entity formed under chapter 317A, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with, corporate office held by, or court appointment of the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 40 percent or more of the voting securities of any other person or if any person, directly or indirectly, constitutes 40 percent or more of the membership

of an entity formed under chapter 317A. The attorney general may determine that control exists in fact, notwithstanding the absence of a presumption to that effect.

Subd. 4. **Conversion benefit entity.** "Conversion benefit entity" means a foundation, corporation, limited liability company, trust, partnership, or other entity that receives, in connection with a conversion transaction, the value of any public benefit asset in accordance with section 145D.32, subdivision 5.

Subd. 5. **Conversion transaction.** "Conversion transaction" means a transaction otherwise permitted under applicable law in which a nonprofit health coverage entity:

(1) merges, consolidates, converts, or transfers all or substantially all of its assets to any entity except a corporation that is exempt under United States Code, title 26, section 501(c)(3);

(2) makes a series of separate transfers within a 60-month period that in the aggregate constitute a transfer of all or substantially all of the nonprofit health coverage entity's assets to any entity except a corporation that is exempt under United States Code, title 26, section 501(c)(3); or

(3) adds or substitutes one or more directors or officers that effectively transfer the control of, responsibility for, or governance of the nonprofit health coverage entity to any entity except a corporation that is exempt under United States Code, title 26, section 501(c)(3).

Subd. 6. **Corporation.** "Corporation" has the meaning given in section 317A.011, subdivision 6, and also includes a nonprofit limited liability company organized under section 322C.1101.

Subd. 7. **Director.** "Director" has the meaning given in section 317A.011, subdivision 7.

Subd. 8. **Family member.** "Family member" means a spouse, parent, child, spouse of a child, brother, sister, or spouse of a brother or sister.

Subd. 9. **Full and fair value.** "Full and fair value" means at least the amount that the public benefit assets of the nonprofit health coverage entity would be worth if the assets were equal to stock in the nonprofit health coverage entity, if the nonprofit health coverage entity was a for-profit corporation and if the nonprofit health coverage entity had 100 percent of its stock authorized by the corporation and available for purchase without transfer restrictions. The valuation shall consider market value, investment or earning value, net asset value, goodwill, amount of donations received, and control premium, if any.

Subd. 10. **Key employee.** "Key employee" means an individual, regardless of title, who:

(1) has responsibilities, power, or influence over an organization similar to those of an officer or director;

(2) manages a discrete segment or activity of the organization that represents ten percent or more of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole; or

(3) has or shares authority to control or determine ten percent or more of the organization's capital expenditures, operating budget, or compensation for employees.

Subd. 11. **Nonprofit health coverage entity.** "Nonprofit health coverage entity" means a nonprofit health service plan corporation operating under chapter 62C or a nonprofit health maintenance organization operating under chapter 62D.

Subd. 12. **Officer.** "Officer" has the meaning given in section 317A.011, subdivision 15.

Subd. 13. **Public benefit assets.** "Public benefit assets" means the entirety of a nonprofit health coverage entity's assets, whether tangible or intangible, including but not limited to its goodwill and anticipated future revenue.

Subd. 14. **Related organization.** "Related organization" has the meaning given in section 317A.011, subdivision 18.

Sec. 51. **[145D.31] CERTAIN CONVERSION TRANSACTIONS PROHIBITED.**

A nonprofit health coverage entity must not enter into a conversion transaction if:

(1) doing so would result in less than the full and fair market value of all public benefit assets remaining dedicated to the public benefit; or

(2) an individual who has been an officer, director, or other executive of the nonprofit health coverage entity or of a related organization, or a family member of such an individual:

(i) has held or will hold, whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in an entity to which the nonprofit health coverage entity transfers public benefit assets in connection with the conversion transaction;

(ii) has received or will receive any type of compensation or other financial benefit from an entity to which the nonprofit health coverage entity transfers public benefit assets in connection with the conversion transaction;

(iii) has held or will hold, whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in an entity that has or will have a business relationship with an entity to which the nonprofit health coverage entity transfers public benefit assets in connection with the conversion transaction; or

(iv) has received or will receive any type of compensation or other financial benefit from an entity that has or will have a business relationship with an entity to which the nonprofit health coverage entity transfers public benefit assets in connection with the conversion transaction.

