SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 5046

(SENATE AUTHORS: KLEIN)

DATE	D-PG	OFFICIAL STATUS
04/09/2026		Introduction and first reading
		Referred to Commerce and Consumer Protection

A bill for an act

relating to commerce; eliminating the Prescription Drug Affordability Advisory Council; modifying various provisions governing nondepository financial institutions; providing for health plan regulatory alignment; transferring duties and employees; modifying the premium security plan; appropriating money and making reductions; requiring reports; amending Minnesota Statutes 2024, sections 47.20, subdivision 1; 47.59, subdivision 1; 47.60, subdivision 1; 53.04, subdivision 3a; 53B.74; 53C.09, subdivision 4; 56.002; 56.01; 56.05; 58.06, subdivision 2; 58B.051; 60A.50, subdivisions 1, 3; 60A.951, subdivision 3; 60A.985, subdivision 8; 60A.9853, subdivision 1; 60A.9854; 60B.03, subdivision 2; 60G.01, subdivisions 2, 4; 62A.02, subdivision 8; 62A.021, subdivision 1; 62A.61; 62A.65, subdivisions 7, 8; 62D.08, subdivisions 1, 2, 3, 7, by adding a subdivision; 62D.12, subdivision 1; 62D.124, subdivision 5; 62D.221, subdivisions 1, 2; 62E.11, subdivisions 9, 13; 62E.23, subdivision 1; 62J.40; 62J.60, subdivision 5; 62J.89, subdivisions 1, 2; 62J.90, subdivision 2; 62K.07, subdivision 2; 62L.02, subdivision 8; 62L.08, subdivision 11; 62L.09, subdivision 3; 62L.10, subdivision 4; 62L.11, subdivision 2; 62M.11; 62Q.01, subdivision 2; 62Q.106; 62Q.188, subdivision 2; 62Q.37, subdivision 2; 62Q.47; 62Q.51, subdivision 3; 62Q.556, subdivisions 3, 4; 62Q.69, subdivisions 2, 3; 62Q.71; 62Q.73, subdivisions 3, 10; 62Q.81, subdivision 7; 62U.04, subdivision 13; 62W.06, by adding a subdivision; 332.52, subdivision 3; 332A.04, subdivision 1; 332B.04, subdivision 1; Minnesota Statutes 2025 Supplement, sections 62D.21; 62D.211; 62E.23, subdivisions 1a, 2; 297I.20, subdivision 7; proposing coding for new law in Minnesota Statutes, chapters 60A; 62D; repealing Minnesota Statutes 2024, sections 56.08; 62J.86, subdivision 2; 62J.88; 332A.02, subdivision 2; 332B.02, subdivision 2.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1
COMMERCE FINANCE

Section 1. **HEALTH MAINTENANCE ORGANIZATIONS AND COUNTY-BASED PURCHASERS REGULATION; APPROPRIATION.**

$1,750,000 in fiscal year 2027 is appropriated from the general fund to the commissioner of commerce to regulate health maintenance organizations and county-based purchasers.

Sec. 2. **APPROPRIATION REDUCTION.**

The commissioner of management and budget must reduce the Department of Health's fiscal year 2027 general fund appropriation by $1,750,000 and must reduce the Department of Health's fiscal year 2027 state government special revenue fund appropriation by $1,836,000 to account for the transfer of health maintenance organization and county-based purchaser regulatory responsibilities to the commissioner of commerce. These reductions are ongoing.

ARTICLE 2
PRESCRIPTION DRUG AFFORDABILITY ADVISORY COUNCIL

Section 1. Minnesota Statutes 2024, section 62J.89, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For purposes of this section, "conflict of interest" means a financial or personal association that has the potential to bias or have the appearance of biasing a person's decisions in matters related to the board~~, the advisory council,~~ or in the conduct of the board's ~~or council's~~ activities. A conflict of interest includes any instance in which a person, a person's immediate family member, including a spouse, parent, child, or other legal dependent, or an in-law of any of the preceding individuals, has received or could receive a direct or indirect financial benefit of any amount deriving from the result or findings of a decision or determination of the board. For purposes of this section, a financial benefit includes honoraria, fees, stock, the value of the member's, immediate family member's, or in-law's stock holdings, and any direct financial benefit deriving from the finding of a review conducted under sections 62J.85 to 62J.95. Ownership of securities is not a conflict of interest if the securities are: (1) part of a diversified mutual or exchange traded fund; or (2) in a tax-deferred or tax-exempt retirement account that is administered by an independent trustee.

