Senator ..... moves to amend S.F. No. 1703 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

HEALTH AND HUMAN SERVICES FINANCE POLICY

Section 1. Minnesota Statutes 2022, section 16A.151, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific injured persons or entities, this section does not prohibit distribution of money to the specific injured persons or entities on whose behalf the litigation or settlement efforts were initiated. If money recovered on behalf of injured persons or entities cannot reasonably be distributed to those persons or entities because they cannot readily be located or identified or because the cost of distributing the money would outweigh the benefit to the persons or entities, the money must be paid into the general fund.

(b) Money recovered on behalf of a fund in the state treasury other than the general fund may be deposited in that fund.

(c) This section does not prohibit a state official from distributing money to a person or entity other than the state in litigation or potential litigation in which the state is a defendant or potential defendant.

(d) State agencies may accept funds as directed by a federal court for any restitution or monetary penalty under United States Code, title 18, section 3663(a)(3), or United States Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue account and are appropriated to the commissioner of the agency for the purpose as directed by the federal court.

(e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph (t), may be deposited as provided in section 16A.98, subdivision 12.

(f) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state, on behalf of the state or a state agency, related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids, must be deposited in the settlement account established in the opiate epidemic response fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees

and costs awarded to the state or the Attorney General's Office, to contract attorneys hired by the state or Attorney General's Office, or to other state agency attorneys.

(g) Notwithstanding paragraph (f), if money is received from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency against a consulting firm working for an opioid manufacturer or opioid wholesale drug distributor, the commissioner shall deposit any money received into the settlement account established within the opiate epidemic response fund under section 256.042, subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), any amount deposited into the settlement account in accordance with this paragraph shall be appropriated to the commissioner of human services to award as grants as specified by the opiate epidemic response advisory council in accordance with section 256.043, subdivision 3a, paragraph (d).

(h) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine use, must be deposited in the settlement account established in the tobacco use prevention account under section 144.398. This paragraph does not apply to: (1) attorney fees and costs awarded or paid to the state or the Attorney General's Office; (2) contract attorneys hired by the state or Attorney General's Office; or (3) other state agency attorneys.

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

Sec. 2. Minnesota Statutes 2022, section 62J.84, subdivision 2, is amended to read:

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

(b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics license application approved under United States Code, title 42, section 262(K)(3).

(c) "Brand name drug" means a drug that is produced or distributed pursuant to:

(1) ~~an original,~~ a new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or

(2) a biologics license application approved under United States Code, title ~~45~~ 42, section 262(a)(c).

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

(e) "Generic drug" means a drug that is marketed or distributed pursuant to:

(1) an abbreviated new drug application approved under United States Code, title 21, section 355(j);

(2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42, section 447.502; or

(3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

(f) "Manufacturer" means a drug manufacturer licensed under section 151.252.

(g) "New prescription drug" or "new drug" means a prescription drug approved for marketing by the United States Food and Drug Administration (FDA) for which no previous wholesale acquisition cost has been established for comparison.

(h) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

(i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision 8.

(j) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

(k) "30-day supply" means the total daily dosage units of a prescription drug recommended by the prescribing label approved by the FDA for 30 days. If the FDA-approved prescribing label includes more than one recommended daily dosage, the 30-day supply is based on the maximum recommended daily dosage on the FDA-approved prescribing label.

(l) "Course of treatment" means the total dosage of a single prescription for a prescription drug recommended by the FDA-approved prescribing label. If the FDA-approved prescribing label includes more than one recommended dosage for a single course of treatment, the course of treatment is the maximum recommended dosage on the FDA-approved prescribing label.

(m) "Drug product family" means a group of one or more prescription drugs that share a unique generic drug description or nontrade name and dosage form.

(n) "National drug code" means the three-segment code maintained by the federal Food and Drug Administration that includes a labeler code, a product code, and a package code for a drug product and that has been converted to an 11-digit format consisting of five digits in the first segment, four digits in the second segment, and two digits in the third segment. A three-segment code shall be considered converted to an 11-digit format when, as necessary, at least one "0" has been added to the front of each segment containing less than the specified number of digits such that each segment contains the specified number of digits.

(o) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded, or dispensed under the supervision of a pharmacist.

(p) "Pharmacy benefits manager" or "PBM" means an entity licensed to act as a pharmacy benefits manager under section 62W.03.

(q) "Pricing unit" means the smallest dispensable amount of a prescription drug product that could be dispensed.

(r) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefits manager, wholesale drug distributor, or any other entity required to submit data under section 62J.84.

(s) "Wholesale drug distributor" or "wholesaler" means an entity that:

(1) is licensed to act as a wholesale drug distributor under section 151.47; and

(2) distributes prescription drugs, of which it is not the manufacturer, to persons or entities, or both, other than a consumer or patient in the state.

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

Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022, a drug manufacturer must submit to the commissioner the information described in paragraph (b) for each prescription drug for which the price was $100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for brand name drugs where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in the price over the previous 24-month period; and

(2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the price increase goes into effect, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the ~~name~~ description and price of the drug and the net increase, expressed as a percentage~~;~~, with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

(2) the factors that contributed to the price increase;

(3) the name of any generic version of the prescription drug available on the market;

(4) the introductory price of the prescription drug when it was ~~approved for marketing by the Food and Drug Administration and the net yearly increase, by calendar year, in the price of the prescription drug during the previous five years~~ introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the price increase;

(5) the direct costs incurred during the previous 12-month period by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

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

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

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

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

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

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

(12) if a brand name prescription drug, the ~~ten~~ highest ~~prices~~ price paid for the prescription drug during the previous calendar year in ~~any country other than~~ the ten countries, excluding the United States~~.~~, that charged the highest single price for the prescription drug; and

(13) if the prescription drug was acquired by the manufacturer during the previous 12-month period, all of the following information:

(i) price at acquisition;

(ii) price in the calendar year prior to acquisition;

(iii) name of the company from which the drug was acquired;

(iv) date of acquisition; and

(v) acquisition price.