Sec. 52. **[145D.32] REQUIREMENTS FOR NONPROFIT HEALTH COVERAGE ENTITY CONVERSION TRANSACTIONS.**

Subdivision 1. **Notice.** (a) Before entering into a conversion transaction, a nonprofit health coverage entity must notify the attorney general according to section 317A.811. In addition to the elements listed in section 317A.811, subdivision 1, the notice required by this subdivision must also include: (1) an itemization of the nonprofit health coverage entity's public benefit assets and an independent third-party valuation of the nonprofit health coverage entity's public benefit assets; (2) a proposed plan to distribute the value of those public benefit assets to a conversion benefit entity that meets the requirements of section 145D.33; and (3) other information contained in forms provided by the attorney general.

(b) When the nonprofit health coverage entity provides the attorney general with the notice and other information required under paragraph (a), the nonprofit health coverage entity must also provide a copy of this notice and other information to the applicable commissioner.

Subd. 2. **Nonprofit health coverage entity requirements.** Before entering into a conversion transaction, a nonprofit health coverage entity must ensure that:

(1) the proposed conversion transaction complies with chapters 317A and 501B and other applicable laws;

(2) the proposed conversion transaction does not involve or constitute a breach of charitable trust;

(3) the nonprofit health coverage entity shall receive full and fair value for its public benefit assets;

(4) the value of the public benefit assets to be transferred has not been manipulated in a manner that causes or caused the value of the assets to decrease;

(5) the proceeds of the proposed conversion transaction shall be used in a manner consistent with the public benefit for which the assets are held by the nonprofit health coverage entity;

(6) the proposed conversion transaction shall not result in a breach of fiduciary duty; and

(7) the conversion benefit entity that receives the value of the nonprofit health coverage entity's public benefit assets meets the requirements in section 145D.33.

Subd. 3. **Listening sessions and public comment.** The attorney general or the commissioner may hold public listening sessions or forums and may solicit public comments regarding the proposed conversion transaction, including on the formation of a conversion benefit entity under section 145D.33.

Subd. 4. **Waiting period.** (a) Subject to paragraphs (b) and (c), a nonprofit health coverage entity must not enter into a conversion transaction until 90 days after the nonprofit health coverage entity has given written notice as required in subdivision 1.

(b) The attorney general may waive all or part of the waiting period or may extend the waiting period for an additional 90 days by notifying the nonprofit health coverage entity of the extension in writing.

(c) The time periods specified in this subdivision shall be suspended while an investigation into the conversion transaction is pending or while a request from the attorney general for additional information is outstanding.

Subd. 5. **Transfer of value of assets required.** As part of a conversion transaction for which notice is provided under subdivision 1, the nonprofit health coverage entity must transfer the entirety of the full and fair value of its public benefit assets to one or more conversion benefit entities that meet the requirements in section 145D.33.

Subd. 6. **Funds restricted for a particular purpose.** Nothing in this section relieves a nonprofit health coverage entity from complying with requirements for funds that are restricted for a particular purpose. Funds restricted for a particular purpose must continue to be used in accordance with the purpose for which they were restricted under sections 317A.671 and 501B.31. A nonprofit health coverage entity may not convert assets that would conflict with their restricted purpose.

Sec. 53. **[145D.33] CONVERSION BENEFIT ENTITY REQUIREMENTS.**

Subdivision 1. **Requirements.** In order to receive the value of a nonprofit health coverage entity's public benefit assets as part of a conversion transaction, a conversion benefit entity must:

(1) be: (i) an existing or new domestic, nonprofit corporation operating under chapter 317A, a nonprofit limited liability company operating under chapter 322C, or a wholly owned subsidiary thereof; and (ii) exempt under United States Code, title 26, section 501(c)(3);

(2) have in place procedures and policies to prohibit conflicts of interest, including but not limited to conflicts of interest relating to any grant-making activities that may benefit:

(i) the officers, directors, or key employees of the conversion benefit entity;

(ii) any entity to which the nonprofit health coverage entity transfers public benefit assets in connection with a conversion transaction; or

(iii) any officers, directors, or key employees of an entity to which the nonprofit health coverage entity transfers public benefit assets in connection with a conversion transaction;

(3) operate to benefit the health of the people in this state;

(4) have in place procedures and policies that prohibit:

(i) an officer, director, or key employee of the nonprofit health coverage entity from serving as an officer, director, or key employee of the conversion benefit entity for the five-year period following the conversion transaction;

(ii) an officer, director, or key employee of the nonprofit health coverage entity or of the conversion benefit entity from directly or indirectly benefiting from the conversion transaction; and

(iii) elected or appointed public officials from serving as an officer, director, or key employee of the conversion benefit entity;

(5) not make grants or payments or otherwise provide financial benefit to an entity to which a nonprofit health coverage entity transfers public benefit assets as part of a conversion transaction or to a related organization of the entity to which the nonprofit health coverage entity transfers public benefit assets as part of a conversion transaction; and

(6) not have as an officer director, or key employee any individual who has been an officer, director, or key employee of an entity that receives public benefit assets as part of a conversion transaction.

Subd. 2. **Review and approval.** The commissioner must review and approve a conversion benefit entity before the conversion benefit entity receives the value of public benefit assets from a nonprofit health coverage entity. In order to be approved under this subdivision, the conversion benefit entity's governance must be broadly based in the community served by the nonprofit health coverage entity and must be independent of the entity to which the nonprofit health coverage entity transfers public benefit assets as part of the conversion transaction. As part of the review of the conversion benefit entity's governance, the commissioner may hold a public hearing. The public hearing, if held by the commissioner of health, may be held concurrently with the hearing authorized under section 62D.31. If the commissioner finds it necessary, a portion of the value of the public benefit assets must be used to develop a community-based plan for use by the conversion benefit entity.

Subd. 3. **Community advisory committee.** The commissioner must establish a community advisory committee for a conversion benefit entity receiving the value of public benefit assets. The members of the community advisory committee must be selected to represent the diversity of the community previously served by the nonprofit health coverage entity. The community advisory committee must:

(1) provide a slate of three nominees for each vacancy on the governing board of the conversion benefit entity, from which the remaining board members must select new members to the board;

(2) provide the conversion benefit entity's governing board with guidance on the health needs of the community previously served by the nonprofit health coverage entity; and

(3) promote dialogue and information sharing between the conversion benefit entity and the community previously served by the nonprofit health coverage entity.

Sec. 54. **[145D.34] ENFORCEMENT AND REMEDIES.**

Subdivision 1. **Investigation.** The attorney general has the powers in section 8.31. Nothing in this subdivision limits the powers, remedies, or responsibilities of the attorney general under this chapter; chapter 8, 309, 317A, or 501B; or any other chapter. For purposes of this section, an approval by the commissioner for regulatory purposes does not impair or inform the attorney general's authority.

Subd. 2. **Enforcement and penalties.** (a) The attorney general may bring an action in district court to enjoin or unwind a conversion transaction or seek other equitable relief necessary to protect the public interest if:

(1) a nonprofit health coverage entity or conversion transaction violates sections 145D.30 to 145D.33; or

(2) the conversion transaction is contrary to the public interest.

In seeking injunctive relief, the attorney general must not be required to establish irreparable harm but must instead establish that a violation of sections 145D.30 to 145D.33 occurred or that the requested order promotes the public interest.

(b) Factors informing whether a conversion transaction is contrary to the public interest include but are not limited to whether:

(1) the conversion transaction shall result in increased health care costs for patients; and

(2) the conversion transaction shall adversely impact provider cost trends and containment of total health care spending.

(c) The attorney general may enforce sections 145D.30 to 145D.33 under section 8.31.

(d) Failure of the entities involved in a conversion transaction to provide timely information as required by the attorney general or the commissioner shall be an independent and sufficient ground for a court to enjoin or unwind the transaction or provide other equitable relief, provided the attorney general notifies the entities of the inadequacy of the information provided and provides the entities with a reasonable opportunity to remedy the inadequacy.

(e) An officer, director, or other executive found to have violated sections 145D.30 to 145D.33 shall be subject to a civil penalty of up to $100,000 for each violation. A corporation or other entity which is a party to or materially participated in a conversion transaction found to have violated sections 145D.30 to 145D.33 shall be subject to a civil penalty of up to $1,000,000. A court may also award reasonable attorney fees and costs of investigation and litigation.