Sec. 2. Minnesota Statutes 2024, section 62J.89, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Prior to the acceptance of an appointment or employment, or prior to entering into a contractual agreement, a board ~~or advisory council~~ member, board staff member, or third-party contractor must disclose to the appointing authority or the board any conflicts of interest. The information disclosed must include the type, nature, and magnitude of the interests involved.

(b) A board member, board staff member, or third-party contractor with a conflict of interest with regard to any prescription drug product under review must recuse themselves from any discussion, review, decision, or determination made by the board relating to the prescription drug product.

(c) Any conflict of interest must be disclosed in advance of the first meeting after the conflict is identified or within five days after the conflict is identified, whichever is earlier.

Sec. 3. Minnesota Statutes 2024, section 62J.90, subdivision 2, is amended to read:

Subd. 2. **Identification of certain prescription drug products.** (a) The board~~, in consultation with the advisory council, shall~~ must identify selected prescription drug products based on the following criteria:

(1) brand name drugs or biologics for which the WAC increases by more than 15 percent or by more than $3,000 during any 12-month period or course of treatment if less than 12 months, after adjusting for changes in the consumer price index (CPI);

(2) brand name drugs or biologics with a WAC of $60,000 or more per calendar year or per course of treatment;

(3) biosimilar drugs that have a WAC that is not at least 20 percent lower than the referenced brand name biologic at the time the biosimilar is introduced; and

(4) generic drugs for which the WAC:

(i) is $100 or more, after adjusting for changes in the CPI, for:

(A) a 30-day supply;

(B) a course of treatment lasting less than 30 days; or

(C) one unit of the drug, if the labeling approved by the Food and Drug Administration does not recommend a finite dosage; and

(ii) increased by 200 percent or more during the immediate preceding 12-month period, as determined by the difference between the resulting WAC and the average WAC reported over the preceding 12 months, after adjusting for changes in the CPI.

The board is not required to identify all prescription drug products that meet the criteria in this paragraph.

(b) The board, in consultation with ~~the advisory council and~~ the commissioner of health, may identify prescription drug products not described in paragraph (a) that may impose costs that create significant affordability challenges for the state health care system or for patients, including but not limited to drugs to address public health emergencies.

(c) The board shall make available to the public the names and related price information of the prescription drug products identified under this subdivision, with the exception of information determined by the board to be proprietary under the standards developed by the board under section 62J.91, subdivision 3, and information provided by the commissioner of health classified as not public data under section 13.02, subdivision 8a, or as trade secret information under section 13.37, subdivision 1, paragraph (b), or as trade secret information under the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended.

Sec. 4. **REPEALER.**

Minnesota Statutes 2024, sections 62J.86, subdivision 2; and 62J.88, are repealed.

ARTICLE 3
NON-DEPOSITORY INSTITUTIONS

Section 1. Minnesota Statutes 2024, section 47.20, subdivision 1, is amended to read:

Subdivision 1. **General authority.** Pursuant to rules the commissioner of commerce finds to be necessary and proper, if any, banks, savings banks, and savings associations organized under the laws of this state or the United States, trust companies, trust companies acting as fiduciaries, and other banking institutions subject to the supervision of the commissioner of commerce, including residential mortgage originators and servicers under chapter 58, and mortgagees or lenders approved or certified by the secretary of housing and urban development or approved or certified by the administrator of veterans affairs, or approved or certified by the administrator of the Farmers Home Administration or any successor, or approved or certified by the Federal Home Loan Mortgage Corporation, or approved or certified by the Federal National Mortgage Association, are authorized:

(1) to make loans and advances of credit and purchases of obligations representing loans and advances of credit which are insured or guaranteed by the secretary of housing and urban development pursuant to the National Housing Act, as amended, or the administrator of veterans affairs pursuant to the Servicemen's Readjustment Act of 1944, as amended, or the administrator of the Farmers Home Administration or any successor pursuant to the Consolidated Farm and Rural Development Act, Public Law 87-128, as amended, and to obtain the insurance or guarantees;