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

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

Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no later than 60 days after a manufacturer introduces a new prescription drug for sale in the United States that is a new brand name drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting less than 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting less than 30 days and is not at least 15 percent lower than the referenced brand name drug when the generic or biosimilar drug is launched, the manufacturer must submit to the commissioner, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the description of the drug, with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

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

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

~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug; and

~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

(b) The manufacturer may submit documentation necessary to support the information reported under this subdivision.

Sec. 5. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3~~, 4, and 5,~~ to 6 and 9 to 14 and the manufacturers of those prescription drugs; and

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

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public

disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

Sec. 6. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section.

(b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting entities to establish a standard format for reporting information under this section and may use existing reporting methodologies to establish a standard format to minimize administrative burdens to the state and ~~manufacturers~~ reporting entities.

Sec. 7. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

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

(1) failing to register under subdivision 15;

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

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

~~(3)~~ (4) providing inaccurate or incomplete information under this section.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section shall be deposited in the health care access fund.

Sec. 8. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each year thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state and other payers in the management of pharmaceutical costs.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3~~, 4, and 5~~ to 6 and 9 to 14.

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

Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the department's website a list of prescription drugs that the department determines to represent a substantial public interest and for which the department intends to request data under subdivisions 9 to 14, subject to paragraph (c). The department shall base its inclusion of prescription drugs on any information the department determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in

the state, and the department shall consider drug product families that include prescription drugs:

(1) that triggered reporting under subdivisions 3, 4, or 6 during the previous calendar quarter;

(2) for which average claims paid amounts exceeded 125 percent of the price as of the claim incurred date during the most recent calendar quarter for which claims paid amounts are available; or

(3) that are identified by members of the public during a public comment period process.

(b) Not sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via email, reporting entities registered with the department of the requirement to report under subdivisions 9 to 14.

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

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

Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a manufacturer must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the manufacturer by the department under subdivision 10;

(2) which the manufacturer manufactures or repackages;

(3) for which the manufacturer sets the wholesale acquisition cost; and

(4) for which the manufacturer has not submitted data under subdivision 3 or 6 during the 120-day period prior to the date of the notification to report.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the price of the drug product on the later of:

(i) the day one year prior to the date of the notification to report;

(ii) the introduced to market date; or

(iii) the acquisition date;

(3) the price of the drug product on the date of the notification to report;

(4) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the date of the notification to report;

(5) the direct costs incurred during the 12-month period prior to the date of the notification to report by the manufacturers that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

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

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

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

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

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

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

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

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

(14) if the prescription drug is a brand name prescription drug, the ten countries other than the United States that paid the highest prices for the prescription drug during the previous calendar year and their prices; and

(15) if the prescription drug was acquired by the manufacturer within a 12-month period prior to the date of the notification to report, all of the following information:

(i) the price at acquisition;

(ii) the price in the calendar year prior to acquisition;

(iii) the name of the company from which the drug was acquired;

(iv) the date of acquisition; and

(v) the acquisition price.

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

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

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the pharmacy by the department under subdivision 9.

(b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug acquired during the 12-month period prior to the date of the notification to report;

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

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

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

(6) the total payment receivable by the pharmacy for dispensing the drug including ingredient cost, dispensing fee, and administrative fees during the 12-month period prior to the date of the notification to report;

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

(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the 12-month period prior to the date of the notification to report.

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

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

Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a PBM must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the PBM by the department under subdivision 9.

(b) For each of the drugs described in paragraph (a), the PBM shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

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

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

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

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

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

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

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

(b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

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

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

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

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

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

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

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

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

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

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

Sec. 16. **[144.0526] MINNESOTA ONE HEALTH ANTIMICROBIAL STEWARDSHIP COLLABORATIVE.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota One Health Antimicrobial Stewardship Collaborative. The commissioner shall appoint a director to execute operations, conduct health education, and provide technical assistance.

Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program to:

(1) maintain the position of director of One Health Antimicrobial Stewardship to lead state antimicrobial stewardship initiatives across human, animal, and environmental health;

(2) communicate to professionals and the public the interconnectedness of human, animal, and environmental health, especially related to preserving the efficacy of antibiotic medications, which are a shared resource;

(3) leverage new and existing partnerships. The commissioner of health shall consult and collaborate with organizations and agencies in fields including but not limited to health care, veterinary medicine, animal agriculture, academic institutions, and industry and community organizations to inform strategies for education, practice improvement, and research in all settings where antimicrobials are used;

(4) ensure that veterinary settings have education and strategies needed to practice appropriate antibiotic prescribing, implement clinical antimicrobial stewardship programs, and prevent transmission of antimicrobial-resistant microbes; and

(5) support collaborative research and programmatic initiatives to improve the understanding of the impact of antimicrobial use and resistance in the natural environment.

Sec. 17. **[144.0752] CULTURAL COMMUNICATIONS.**

Subdivision 1. **Establishment.** The commissioner of health shall establish:

(1) a cultural communications program that advances culturally and linguistically appropriate communication services for communities most impacted by health disparities which includes limited English proficient (LEP) populations, African American, LGBTQ+, and people with disabilities; and

(2) a position that works with department leadership and division to ensure that the department follows the National Standards for Culturally and Linguistically Appropriate Services (CLAS) Standards.

Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program to:

(1) align the department services, policies, procedures, and governance with the National CLAS Standards and establish culturally and linguistically appropriate goals, policies, and management accountability and apply them throughout the organization's planning and operations;

(2) ensure the department services respond to the cultural and linguistic diversity of Minnesotans and that the department partners with the community to design, implement, and evaluate policies, practices, and services that are aligned with the national cultural and linguistic appropriateness standard; and

(3) ensure the department leadership, workforce, and partners embed culturally and linguistically appropriate policies and practices into leadership and public health program planning, intervention, evaluation, and dissemination.

Subd. 3. **Eligible contractors.** Organizations eligible to receive contract funding under this section include:

(1) master contractors that are selected through the state to provide language and communication services; and

(2) organizations that are able to provide services for languages that master contracts are unable to cover.

Sec. 18. **[144.0754] OFFICE OF AFRICAN AMERICAN HEALTH; DUTIES.**

The commissioner shall establish the Office of African American Health to address the unique public health needs of African American Minnesotans and work to develop solutions and systems to address identified health disparities of African American Minnesotans arising from a context of cumulative and historical discrimination and disadvantages in multiple systems, including but not limited to housing, education, employment, gun violence, incarceration, environmental factors, and health care discrimination and shall:

(1) convene the African American Health State Advisory Council (AAHSAC) under section 144.0755 to advise the commissioner on issues and to develop specific, targeted policy solutions to improve the health of African American Minnesotans, with a focus on US-born African Americans;

(2) based upon input from and collaboration with the AAHSAC, health indicators, and identified disparities, conduct analysis and develop policy and program recommendations and solutions targeted at improving African American health outcomes;

(3) coordinate and conduct community engagement across multiple systems, sectors, and communities to address racial disparities in labor force participation, educational achievement, and involvement with the criminal justice system that impact African American health and well-being;

(4) conduct data analysis and research to support policy goals and solutions;

(5) award and administer African American health special emphasis grants to health and community-based organizations to plan and develop programs targeted at improving African American health outcomes, based upon needs identified by the council, health indicators, and identified disparities and addressing historical trauma and systems of US born African American Minnesotans; and

(6) develop and administer Department of Health immersion experiences for students in secondary education and community colleges to improve diversity of the public health workforce and introduce career pathways that contribute to reducing health disparities.

Sec. 19. **[144.0755] AFRICAN AMERICAN HEALTH STATE ADVISORY COUNCIL.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall establish and administer the African American Health State Advisory Council to advise the commissioner on implementing specific strategies to reduce health inequities and disparities that particularly affect African Americans in Minnesota.

Subd. 2. **Members.** (a) The council shall include no fewer than 12 or more than 20 members from any of the following groups:

(1) representatives of community-based organizations serving or advocating for African American citizens;

(2) at-large community leaders or elders, as nominated by other council members;

(3) African American individuals who provide and receive health care services;

(4) African American secondary or college students;

(5) health or human service professionals serving African American communities or clients;

(6) representatives with research or academic expertise in racial equity; and

(7) other members that the commissioner deems appropriate to facilitate the goals and duties of the council.

(b) The commissioner shall make recommendations for committee membership and, after considering recommendations from the council, shall appoint a chair or chairs of the committee. Committee members shall be appointed by the governor.

Subd. 3. **Terms.** A term shall be for two years and appointees may be reappointed to serve two additional terms. The commissioner shall recommend appointments to replace

members vacating their positions in a timely manner, no more than three months after the council reviews panel recommendations.

Subd. 4. **Duties of commissioner.** The commissioner or commissioner's designee shall:

(1) maintain and actively engage with the council established in this section;

(2) based on recommendations of the council, review identified department or other related policies or practices that maintain health inequities and disparities that particularly affect African Americans in Minnesota;

(3) in partnership with the council, recommend or implement action plans and resources necessary to address identified disparities and advance African American health equity;

(4) support interagency collaboration to advance African American health equity; and

(5) support member participation in the council, including participation in educational and community engagement events across Minnesota that specifically address African American health equity.

Subd. 5. **Duties of council.** The council shall:

(1) identify health disparities found in African American communities and contributing factors;

(2) recommend to the commissioner for review any statutes, rules, or administrative policies or practices that would address African American health disparities;

(3) recommend policies and strategies to the commissioner of health to address disparities specifically affecting African American health;

(4) form work groups of council members who are persons who provide and receive services and representatives of advocacy groups;

(5) provide the work groups with clear guidelines, standardized parameters, and tasks for the work groups to accomplish; and

(6) annually submit to the commissioner a report that summarizes the activities of the council, identifies disparities specially affecting the health of African American Minnesotans, and makes recommendations to address identified disparities.

Subd. 6. **Duties of council members.** The members of the council shall:

(1) attend scheduled meetings with no more than three absences per year, participate in scheduled meetings, and prepare for meetings by reviewing meeting notes;

(2) maintain open communication channels with respective constituencies;

(3) identify and communicate issues and risks that may impact the timely completion of tasks;

(4) participate in any activities the council or commissioner deems appropriate and necessary to facilitate the goals and duties of the council; and

(5) participate in work groups to carry out council duties.

Subd. 7. **Staffing; office space; equipment.** The commissioner shall provide the advisory council with staff support, office space, and access to office equipment and services.

Subd. 8. **Reimbursement.** Compensation or reimbursement for travel and expenses, or both, incurred for council activities is governed in accordance with section 15.059, subdivision 3.