Subd. 3. **Commissioner of health; data and research.** The commissioner of health must provide the attorney general, upon request, with data and research on broader market

trends, impacts on prices and outcomes, public health and population health considerations, and health care access, for the attorney general to use when evaluating whether a conversion transaction is contrary to public interest. The commissioner may share with the attorney general, according to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision 8a, held by the commissioner to aid in the investigation and review of the conversion transaction, and the attorney general must maintain this data with the same classification according to section 13.03, subdivision 4, paragraph (c).

Subd. 4. **Failure to take action.** Failure by the attorney general to take action with respect to a conversion transaction under this section does not constitute approval of the conversion transaction or waiver, nor shall failure prevent the attorney general from taking action in the same, similar, or subsequent circumstances.

Sec. 55. **[145D.35] DATA PRACTICES.**

Section 13.65 applies to data provided by a nonprofit health coverage entity or the commissioner to the attorney general under sections 145D.30 to 145D.33. Section 13.39 applies to data provided by a nonprofit health coverage entity to the commissioner under sections 145D.30 to 145D.33. The attorney general or the commissioner may make any data classified as confidential or protected nonpublic under this section accessible to any civil or criminal law enforcement agency if the attorney general or commissioner determines that the access aids the law enforcement process.

Sec. 56. **[145D.36] COMMISSIONER OF HEALTH; REPORTS AND ANALYSIS.**

Notwithstanding any law to the contrary, the commissioner of health may use data or information submitted under sections 60A.135 to 60A.137, 60A.17, 60D.18, 60D.20, 62D.221, and 145D.32 to conduct analyses of the aggregate impact of transactions within nonprofit health coverage entities and organizations which include nonprofit health coverage entities or their affiliates on access to or the cost of health care services, health care market consolidation, and health care quality. The commissioner of health must issue periodic public reports on the number and types of conversion transactions subject to sections 145D.30 to 145D.35 and on the aggregate impact of conversion transactions on health care costs, quality, and competition in Minnesota.

Sec. 57. **[145D.37] RELATION TO OTHER LAW.**

(a) Sections 145D.30 to 145D.36 are in addition to and do not affect or limit any power, remedy, or responsibility of a health maintenance organization, a service plan corporation, a conversion benefit entity, the attorney general, the commissioner of health, or the commissioner of commerce under this chapter; chapter 8, 62C, 62D, 309, 317A, or 501B; or other law.

(b) Nothing in sections 145D.03 to 145D.36 authorizes a nonprofit health coverage entity to enter into a conversion transaction not otherwise permitted under chapter 317A or 501B or other law.

Sec. 27. **[214.41] PHYSICIAN WELLNESS PROGRAM.**

Subdivision 1. **Definition.** For the purposes of this section, "physician wellness program" means a program of evaluation, counseling, or other modality to address an issue related to career fatigue or wellness related to work stress for physicians licensed under chapter 147 that is administered by a statewide association that is exempt from taxation under United States Code, title 26, section 501(c)(6), and that primarily represents physicians and osteopaths of multiple specialties. Physician wellness program does not include the provision of services intended to monitor for impairment under the authority of section 214.31.

Subd. 2. **Confidentiality.** Any record of a person's participation in a physician wellness program is confidential and not subject to discovery, subpoena, or a reporting requirement to the applicable board, unless the person voluntarily provides for written release of the information or the disclosure is required to meet the licensee's obligation to report according to section 147.111.

Subd. 3. **Civil liability.** Any person, agency, institution, facility, or organization employed by, contracting with, or operating a physician wellness program is immune from civil liability for any action related to their duties in connection with a physician wellness program when acting in good faith.

Sec. 28. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 3a, is amended to read:

Subd. 3a. **Gender-affirming services.** Medical assistance covers gender-affirming ~~services~~ care, as defined in section 62Q.585.

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

Sec. 29. Minnesota Statutes 2022, section 256B.0625, subdivision 12, is amended to read:

Subd. 12. **Eyeglasses~~, dentures, and prosthetic and orthotic devices~~.** ~~(a)~~ Medical assistance covers eyeglasses~~, dentures, and prosthetic and orthotic devices~~ if prescribed by a licensed practitioner.