(2) to make loans secured by mortgages on real property and loans secured by a share or shares of stock or a membership certificate or certificates issued to a stockholder or member by a cooperative apartment corporation which the secretary of housing and urban development, the administrator of veterans affairs, or the administrator of the Farmers Home Administration or any successor has insured or guaranteed or made a commitment to insure or guarantee, and to obtain the insurance or guarantees;

(3) to make, purchase, or participate in such loans and advances of credit; including reverse mortgage loans, notwithstanding anything in subdivision 4b, sections 47.58 and 334.01, and chapter 56 or 58 to the contrary; as would be eligible for purchase, in whole or in part, by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation, but without regard to any limitation placed upon the maximum principal amount of an eligible loan; and

(4) to make, purchase or participate in such loans and advances of credit secured by mortgages on real property which are authorized or allowed by the Office of Thrift Supervision or the Office of the Comptroller of the Currency, or any successor to these federal agencies.

Sec. 2. Minnesota Statutes 2024, section 47.59, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following definitions shall apply.

(a) "Actuarial method" has the meaning given the term in Code of Federal Regulations, title 12, part 226, and appendix J thereto.

(b) "Annual percentage rate" has the meaning given the term in Code of Federal Regulations, title 12, part 226, but using the definition of "finance charge" used in this section.

(c) "Borrower" means a debtor under a loan or a purchaser or debtor under a credit sale contract.

(d) "Business purpose" means a purpose other than a personal, family, household, or agricultural purpose.

(e) "Cardholder" means a person to whom a credit card is issued or who has agreed with the financial institution to pay obligations arising from the issuance to or use of the card by another person.

(f) "Consumer loan" means a loan made by a financial institution in which:

(1) the debtor is a person other than an organization;

(2) the debt is incurred primarily for a personal, family, or household purpose; and

(3) the debt is payable in installments or a finance charge is made.

(g) "Credit" means the right granted by a financial institution to a borrower to defer payment of a debt, to incur debt and defer its payment, or to purchase property or services and defer payment.

(h) "Credit card" means a card or device issued under an arrangement pursuant to which a financial institution gives to a cardholder the privilege of obtaining credit from the financial institution or other person in purchasing or leasing property or services, obtaining loans, or otherwise. A transaction is "pursuant to a credit card" only if credit is obtained according to the terms of the arrangement by transmitting information contained on the card or device orally, in writing, by mechanical or electronic methods, or in any other manner. A transaction is not "pursuant to a credit card" if the card or device is used solely in that transaction to:

(1) identify the cardholder or evidence the cardholder's creditworthiness and credit is not obtained according to the terms of the arrangement;

(2) obtain a guarantee of payment from the cardholder's deposit account, whether or not the payment results in a credit extension to the cardholder by the financial institution; or

(3) effect an immediate transfer of funds from the cardholder's deposit account by electronic or other means, whether or not the transfer results in a credit extension to the cardholder by the financial institution.

(i) "Credit sale contract" means a contract evidencing a credit sale. "Credit sale" means a sale of goods or services, or an interest in land, in which:

(1) credit is granted by a seller who regularly engages as a seller in credit transactions of the same kind; and

(2) the debt is payable in installments or a finance charge is made.

(j) "Finance charge" has the meaning given in Code of Federal Regulations, title 12, part 226, except that the following will not in any event be considered a finance charge:

(1) a charge as a result of default or delinquency under subdivision 6 if made for actual unanticipated late payment, delinquency, default, or other similar occurrence, and a charge made for an extension or deferment under subdivision 5, unless the parties agree that these charges are finance charges;

(2) an additional charge under subdivision 6;

(3) a discount, if a financial institution purchases a loan at less than the face amount of the obligation or purchases or satisfies obligations of a cardholder pursuant to a credit card and the purchase or satisfaction is made at less than the face amount of the obligation;

(4) fees paid by a borrower to a broker, provided the financial institution or a person described in subdivision 4 does not require use of the broker to obtain credit; or

(5) a commission, expense reimbursement, or other sum received by a financial institution or a person described in subdivision 4 in connection with insurance described in subdivision 6.