Sec. 20. **[144.0757] OFFICE OF AMERICAN INDIAN HEALTH .**

Subdivision 1. **Duties.** The Office of American Indian Health is established to address unique public health needs of American Indian Tribal communities in Minnesota, and shall:

(1) coordinate with Minnesota's Tribal Nations and urban American Indian community-based organizations to identify underlying causes of health disparities, address unique health needs of Minnesota's Tribal communities, and develop public health approaches to achieve health equity;

(2) strengthen capacity of American Indian and community-based organizations and Tribal Nations to address identified health disparities and needs;

(3) administer state and federal grant funding opportunities targeted to improve the health of American Indians;

(4) provide overall leadership for targeted development of holistic health and wellness strategies to improve health and to support Tribal and urban American Indian public health leadership and self-sufficiency;

(5) provide technical assistance to Tribal and American Indian urban community leaders to develop culturally appropriate activities to address public health emergencies;

(6) develop and administer the department immersion experiences for American Indian students in secondary education and community colleges to improve diversity of the public health workforce and introduce career pathways that contribute to reducing health disparities; and

(7) identify and promote workforce development strategies for Department of Health staff to work with the American Indian population and Tribal Nations more effectively in Minnesota.

Subd. 2. **Grants and contracts.** To carry out these duties, the office may contract with or provide grants to qualifying entities.

Sec. 21. **[144.398] TOBACCO USE PREVENTION ACCOUNT; ESTABLISHMENT AND USES.**

Subdivision 1. **Definitions.** (a) As used in this section, the terms in this subdivision have the meanings given.

(b) "Electronic delivery device" has the meaning given in section 609.685, subdivision 1, paragraph (c).

(c) "Tobacco" has the meaning given in section 609.685, subdivision 1, paragraph (a).

(d) "Tobacco-related devices" has the meaning given in section 609.685, subdivision 1, paragraph (b).

(e) "Nicotine delivery product" has the meaning given in section 609.6855, subdivision 1, paragraph (c).

Subd. 2. **Account created.** A tobacco use prevention account is created in the special revenue fund. Pursuant to section 16A.151, subdivision 2, paragraph (h), the commissioner of management and budget shall deposit into the account any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine use.

Subd. 3. **Appropriations from tobacco use prevention account.** (a) Each fiscal year, the amount of money in the tobacco use prevention account is appropriated to the commissioner of health for:

(1) tobacco and electronic delivery device use prevention and cessation projects consistent with the duties specified in section 144.392;

(2) a public information program under section 144.393;

(3) the development of health promotion and health education materials about tobacco and electronic delivery device use prevention and cessation;

(4) tobacco and electronic delivery device use prevention activities under section 144.396; and

(5) statewide tobacco cessation services under section 144.397.

(b) In activities funded under this subdivision, the commissioner of health must:

(1) prioritize preventing persons under the age of 21 from using commercial tobacco, electronic delivery devices, tobacco-related devices, and nicotine delivery products;

(2) promote racial and health equity; and

(3) use strategies that are evidence-based or based on promising practices.

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

Sec. 22. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

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

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

(c) "Department" means the Department of Health.

(d) "Lifeline center" means a state-identified center that is a member of the Suicide and Crisis Lifeline network that responds to statewide or regional 988 contacts.

(e) "988" or "988 hotline" means the universal telephone number for the national suicide prevention and mental health crisis hotline system within the United States operating through the Suicide and Crisis Lifeline, or its successor, maintained by the assistant secretary for mental health and substance use under section 520E-2 of the Public Health Service Act.

(f) "988 administrator" means the administrator of the 988 Suicide and Crisis Lifeline maintained by the assistant secretary for mental health and substance use under section 520E-3 of the Public Health Service Act.

(g) "988 contact" means a communication with the 988 national suicide prevention and mental health crisis hotline system within the United States via modalities offered that may include call, chat, or text.

(h) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the secretary of veterans affairs under United States Code, title 38, section 170F(h).

Subd. 2. **988 hotline; lifeline centers.** (a) The commissioner shall administer the designation of and oversee a lifeline center or network of lifeline centers to answer 988 contacts from individuals accessing the Suicide and Crisis Lifeline from any location in Minnesota 24 hours per day, seven days per week.

(b) The designated lifeline center or centers must:

(1) have an active agreement with the 988 administrator for participation within the network and with the department;

(2) meet the 988 administrator's requirements and best practice guidelines for operational and clinical standards;

(3) provide data, engage in reporting, and participate in evaluations and related quality improvement activities as required by the 988 administrator and the department;

(4) identify or adapt technology that is demonstrated to be interoperable across crisis and emergency response systems used in the state for the purpose of crisis care coordination;

(5) connect people to crisis response and outgoing services, including mobile crisis teams, in accordance with guidelines established by the 988 administrator and the department and in collaboration with the Department of Human Services;

(6) actively collaborate and coordinate service linkages with mental health and substance use disorder treatment providers; local community mental health centers, including certified community behavioral health clinics and community behavioral health centers; mobile crisis teams; and emergency departments;

(7) offer follow-up services to individuals accessing the lifeline center that are consistent with guidelines established by the 988 administrator and the department; and

(8) meet requirements set by the 988 administrator and the department for serving high-risk and specialized populations and culturally or ethnically diverse populations.

(c) The commissioner shall use the commissioner's rulemaking authority to allow appropriate information sharing and communication between and across crisis and emergency response systems.

(d) The commissioner, having primary oversight of suicide prevention, shall work with the Suicide and Crisis Lifeline, Veterans Crisis Line, and other SAMHSA-approved networks to ensure consistency of public messaging about 988 services. The commissioner may engage in activities to publicize and raise awareness about 988 services, or may provide grants to other organizations for these purposes.