~~(b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner" includes a physician, an advanced practice registered nurse, a physician assistant, or a podiatrist.~~

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

Sec. 30. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 16, is amended to read:

Subd. 16. **Abortion services.** Medical assistance covers ~~abortion services determined to be medically necessary by the treating provider and delivered in accordance with all~~

Sec. 58. Minnesota Statutes 2022, section 256B.0625, subdivision 12, is amended to read:

Subd. 12. **Eyeglasses~~, dentures, and prosthetic and orthotic devices~~.** ~~(a)~~ Medical assistance covers eyeglasses~~, dentures, and prosthetic and orthotic devices~~ if prescribed by a licensed practitioner.

~~(b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner" includes a physician, an advanced practice registered nurse, a physician assistant, or a podiatrist.~~

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

Sec. 59. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 16, is amended to read:

Subd. 16. **Abortion services.** Medical assistance covers ~~abortion services determined to be medically necessary by the treating provider and delivered in accordance with all~~

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~~applicable Minnesota laws~~ abortions and abortion-related services, including preabortion services and follow-up services.

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

Sec. 31. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 72. **Orthotic and prosthetic devices.** Medical assistance covers orthotic and prosthetic devices, supplies, and services according to section 256B.066.

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

Sec. 32. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 73. **Scalp hair prostheses.** Medical assistance covers scalp hair prostheses prescribed for hair loss suffered as a result of treatment for cancer. Medical assistance must meet the requirements that would otherwise apply to a health plan under section 62A.28, except for the limitation on coverage required per benefit year set forth in section 62A.28, subdivision 2, paragraph (c).

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to all policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

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~~applicable Minnesota laws~~ abortions and abortion-related services, including preabortion services and follow-up services.

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

HOUSE ARTICLE 4, SECTION 60, WAS MOVED TO MATCH SENATE ARTICLE 2, SECTION 11.

Sec. 61. Minnesota Statutes 2022, section 256B.0625, subdivision 32, is amended to read:

Subd. 32. **Nutritional products.** Medical assistance covers nutritional products needed for nutritional supplementation because solid food or nutrients thereof cannot be properly absorbed by the body or needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow's milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product. Medical assistance covers amino acid-based elemental formulas in the same manner as is required under section 62Q.531. Nutritional products needed for the treatment of a combined allergy to human milk, cow's milk, and soy formula require prior authorization. Separate payment shall not be made for nutritional products for residents of long-term care facilities. Payment for dietary requirements is a component of the per diem rate paid to these facilities.

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

Sec. 62. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 72. **Orthotic and prosthetic devices.** Medical assistance covers orthotic and prosthetic devices, supplies, and services according to section 256B.066.

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

Sec. 64. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 74. **Scalp hair prostheses.** Medical assistance covers scalp hair prostheses and all equipment and accessories necessary for their regular use under the conditions and in compliance with the requirements specified in section 62A.28, except that the limitation on coverage required per benefit year set forth in section 62A.28, subdivision 2, paragraph (c), does not apply.

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

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Sec. 33. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 74. **Intermittent catheters.** Medical assistance covers intermittent urinary catheters and insertion supplies if intermittent catheterization is recommended by the enrollee's health care provider. Medical assistance must meet the requirements that would otherwise apply to a health plan under section 62Q.666.

Sec. 34. **[256B.066] ORTHOTIC AND PROSTHETIC DEVICES, SUPPLIES, AND SERVICES.**

Subdivision 1. **Definitions.** All terms used in this section have the meanings given them in section 62Q.665, subdivision 1.

Subd. 2. **Coverage requirements.** (a) Medical assistance covers orthotic and prosthetic devices, supplies, and services:

(1) furnished under an order by a prescribing physician or licensed health care prescriber who has authority in Minnesota to prescribe orthoses and prostheses. Coverage for orthotic and prosthetic devices, supplies, accessories, and services under this clause includes those devices or device systems, supplies, accessories, and services that are customized to the enrollee's needs;

(2) determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for purposes of performing physical activities, as applicable, including but not limited to running, biking, and swimming, and maximizing the enrollee's limb function; or

(3) for showering or bathing.

(b) The coverage set forth in paragraph (a) includes the repair and replacement of those orthotic and prosthetic devices, supplies, and services described therein.