(k) "Financial institution" means a state or federally chartered bank, a state or federally chartered bank and trust, a trust company with banking powers, a state or federally chartered saving bank, a state or federally chartered savings association, an industrial loan and thrift company organized under chapter 53, a sales finance company organized under chapter 53C, a regulated lender organized under chapter 56, a mortgage originator or servicer licensed under chapter 58, or an operating subsidiary of any such institution.

(l) "Loan" means:

(1) the creation of debt by the financial institution's payment of money to the borrower or a third person for the account of the borrower;

(2) the creation of debt pursuant to a credit card in any manner, including a cash advance or the financial institution's honoring a draft or similar order for the payment of money drawn or accepted by the borrower, paying or agreeing to pay the borrower's obligation, or purchasing or otherwise acquiring the borrower's obligation from the obligee or the borrower's assignee;

(3) the creation of debt by a cash advance to a borrower pursuant to an overdraft line of credit arrangement;

(4) the creation of debt by a credit to an account with the financial institution upon which the borrower is entitled to draw immediately;

(5) the forbearance of debt arising from a loan; and

(6) the creation of debt pursuant to open-end credit.

"Loan" does not include the forbearance of debt arising from a sale or lease, a credit sale contract, or an overdraft from a person's deposit account with a financial institution which is not pursuant to a written agreement to pay overdrafts with the right to defer repayment thereof.

(m) "Official fees" means:

(1) fees and charges which actually are or will be paid to public officials for determining the existence of or for perfecting, releasing, terminating, or satisfying a security interest or mortgage relating to a loan or credit sale, and any separate fees or charges which actually are or will be paid to public officials for recording a notice described in section 580.032, subdivision 1; and

(2) premiums payable for insurance in lieu of perfecting a security interest or mortgage otherwise required by a financial institution in connection with a loan or credit sale, if the premium does not exceed the fees and charges described in clause (1), which would otherwise be payable.

(n) "Organization" means a corporation, government, government subdivision or agency, trust, estate, partnership, joint venture, cooperative, limited liability company, limited liability partnership, or association.

(o) "Person" means a natural person or an organization.

(p) "Principal" means the total of:

(1) the amount paid to, received by, or paid or repayable for the account of, the borrower; and

(2) to the extent that payment is deferred:

(i) the amount actually paid or to be paid by the financial institution for additional charges permitted under this section; and

(ii) prepaid finance charges.

Sec. 3. Minnesota Statutes 2024, section 47.60, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the terms defined have the meanings given them:

(a) "Consumer small loan" is a loan transaction in which cash is advanced to a borrower for the borrower's own personal, family, or household purpose. A consumer small loan is a short-term, unsecured loan to be repaid in a single installment. The cash advance of a consumer small loan is equal to or less than $350. A consumer small loan includes an indebtedness evidenced by but not limited to a promissory note or agreement to defer the presentation of a personal check for a fee.

(b) "Consumer small loan lender" is a financial institution as defined in section 47.59 or a business entity registered with the commissioner and engaged in the business of making or arranging consumer small loans. For purposes of this paragraph, arranging a consumer small loan includes but is not limited to any substantial involvement to facilitate, market, generate leads for, underwrite, or collect a consumer small loan.

(c) "Annual percentage rate" means a measure of the cost of credit, expressed as a yearly rate, that relates the amount and timing of value received by the consumer to the amount and timing of payments made. Annual percentage rate includes all interest, finance charges, and fees. The annual percentage rate must be determined in accordance with either the actuarial method or the United States Rule method.

Sec. 4. Minnesota Statutes 2024, section 53.04, subdivision 3a, is amended to read:

Subd. 3a. **Loans.** (a) The right to make loans, secured or unsecured, at the rates and on the terms and other conditions permitted under chapters 47 and 334. Loans made under this authority must be in amounts in compliance with section 53.05, clause (7). A licensee making a loan under this chapter secured by a lien on real estate shall comply with the requirements of section 47.20, subdivision 8. A licensee making a loan that is a consumer small loan, as defined in section 47.60, subdivision 1, paragraph (a), must comply with section 47.60. A licensee making a loan that is a consumer short-term loan, as defined in section 47.601, subdivision 1, paragraph ~~(d)~~ (e), must comply with section 47.601.

(b) Loans made under this subdivision may be secured by real or personal property, or both. If the proceeds of a loan secured by a first lien on the borrower's primary residence are used to finance the purchase of the borrower's primary residence, the loan must comply with the provisions of section 47.20.