(e) The commissioner shall provide an annual report to the legislature on usage of the 988 hotline, including answer rates, rates of abandoned calls, and referral rates to 911 emergency response and to mental health crisis teams. Notwithstanding section 144.05, subdivision 7, the reports required under this paragraph do not expire.

Subd. 3. **988 special revenue account.** (a) A 988 special revenue account is established as a dedicated account in the special revenue fund to create and maintain a statewide 988 suicide prevention crisis system according to the National Suicide Hotline Designation Act of 2020, the Federal Communications Commission's report and order FCC 20-100 adopted July 16, 2020, and national guidelines for crisis care.

(b) The 988 special revenue account shall consist of:

(1) a 988 telecommunications fee imposed under subdivision 4;

(2) a prepaid wireless 988 fee imposed under section 403.161;

(3) transfers of state money into the account;

(4) grants and gifts intended for deposit in the account;

(5) interest, premiums, gains, and other earnings of the account; and

(6) money from any other source that is deposited in or transferred to the account.

(c) The account shall be administered by the commissioner. Money in the account shall only be used to offset costs that are or may reasonably be attributed to:

(1) implementing, maintaining, and improving the 988 suicide and crisis lifeline, including staff and technology infrastructure enhancements needed to achieve the operational standards and best practices set forth by the 988 administrator and the department;

(2) data collection, reporting, participation in evaluations, public promotion, and related quality improvement activities as required by the 988 administrator and the department; and

(3) administration, oversight, and evaluation of the account.

(d) Money in the account:

(1) does not cancel at the end of any state fiscal year and is carried forward in subsequent state fiscal years;

(2) is not subject to transfer to any other account or fund or to transfer, assignment, or reassignment for any use or purpose other than the purposes specified in this subdivision; and

(3) is appropriated to the commissioner for the purposes specified in this subdivision.

(e) The commissioner shall submit an annual report to the legislature and to the Federal Communications Commission on deposits to and expenditures from the account. Notwithstanding section 144.05, subdivision 7, the reports required under this paragraph do not expire.

Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide Hotline Designation Act of 2020, the commissioner shall impose a monthly statewide fee on each subscriber of a wireline, wireless, or IP-enabled voice service at a rate that provides for the robust creation, operation, and maintenance of a statewide 988 suicide prevention and crisis system.

(b) The commissioner shall annually recommend to the Public Utilities Commission an adequate and appropriate fee to implement this section. The amount of the fee must comply with the limits in paragraph (c). The commissioner shall provide telecommunication service providers and carriers a minimum of 30 days' notice of each fee change.

(c) The amount of the 988 telecommunications fee must not be more than 25 cents per month on or after January 1, 2024, for each consumer access line, including trunk equivalents as designated by the commission pursuant to section 403.11, subdivision 1. The 988 telecommunications fee must be the same for all subscribers.

(d) Each wireline, wireless, and IP-enabled voice telecommunication service provider shall collect the 988 telecommunications fee and transfer the amounts collected to the commissioner of public safety in the same manner as provided in section 403.11, subdivision 1, paragraph (d).

(e) The commissioner of public safety shall deposit the money collected from the 988 telecommunications fee to the 988 special revenue account established in subdivision 3.

(f) All 988 telecommunications fee revenue must be used to supplement, and not supplant, federal, state, and local funding for suicide prevention.

(g) The 988 telecommunications fee amount shall be adjusted as needed to provide for continuous operation of the lifeline centers and 988 hotline, volume increases, and maintenance.

(h) The commissioner shall annually report to the Federal Communications Commission on revenue generated by the 988 telecommunications fee.

Subd. 5. **988 fee for prepaid wireless telecommunications services.** (a) The 988 telecommunications fee established in subdivision 4 does not apply to prepaid wireless

telecommunications services. Prepaid wireless telecommunications services are subject to the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

(b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by sections 403.161 and 403.162.

Subd. 6. **Biennial budget; annual financial report.** The commissioner must prepare a biennial budget for maintaining the 988 system. By December 15 of each year, the commissioner must submit a report to the legislature detailing the expenditures for maintaining the 988 system, the 988 fees collected, the balance of the 988 fund, the 988-related administrative expenses of the commissioner, and the most recent forecast of revenues and expenditures for the 988 special revenue account, including a separate projection of 988 fees from prepaid wireless customers and projections of year-end fund balances.

Subd. 7. **Waiver.** A wireless telecommunications service provider or wire-line telecommunications service provider may petition the commissioner for a waiver of all or portions of the requirements of this section. The commissioner may grant a waiver upon a demonstration by the petitioner that the requirement is economically infeasible.

Sec. 23. **[145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL.**

Subdivision 1. **Establishment; composition of advisory council.** The commissioner shall establish and appoint a health equity advisory and leadership (HEAL) council to provide guidance to the commissioner of health regarding strengthening and improving the health of communities most impacted by health inequities across the state. The council shall consist of 18 members who will provide representation from the following groups:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x communities;

(4) American Indian communities and Tribal governments and nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

(7) representatives who reside outside the seven-county metropolitan area.

Subd. 2. **Organization and meetings.** The advisory council shall be organized and administered under section 15.059. Meetings shall be held at least quarterly and hosted by the department. Subcommittees may be convened as necessary. Advisory council meetings are subject to the open meeting law under chapter 13D.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner on health equity issues and the health equity priorities and concerns of the populations specified in subdivision 1;

(2) assist the agency in efforts to advance health equity, including consulting in specific agency policies and programs, providing ideas and input about potential budget and policy proposals, and recommending review of agency policies, standards, or procedures that may create or perpetuate health inequities; and

(3) assist the agency in developing and monitoring meaningful performance measures related to advancing health equity.

Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities in the state are eliminated. Health inequities will be considered eliminated when race, ethnicity, income, gender, gender identity, geographic location, or other identity or social marker will no longer be predictors of health outcomes in the state. Section 145.928 describes nine health disparities that must be considered when determining whether health inequities have been eliminated in the state.

Sec. 24. Minnesota Statutes 2022, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must be actively engaged in the treatment of persons with mental illness~~ is an actively practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one of whom specializes in pediatrics, and one of whom actively treats persons with disabilities; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; ~~and one~~ at least four consumer

~~representative~~ representatives, all of whom must have a personal or professional connection to medical assistance; and one representative designated by the Minnesota Rare Disease Advisory Council established under section 256.4835; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed once by the commissioner. The committee members shall vote on a chair from among their membership. The chair shall preside over all committee meetings. The Formulary Committee shall meet at least ~~twice~~ four times per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee is subject to the Open Meeting Law under chapter 13D. The Formulary Committee expires June 30, ~~2023~~ 2027.

Sec. 25. **[256N.262] FOSTER CHILDREN BENEFITS TRUST.**

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

(b) "Beneficiary" means a current or former child in foster care who is or was entitled to cash benefits.

(c) "Cash benefits" means all sources of income a child in foster care is entitled to, including death benefits; survivor benefits; crime victim impact payments; federal cash benefits from programs administered by the Social Security Administration, including from the Supplemental Security Income and the Retirement, Survivors, Disability Insurance programs; and any other eligible income as determined by the Office of the Foster Youth Ombudsperson.

Subd. 2. **Establishment.** (a) The foster children benefits trust is established. The trust must be funded by appropriations to the Office of the Foster Youth Ombudsperson to compensate beneficiaries for cash benefits taken by a financially responsible agency to pay for the beneficiaries' care. The trust must be managed to ensure the stability and growth of the trust.

(b) All assets of the trust are held in trust for the exclusive benefit of beneficiaries. Assets must be held in a separate account in the state treasury to be known as the foster children benefits trust account or in accounts with the third-party provider selected pursuant to subdivision 9.

Subd. 3. **Requirements of financially responsible agencies.** (a) A financially responsible agency must assess whether each child the agency is responsible for is eligible to receive any cash benefits as soon as the custody of the child is transferred to a child placing agency or responsible social services agency pursuant to section 260C.201, subdivision 1, or the child is otherwise transferred to the state.

(b) If a child placed in foster care is eligible to receive cash benefits, the financially responsible agency must:

(1) apply to be the payee for the child for the duration of the child's placement in foster care;

(2) at least monthly, transfer all cash benefits received on behalf of a beneficiary to the Office of the Foster Youth Ombudsperson to be deposited in the trust;

(3) at least annually, notify the Office of the Foster Youth Ombudsperson of all cash benefits received for each beneficiary along with documentation identifying the beneficiary and amounts received for the child;

(4) notify each beneficiary 18 years of age or older that the beneficiary may be entitled to disbursements pursuant to the foster children benefits trust and inform the child how to contact the Office of the Foster Youth Ombudsperson about the trust; and

(5) retain all documentation related to cash benefits received for a beneficiary for at least five years after the agency is no longer the beneficiary's financially responsible agency.

(c) The financially responsible agency is liable to a beneficiary for any benefit payment that the agency receives as payee for a beneficiary and that is not included in the documentation sent to the Office of the Foster Youth Ombudsperson as required by this subdivision.

Subd. 4. **Deposits.** The Office of the Foster Youth Ombudsperson must deposit an amount equal to the cash benefits received by a financially responsible agency in a separate account for each beneficiary.

Subd. 5. **Ombudsperson's duties.** (a) The Office of the Foster Youth Ombudsperson must keep a record of the amounts deposited pursuant to subdivision 4 and all disbursements for each beneficiary's account.

(b) Annually, The Office of the Foster Youth Ombudsperson must determine the annual interest earnings of the trust, which include realized capital gains and losses.

(c) The Office of the Foster Youth Ombudsperson must apportion any annual capital gains earnings to the separate beneficiaries' accounts. The rate to be used in this apportionment, computed to the last full quarter percent, must be determined by dividing the capital gains earnings by the total invested assets of the trust.

(d) For each beneficiary between the ages of 14 and 18, the Office of the Foster Youth Ombudsperson must notify the beneficiary of the amount of cash benefits received on the beneficiary's behalf in the prior calendar year and the tax implications of those benefits by February 1 of each year.

(e) Account owner data, account data, and data on beneficiaries of accounts are private data on individuals or nonpublic data as defined in section 13.02.

Subd. 6. **Account protections.** (a) Trust assets are not subject to claims by creditors of the state, are not part of the general fund, and are not subject to appropriation by the state.

(b) Trust assets may not be used as collateral, as a part of a structured settlement, or in any way contracted to be paid to anyone who is not the beneficiary.

(c) Trust assets are not subject to seizure or garnishment as assets or income of the beneficiary.

Subd. 7. **Reports.** (a) By December 1, 2024, the Office of the Foster Youth Ombudsperson must submit a report to the legislative committees with jurisdiction over human services on the potential tax and state and federal benefit impacts of the trust and disbursements on beneficiaries and include recommendations on how best to minimize any increased tax burden or benefit reduction due to the trust.

(b) By December 1 of each year, the Office of the Foster Youth Ombudsperson must submit a report to the legislative committees with jurisdiction over foster youth on the cost of depositing into the trust pursuant to subdivision 4 and a projection for future costs.

Subd. 8. **Disbursements.** (a) Once a beneficiary has reached 18 years of age, the Office of the Foster Youth Ombudsperson must disburse$700each month to the beneficiary until the beneficiary's account is depleted. If the total amount remaining in a beneficiary's account is less than $700, the Office of the Foster Youth Ombudsperson must disburse that total amount remaining to the beneficiary.