(c) Coverage of a prosthetic or orthotic benefit must not be denied for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

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Sec. 63. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 73. **Rapid whole genome sequencing.** Medical assistance covers rapid whole genome sequencing (rWGS) testing. Coverage and eligibility for rWGS testing, and the use of genetic data, must meet the requirements specified in section 62A.3098, subdivisions 1 to 3 and 6.

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

Sec. 65. **[256B.066] ORTHOTIC AND PROSTHETIC DEVICES, SUPPLIES, AND SERVICES.**

Subdivision 1. **Definitions.** All terms used in this section have the meanings given them in section 62Q.665, subdivision 1.

Subd. 2. **Coverage requirements.** (a) Medical assistance covers orthotic and prosthetic devices, supplies, and services:

(1) furnished under an order by a prescribing physician or licensed health care prescriber who has authority in Minnesota to prescribe orthoses and prostheses. Coverage for orthotic and prosthetic devices, supplies, accessories, and services under this clause includes those devices or device systems, supplies, accessories, and services that are customized to the enrollee's needs;

(2) determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for purposes of performing physical activities, as applicable, including but not limited to running, biking, and swimming, and maximizing the enrollee's limb function; or

(3) for showering or bathing.

(b) The coverage set forth in paragraph (a) includes the repair and replacement of those orthotic and prosthetic devices, supplies, and services described therein.

(c) Coverage of a prosthetic or orthotic benefit must not be denied for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

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(d) If coverage for prosthetic or custom orthotic devices is provided, payment must be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of the devices, without regard to useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of a device, is necessary because:

(1) of a change in the physiological condition of the enrollee;

(2) of an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

Subd. 3. **Restrictions on coverage.** (a) Prior authorization may be required for orthotic and prosthetic devices, supplies, and services.

(b) A utilization review for a request for coverage of prosthetic or orthotic benefits must apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists.

(c) Utilization review determinations must be rendered in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely on the basis of an enrollee's actual or perceived disability.

(d) Evidence of coverage and any benefit denial letters must include language describing an enrollee's rights pursuant to paragraphs (b) and (c).

(e) Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

Subd. 4. **Managed care plan access to care.** (a) Managed care plans and county-based purchasing plans subject to this section must ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from at least two distinct prosthetic and custom orthotic providers in the plan's provider network located in Minnesota.

(b) In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider, the plan must provide processes to refer an enrollee to an out-of-network provider and must fully reimburse the out-of-network provider at a mutually agreed upon rate less enrollee cost sharing determined on an in-network basis.

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

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(d) If coverage for prosthetic or custom orthotic devices is provided, payment must be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of the devices, without regard to useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of a device, is necessary because:

(1) of a change in the physiological condition of the enrollee;

(2) of an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

Subd. 3. **Restrictions on coverage.** (a) Prior authorization may be required for orthotic and prosthetic devices, supplies, and services.

(b) A utilization review for a request for coverage of prosthetic or orthotic benefits must apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists.

(c) Utilization review determinations must be rendered in a nondiscriminatory manner and must not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely on the basis of an enrollee's actual or perceived disability.

(d) Evidence of coverage and any benefit denial letters must include language describing an enrollee's rights pursuant to paragraphs (b) and (c).

(e) Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

Subd. 4. **Managed care plan access to care.** (a) Managed care plans and county-based purchasing plans subject to this section must ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from at least two distinct prosthetic and custom orthotic providers in the plan's provider network located in Minnesota.

(b) In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider, the plan must provide processes to refer an enrollee to an out-of-network provider and must fully reimburse the out-of-network provider at a mutually agreed upon rate less enrollee cost sharing determined on an in-network basis.

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

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Sec. 35. Minnesota Statutes 2022, section 317A.811, subdivision 1, is amended to read:

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

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

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

(b) Except as provided in subdivision 6, the following corporations shall notify the attorney general of their intent to dissolve, merge, consolidate, convert, or transfer at least ten percent of their assets:

(1) a corporation that is a nonprofit health service plan corporation operating under chapter 62C; or

(2) a corporation that is a health maintenance organization operating under chapter 62D.

~~(b)~~ (c) The notice must include:

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

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

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

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

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

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

(7) a list of persons to whom assets will be transferred, if known, or the name of the converted organization;

(8) the purposes of persons receiving the assets or of the converted organization; and

(9) the terms, conditions, or restrictions, if any, to be imposed on the transferred or converted assets.