(c) An agency or instrumentality of the United States government or a corporation otherwise created by an act of the United States Congress or a lender approved or certified by the secretary of housing and urban development, or approved or certified by the administrator of veterans affairs, or approved or certified by the administrator of the Farmers Home Administration, or approved or certified by the Federal Home Loan Mortgage Corporation, or approved or certified by the Federal National Mortgage Association, that engages in the business of purchasing or taking assignments of mortgage loans and undertakes direct collection of payments from or enforcement of rights against borrowers arising from mortgage loans, is not required to obtain a certificate of authorization under this chapter in order to purchase or take assignments of mortgage loans from persons holding a certificate of authorization under this chapter.

(d) This subdivision does not authorize an industrial loan and thrift company to make loans under an overdraft checking plan.

Sec. 5. Minnesota Statutes 2024, section 53B.74, is amended to read:

53B.74 VIRTUAL CURRENCY BUSINESS ACTIVITIES; ADDITIONAL REQUIREMENTS.

(a) A licensee engaged in virtual currency business activities ~~may include virtual currency in the licensee's calculation of tangible net worth, by measuring the average value of the virtual currency in United States dollar equivalent over the prior six months, excluding control of virtual currency for a person entitled to the protections under section 53B.73.~~ is not required to subtract virtual currency from total assets in the licensee's calculation of tangible net worth if:

(1) the licensee's day-to-day business includes incurring obligations to customers denominated in the virtual currency;

(2) the virtual currency asset has a corresponding liability denominated in the virtual currency;

(3) the virtual currency is unencumbered; and

(4) the virtual currency assets that are not subtracted from total assets are limited to the virtual currency assets that have a corresponding liability denominated in the same virtual currency.

(b) A licensee must maintain, for all virtual-currency business activity with or on behalf of a person five years after the date of the activity, a record of:

(1) each of the licensee's transactions with or on behalf of the person, or for the licensee's account in Minnesota, including:

(i) the identity of the person;

(ii) the form of the transaction;

(iii) the amount, date, and payment instructions given by the person; and

(iv) the account number, name, and United States Postal Service address of the person, and, to the extent feasible, other parties to the transaction;

(2) the aggregate number of transactions and aggregate value of transactions by the licensee with or on behalf of the person and for the licensee's account in this state, expressed in the United States dollar equivalent of the virtual currency for the previous 12 calendar months;

(3) each transaction in which the licensee exchanges one form of virtual currency for money or another form of virtual currency with or on behalf of the person;

(4) a general ledger posted at least monthly that lists all of the licensee's assets, liabilities, capital, income, and expenses;

(5) each business-call report the licensee is required to create or provide to the department or NMLS;

(6) bank statements and bank reconciliation records for the licensee and the name, account number, and United States Postal Service address of each bank the licensee uses to conduct virtual-currency business activity with or on behalf of the person;

(7) a report of any dispute with the person; and

(8) a report of any virtual-currency business activity transaction with or on behalf of a person which the licensee was unable to complete.

(c) A licensee must maintain records required by paragraph (b) in a form that enables the commissioner to determine whether the licensee is in compliance with this chapter, any court order, and law of Minnesota other than this chapter.

Sec. 6. Minnesota Statutes 2024, section 53C.09, subdivision 4, is amended to read:

Subd. 4. **Other law may apply.** In lieu of this section and sections 53C.01, subdivisions 2, 4, and 13; 53C.08; 53C.10; and 53C.11, a retail seller or sales finance company may proceed under section 47.59 ~~relating to credit sales made by a third party~~, subdivisions 4, 4a, and 6. In cases where the retail seller or sales finance company proceeds under section

47.59, the remaining provisions of sections 53C.01 to 53C.14 apply notwithstanding section 47.59.

Sec. 7. Minnesota Statutes 2024, section 56.002, is amended to read:

56.002 APPLICATION.

This chapter does not apply to a person doing business under and as permitted by any law of this state or of the United States relating to banks, savings associations, trust companies, licensed pawnbrokers, a residential mortgage originator or servicer licensed under chapter 58 that offers residential mortgage origination services or residential mortgage servicing, or credit unions. Notwithstanding the provisions of section 56.01, an industrial loan and thrift company under chapter 53 may contract for and receive the charges, including those in section 56.155, authorized by this chapter without being licensed pursuant to this chapter, but shall comply with all other provisions of this chapter when contracting for or receiving charges on loans regulated by this chapter.