(b) With each disbursement, the Office of the Foster Youth Ombudsperson must include information about the potential tax and benefits consequences of the disbursement.

(c) On petition of a minor beneficiary who is 14 years of age or older, a court may order the Office of the Foster Youth Ombudsperson to deliver or pay to the beneficiary or expend for the beneficiary's benefit the amount of the beneficiary's trust account as the court considers advisable for the use and benefit of the beneficiary.

Subd. 9. **Administration.** The Office of the Foster Youth Ombudsperson must administer the program pursuant to this section. The Office of the Foster Youth Ombudsperson may contract with one or more third parties to carry out some or all of these administrative duties, including managing the assets of the trust and ensuring that records are maintained.

Subd. 10. **Repayment program.** (a) No later than January 1, 2025, the Office of the Foster Youth Ombudsperson must identify every person for whom a financially responsible agency received cash benefits as the person's representative payee between August 1, 2018, and July 31, 2023, and the amount of money diverted to the financially responsible agency during that time. The Office of the Foster Youth Ombudsperson must attempt to notify every individual identified in this paragraph of the individual's potential eligibility for repayment pursuant to this subdivision no later than July 1, 2025.

(b) No later than January 1, 2026, the Office of the Foster Youth Ombudsperson must begin accepting applications for individuals described in paragraph (a) to receive compensation for cash benefits diverted to the individual's financially responsible agency between August 1, 2018, and July 31, 2023. The Office of the Foster Youth Ombudsperson must develop a system to process the applications and approve all applications that can show that the applicant had cash benefits diverted to a financially responsible agency between August 1, 2018, and July 31, 2023.

(c) For every beneficiary already enrolled in the foster youth benefits trust that the Office of the Foster Youth Ombudsperson determines had cash benefits diverted to a financially responsible agency between August 1, 2018, and July 31, 2023, the Office of the Foster Youth Ombudsperson must deposit an amount equal to the cash benefits diverted to a financially responsible agency between August 1, 2018, and July 31, 2023, into the beneficiary's trust account. The Office of the Foster Youth Ombudsperson must screen beneficiaries for eligibility under this paragraph automatically without requiring an application from the beneficiaries.

(d) For every applicant under paragraph (b) who is not already enrolled in the foster youth benefits trust, the Office of the Foster Youth Ombudsperson must directly award the applicant an amount equal to the cash benefits diverted to a financially responsible agency between August 1, 2018, and July 31, 2023.

(e) No later than January 31, 2025, the Office of the Foster Youth Ombudsperson must issue a report to the chairs and ranking minority members of the legislative committees with jurisdiction over foster youth. The report must include:

(1) the number of persons identified for whom a financially responsible agency received cash benefits as the person's representative payee between August 1, 2018, and July 31, 2023; and

(2) the Office of the Foster Youth Ombudsperson's plan for notifying eligible persons described in paragraph (a).

Subd. 11. **Rulemaking authority.** The Office of the Foster Youth Ombudsperson is authorized, subject to the provisions of chapter 14, to make rules necessary to the operation of the foster youth benefits trust and repayment program and to aid in performing its administrative duties and ensuring an equitable result for beneficiaries and former foster youths.

Sec. 26. **RECOGNIZING COMPARABLE COMPETENCIES TO ACHIEVE COMPARABLE COMPENSATION TASK FORCE.**

Subdivision 1. **Establishment.** The Recognizing Comparable Competencies to Achieve Comparable Compensation Task Force is established to develop methods for incorporating competencies and experiences, as well as educational attainment, into a compensation model for the early childhood workforce.

Subd. 2. **Membership.** (a) The task force shall consist of the following members, appointed by the governor:

(1) two individuals who are directors of a licensed child care center, one from greater Minnesota and one from the seven-county metropolitan area;

(2) two individuals who are license holders of family child care programs, one from greater Minnesota and one from the seven-county metropolitan area;

(3) four individuals who are early childhood educators, one who works in a licensed child care center, one who works in a public-school-based early childhood program, one who works in a Head Start program or a community education program, and one who works in a licensed family child care setting;

(4) one representative of a federally recognized Tribe who has expertise in the early care and education system;

(5) one representative from the Children's Cabinet;

(6) two parents of children under five years of age, one parent whose child attends a private early care and education program and one parent whose child attends a public program. One parent under this clause must be from greater Minnesota, and the other parent must be from the seven-county metropolitan area; and

(7) four individuals who have expertise in early childhood workforce issues.

(b) The governor must select a chair or cochairs for the task force from among the members. The first task force meeting must be convened by the chair or cochairs and held no later than September 1, 2023. Thereafter, the chair or cochairs shall convene the task force at least monthly and may convene other meetings as necessary. The chair or cochairs shall convene meetings in a manner to allow for access from diverse geographic locations in Minnesota.

(c) Compensation of task force members, filling of task force vacancies, and removal of task force members are governed by Minnesota Statutes, section 15.059.

Subd. 3. **Duties.** (a) The task force must develop a compensation framework for the early childhood workforce that incorporates competencies and experiences, as well as educational attainment.

(b) In developing the compensation framework required under this subdivision, the task force must:

(1) identify competencies and experiences to incorporate into the framework, including but not limited to multilingualism and previous work experience in a direct care setting; and

(2) propose mechanisms for including the compensation framework in the state's early childhood programs and services.

Subd. 4. **Administration.** (a) The commissioner of management and budget shall provide staff and administrative services for the task force.

(b) The task force expires upon submission of the final report required under subdivision 5.