The notice must be signed on behalf of the corporation by an authorized person.

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

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Sec. 66. Minnesota Statutes 2022, section 317A.811, subdivision 1, is amended to read:

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

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

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

(3) a nonprofit health coverage entity as defined in section 145D.30.

(b) The notice must include:

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

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

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

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

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

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

(7) a list of persons to whom assets will be transferred, if known, or the name of the converted organization;

(8) the purposes of persons receiving the assets or of the converted organization; and

(9) the terms, conditions, or restrictions, if any, to be imposed on the transferred or converted assets.

The notice must be signed on behalf of the corporation by an authorized person.

Sec. 36. Minnesota Statutes 2022, section 317A.811, subdivision 2, is amended to read:

Subd. 2. **Restriction on transfers.** (a) Subject to subdivision 3, a corporation described in subdivision 1, paragraph (a), may not transfer or convey assets as part of a dissolution, merger, consolidation, or transfer of assets under section 317A.661, and it may not convert until 45 days after it has given written notice to the attorney general, unless the attorney general waives all or part of the waiting period.

(b) Subject to subdivision 3, a corporation described in subdivision 1, paragraph (b), may not transfer or convey assets as part of a dissolution, merger, consolidation, transfer of assets under section 317A.661, or transfer of at least ten percent of its assets and it may not convert until 45 days after it has given written notice to the attorney general, unless the attorney general waives all or part of the waiting period.

(c) For a notice given by a corporation described in subdivision 1, paragraph (b), the attorney general may hold a public hearing with respect to the purpose for which the corporation gave the notice. If the attorney general elects to hold a public hearing, the attorney general must give at least seven days' notice of the hearing to the corporation filing the statement and to the public.

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

Sec. 37. Minnesota Statutes 2022, section 317A.811, subdivision 4, is amended to read:

Subd. 4. **Notice after transfer.** When all or substantially all of the assets of a corporation described in subdivision 1, paragraph (a), or at least ten percent of the assets of a corporation described in subdivision 1, paragraph (b), have been transferred or conveyed following expiration or waiver of the waiting period, the board shall deliver to the attorney general a list of persons to whom the assets were transferred or conveyed. The list must include the addresses of each person who received assets and show what assets the person received.

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

Sec. 38. **COMMISSIONER OF COMMERCE.**

The commissioner of commerce shall consult with health plan companies, pharmacies, and pharmacy benefit managers to develop guidance to implement coverage for the pharmacy services required by sections 2, 3, and 11.

Sec. 39. **TRANSITION.**

(a) A health maintenance organization that has a certificate of authority under Minnesota Statutes, chapter 62D, but that is not a nonprofit corporation organized under Minnesota Statutes, chapter 317A, or a local governmental unit, as defined in Minnesota Statutes, section 62D.02, subdivision 11:

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(1) must not offer, sell, issue, or renew any health maintenance contracts on or after August 1, 2024;

(2) may otherwise continue to operate as a health maintenance organization until December 31, 2025; and

(3) must provide notice to the health maintenance organization's enrollees as of August 1, 2024, of the date the health maintenance organization will cease to operate in this state and any plans to transition enrollee coverage to another insurer. This notice must be provided by October 1, 2024.

(b) The commissioner of health must not issue or renew a certificate of authority to operate as a health maintenance organization on or after August 1, 2024, unless the entity seeking the certificate of authority meets the requirements for a health maintenance organization under Minnesota Statutes, chapter 62D, in effect on or after August 1, 2024.

Sec. 40. **REPEALER.**

(a) Minnesota Statutes 2022, section 62A.041, subdivision 3, is repealed.

(b) Minnesota Statutes 2023 Supplement, section 62Q.522, subdivisions 3 and 4, are repealed.

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

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Sec. 67. **INITIAL REPORTS TO COMMISSIONER OF HEALTH; UTILIZATION MANAGEMENT TOOLS.**

Utilization review organizations must submit initial reports to the commissioner of health under Minnesota Statutes, section 62M.19, by September 1, 2025.

Sec. 68. **REPEALER.**

(a) Minnesota Statutes 2022, section 62A.041, subdivision 3, is repealed.

(b) Minnesota Statutes 2023 Supplement, section 62Q.522, subdivisions 3 and 4, are repealed.

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