Sec. 8. Minnesota Statutes 2024, section 56.01, is amended to read:

56.01 NECESSITY OF LICENSE.

(a) Except as authorized by this chapter and without first obtaining a license from the commissioner, no person shall engage in the business of making loans of money, credit, goods, or things in action, in an amount or of a value not exceeding that specified in section 56.131, subdivision 1, and charge, contract for, or receive on the loan a greater rate of interest, discount, or consideration than the lender would be permitted by law to charge if not a licensee under this chapter. A person must obtain a license from the commissioner under this chapter before arranging a consumer short-term loan under section 47.601.

(b) An agency or instrumentality of the United States government or a corporation otherwise created by an act of the United States Congress or a lender approved or certified by the secretary of housing and urban development, or approved or certified by the administrator of veterans affairs, or approved or certified by the administrator of the Farmers Home Administration, or approved or certified by the Federal Home Loan Mortgage Corporation, or approved or certified by the Federal National Mortgage Association, that engages in the business of purchasing or taking assignments of mortgage loans and undertakes direct collection of payments from or enforcement of rights against borrowers arising from mortgage loans, is not required to be licensed under this chapter in order to purchase or take assignments of mortgage loans from licensees under this chapter.

Sec. 9. Minnesota Statutes 2024, section 56.05, is amended to read:

56.05 LICENSE; TO BE POSTED.

(a) The license shall state the address at which the business is to be conducted and shall state fully the name of the licensee, and if the licensee is a copartnership or association, the names of the members thereof, and if a corporation, the date and place of its incorporation.

(b) The license shall be kept conspicuously posted in the place of business of the licensee, and shall not be transferable or assignable. For a licensee that offers service via the Internet, the license number must be clearly displayed on each web page or other document required by an order issued by the commissioner.

Sec. 10. Minnesota Statutes 2024, section 58.06, subdivision 2, is amended to read:

Subd. 2. **Application contents.** (a) The application must contain the name and complete business address or addresses of the license applicant. The license applicant must be a partnership, limited liability partnership, association, limited liability company, corporation, or other form of business organization, and the application must contain the names and complete business addresses of each partner, member, director, and principal officer. The application must also include a description of the activities of the license applicant, in the detail and for the periods the commissioner may require.

(b) ~~A residential mortgage originator~~ An applicant must submit a surety bond that meets the requirements of section 58.08, subdivision 1a.

(c) The application must also include all of the following:

(1) an affirmation under oath that the applicant:

(i) is in compliance with the requirements of section 58.125;

(ii) will advise the commissioner of any material changes to the information submitted in the most recent application within ten days of the change;

(iii) will advise the commissioner in writing immediately of any bankruptcy petitions filed against or by the applicant or licensee;

(iv) will maintain at all times a surety bond in the amount of at least ~~$100,000~~ $125,000;

(v) complies with federal and state tax laws; and

(vi) complies with sections 345.31 to 345.60, the Minnesota unclaimed property law;

(2) information as to the mortgage lending, servicing, or brokering experience of the applicant and persons in control of the applicant;

(3) information as to criminal convictions, excluding traffic violations, of persons in control of the license applicant;

(4) whether a court of competent jurisdiction has found that the applicant or persons in control of the applicant have engaged in conduct evidencing gross negligence, fraud, misrepresentation, or deceit in performing an act for which a license is required under this chapter;

(5) whether the applicant or persons in control of the applicant have been the subject of: an order of suspension or revocation, cease and desist order, or injunctive order, or order barring involvement in an industry or profession issued by this or another state or federal regulatory agency or by the Secretary of Housing and Urban Development within the ten-year period immediately preceding submission of the application; and

(6) other information required by the commissioner.

Sec. 11. Minnesota Statutes 2024, section 58B.051, is amended to read:

58B.051 REGISTRATION FOR LENDERS.

(a) Beginning January 1, 2025, a lender must register with the commissioner as a lender before providing services in Minnesota. A lender must not offer or make a student loan to a resident of Minnesota without first registering with the commissioner as provided in this section.