(c) The task force is subject to Minnesota Statutes, chapter 13D.

Subd. 5. **Required reports.** By December 1, 2024, the task force must submit its preliminary findings to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over early childhood programs. By January 15, 2025, the task force must submit the compensation framework and proposed mechanisms

for incorporating the framework into the state's early childhood programs and services to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over early childhood programs.

Sec. 27. **EQUITABLE HEALTH CARE TASK FORCE.**

Subdivision 1. **Establishment; composition of task force.** The commissioner of health shall establish an equitable health care task force consisting of up to 20 members from both metropolitan and greater Minnesota. Members must include representatives of:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x/ communities;

(4) American Indian communities and Tribal Nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities;

(7) organizations that advocate for the rights of individuals using the health care system;

(8) health care providers of primary care and specialty care; and

(9) organizations that provide health coverage in Minnesota.

Subd. 2. **Organization and meetings.** The task force shall be organized and administered under Minnesota Statutes, section 15.059. Meetings shall be held at least quarterly. Subcommittees or workgroups may be established as necessary. Task force meetings are subject to Minnesota Statutes, chapter 13D. The task force shall expire on June 30, 2025.

Subd. 3. **Duties of task force.** The task force shall examine inequities in how people access and receive health care based on race, religion, culture, sexual orientation, gender identity, age, or disability and identify strategies to ensure that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes, to include:

(1) identifying inequities experienced by Minnesotans in interacting with the health care system that originate from or can be attributed to their race, religion, culture, sexual orientation, gender identity, age, or disability status;

(2) conducting community engagement across multiple systems, sectors, and communities to identify barriers for these population groups that result in diminished standards of care and foregone care;

(3) identifying promising practices to improve the experience of care and health outcomes for individuals in these population groups; and

(4) making recommendations for changes in health care system practices or health insurance regulations that would address identified issues.

ARTICLE 2
HEALTH CARE AFFORDABILITY AND DELIVERY

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

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

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

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

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

Subdivision 1. **Establishment.** The Legislative Coordinating Commission shall establish the Health Care Affordability Board, which shall be governed as a board under section 15.012, paragraph (a), to protect consumers, state and local governments, health plan companies, providers, and other health care system stakeholders from unaffordable health care costs. The board must be operational by January 1, 2024.

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

(1) five members appointed by the governor;

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

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

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

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

(b) All appointed members must have knowledge and demonstrated expertise in one or more of the following areas: health care finance, health economics, health care management or administration at a senior level, health care consumer advocacy, representing the health care workforce as a leader in a labor organization, purchasing health care insurance as a

health benefits administrator, delivery of primary care, health plan company administration, public or population health, and addressing health disparities and structural inequities.

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

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

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

(b) A board member may resign at any time by giving written notice to the board.

Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from the members appointed by the governor.

(b) The board shall elect a chair to replace the acting chair at the first meeting of the board by a majority of the members. The chair shall serve for two years.

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

Subd. 5. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time executive director and other staff, who shall serve in the unclassified service. The executive director must have significant knowledge and expertise in health economics and demonstrated experience in health policy.

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

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

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

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

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

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

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

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

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

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

(c) At each public meeting, the board shall provide the opportunity for comments from the public, including the opportunity for written comments to be submitted to the board prior to a decision by the board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) enhance the transparency of provider organizations;

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 4. **Office of Patient Protection.** The board shall establish an Office of Patient Protection, to be operational by January 1, 2025. The office shall assist consumers with issues related to access and quality of health care, and advise the legislature on ways to reduce consumer health care spending and improve consumer experiences by reducing complexity for consumers.

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

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

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

(b) The health care spending growth target must:

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

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

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

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

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

(6) incorporate specific benchmarks related to health equity.

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

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

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

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

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

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

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

(5) ensure that growth targets:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The performance improvement plan shall identify the causes of the entity's cost growth and shall include but not be limited to specific strategies, adjustments, and action steps the entity proposes to implement to improve cost performance. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan must not exceed 18 months.

(e) The board shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation. If the board determines that the performance improvement plan is unacceptable or incomplete, the board may provide consultation on the criteria that have not been met and may allow an additional time period of up to 30 calendar days for resubmission. Upon approval of the proposed performance improvement plan, the board shall notify the health care entity to begin immediate

implementation of the performance improvement plan. Public notice shall be provided by the board on its website, identifying that the health care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the board. The board shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

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

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

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

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

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

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

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

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

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

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

(4) knowingly failed to provide information required by this subdivision to the board or knowingly provided false information, the board may assess a civil penalty to the health care entity of not more than $500,000. The board may only impose a civil penalty if the

board determines that the health care entity is unlikely to voluntarily comply with all applicable provisions of this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 10. **[62V.13] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM.**

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

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

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

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

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

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

Subd. 3. **Outreach letter and special enrollment period.** (a) MNsure must provide a written letter of the projected assessment under subdivision 2 to a taxpayer who indicates

to the commissioner of revenue that the taxpayer is interested in obtaining information on access to health insurance.

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2022, section 270B.14, is amended by adding a subdivision to read:

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

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

Sec. 12. **[290.433] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM CHECKOFF.**

Subdivision 1. **Taxpayer designation.** Any individual who files an income tax return may designate on their original return a request that the commissioner provide their return

information to the MNsure board for purposes of providing the individual with information about potential eligibility for financial assistance and health insurance enrollment options under section 62V.13, to the extent necessary to administer the easy enrollment health insurance outreach program.

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

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

Sec. 13. **DIRECTION TO MNSURE BOARD AND COMMISSIONER.**

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

Sec. 14. **RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

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

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

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

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

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

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

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

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