(b) A registration application must include:

(1) the lender's name;

(2) the lender's address;

(3) the names of all officers, directors, owners, or other persons in control of an applicant, as defined in section 58B.02, subdivision 6; and

(4) any other information the commissioner requires ~~by rule~~.

(c) Registration issued or renewed expires December 31 of each year. A lender must renew the lender's registration on an annual basis.

(d) The commissioner may adopt and enforce:

(1) registration procedures for lenders, which may include using the Nationwide Multistate Licensing System and Registry;

(2) nonrefundable registration fees for lenders, which may include fees for using the Nationwide Multistate Licensing System and Registry, to be paid directly by the lender;

(3) procedures and nonrefundable fees to renew a lender's registration, which may include fees for the renewed use of Nationwide Multistate Licensing System and Registry, to be paid directly by the lender; and

(4) alternate registration procedures and nonrefundable fees for postsecondary education institutions that offer student loans.

Sec. 12. Minnesota Statutes 2024, section 332.52, subdivision 3, is amended to read:

Subd. 3. **Credit services organization.** (a) "Credit services organization" means any person that, with respect to the extension of credit by others, sells, provides, performs, or represents that the person will sell, provide, or perform, in return for the payment of money or other valuable consideration, any of the following services:

(1) improve a buyer's credit record, history, or rating;

(2) obtain an extension of credit for a buyer; or

(3) provide advice or assistance to a buyer with regard to either clause (1) or (2).

(b) "Credit services organization" does not include:

(1) any person authorized to make loans or extensions of credit under the laws of this state or the United States, if the person is subject to regulation and supervision by this state or the United States or a lender approved by the United States Secretary of Housing and Urban Development for participation in any mortgage insurance program under the National Housing Act, United States Code, title 12, section 1701 et seq.;

(2) any bank, savings bank, or savings and loan institution whose deposits or accounts are eligible for insurance by the Federal Deposit Insurance Corporation or a subsidiary of the bank, savings bank, or savings and loan institution;

(3) any credit union, federal credit union, or out-of-state credit union doing business in this state;

(4) any nonprofit organization exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, as amended through December 31, 1990;

(5) any person ~~licensed as a prorating agency~~ registered as a debt management services provider or debt settlement services provider under the laws of this state, if the person is acting within the course and scope of ~~that license~~ the applicable registration;

(6) any person licensed as a real estate broker by this state if the person is acting within the course and scope of that license;

(7) any person licensed as a collection agency under the laws of this state if the person is acting within the course and scope of that license;

(8) any person licensed to practice law in this state if the person renders services within the course and scope of practice as an attorney;

(9) any broker-dealer registered with the Securities and Exchange Commission or the Commodity Futures Trading Commission if the broker-dealer is acting within the course and scope of that regulation; or

(10) any consumer reporting agency as defined in the federal Fair Credit Reporting Act, United States Code, title 15, sections 1681 to 1681t, as amended through December 31, 1990.

Sec. 13. Minnesota Statutes 2024, section 332A.04, subdivision 1, is amended to read:

Subdivision 1. **Form.** Application for registration to operate as a debt management services provider in this state must be made in writing to the commissioner, under oath, in the form prescribed by the commissioner, and must contain:

(1) the full name of each principal of the entity applying;

(2) the address, which must not be a post office box, and the telephone number and, if applicable, email address, of the applicant;

(3) identification of the trust account required under section 332A.13;

(4) consent to the jurisdiction of the courts of this state;

(5) the name and address of the registered agent authorized to accept service of process on behalf of the applicant or appointment of the commissioner as the applicant's agent for purposes of accepting service of process;

(6) disclosure of:

(i) whether any controlling or affiliated party has ever been convicted of a crime or found civilly liable for an offense involving moral turpitude, including forgery, embezzlement, obtaining money under false pretenses, larceny, extortion, conspiracy to defraud, or any other similar offense or violation, or any violation of a federal or state law or regulation in connection with activities relating to the rendition of debt management services or involving any consumer fraud, false advertising, deceptive trade practices, or similar consumer protection law;

(ii) any judgments, private or public litigation, tax liens, written complaints, administrative actions, or investigations by any government agency against the applicant or any officer, director, manager, or shareholder owning more than five percent interest in the applicant, unresolved or otherwise, filed or otherwise commenced within the preceding ten years;

(iii) whether the applicant or any person employed by the applicant has had a record of having defaulted in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; and

(iv) whether the applicant's license or registration to provide debt management services in any other state has ever been revoked or suspended;

(7) a copy of the applicant's standard debt management services agreement that the applicant intends to execute with debtors; and

~~(8) proof of accreditation, unless the applicant was licensed in Minnesota as a debt prorater immediately before August 1, 2007; and~~

~~(9)~~ (8) any other information and material as the commissioner may require.

The commissioner may, for good cause shown, temporarily waive any requirement of this subdivision.

Sec. 14. Minnesota Statutes 2024, section 332B.04, subdivision 1, is amended to read:

Subdivision 1. **Form.** Application for registration to operate as a debt settlement services provider in this state must be made in writing to the commissioner, under oath, in the form prescribed by the commissioner, and must contain:

(1) the full name of each principal of the entity applying;

(2) the address, which must not be a post office box, and the telephone number and, if applicable, email address of the applicant;

(3) consent to the jurisdiction of the courts of this state;

(4) the name and address of the registered agent authorized to accept service of process on behalf of the applicant or appointment of the commissioner as the applicant's agent for purposes of accepting service of process;

(5) disclosure of:

(i) whether any controlling or affiliated party has ever been convicted of a crime or found civilly liable for an offense involving moral turpitude, including forgery, embezzlement, obtaining money under false pretenses, larceny, extortion, conspiracy to defraud, or any

other similar offense or violation, or any violation of a federal or state law or regulation in connection with activities relating to the rendition of debt settlement services or involving any consumer fraud, false advertising, deceptive trade practices, or similar consumer protection law;

(ii) any judgments, private or public litigation, tax liens, written complaints, administrative actions, or investigations by any government agency against the applicant or any officer, director, manager, or shareholder owning more than five percent interest in the applicant, unresolved or otherwise, filed or otherwise commenced within the preceding ten years;

(iii) whether the applicant or any person employed by the applicant has had a record of having defaulted in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; and

(iv) whether the applicant's license or registration to provide debt settlement services in any other state has ever been revoked or suspended;

(6) a copy of the applicant's standard debt settlement services agreement that the applicant intends to execute with debtors; and

~~(7) proof of accreditation, unless the applicant submits an affidavit attesting that the applicant does not provide credit counseling services; and~~

~~(8)~~ (7) any other information and material as the commissioner may require.

The commissioner may, for good cause shown, temporarily waive any requirement of this subdivision.

Sec. 15. **REPEALER.**

Minnesota Statutes 2024, sections 56.08; 332A.02, subdivision 2; and 332B.02, subdivision 2, are repealed.

ARTICLE 4
HEALTH PLAN REGULATORY ALIGNMENT

Section 1. **[60A.071] SUBSTANTIAL ENROLLMENT GROWTH; NOTIFICATION.**

Subdivision 1. **Notice required.** (a) No later than April 15 each year, an insurance company that issues health plans, as defined in section 62A.011, and is licensed under this chapter to offer, sell, or issue a policy of accident and sickness insurance, as defined in section 62A.01, subdivision 1, or that is a nonprofit health service plan corporation operating under chapter 62C must notify the commissioner if, for an insurance company or nonprofit

health service plan corporation with at least 25,000 enrollees, the insurance company or nonprofit health service plan corporation:

(1) increases the total number of enrollees, as of April 1 in the current calendar year, by more than 35 percent of the insurance company's or nonprofit health service plan corporation's total number of enrollees for the immediately preceding calendar year; or

(2) increases the total number of enrollees in a specific line of business or product by a percentage that is greater than the percentage of growth threshold established by the commissioner for the specific line of business or product.

(b) For purposes of this section, the number of enrollees must be calculated in a manner consistent with the insurance company or nonprofit health service plan corporation's reported covered lives in the company's National Association of Insurance Commissioners Annual Statement.

Subd. 2. **Additional information.** (a) Upon receiving notice under subdivision 1, the commissioner may request and the insurance company or nonprofit health service plan corporation must provide additional information regarding the insurance company's or nonprofit health service plan corporation's financial readiness to serve the increased enrollment. The additional information requested may include but is not limited to:

(1) the conditions contributing to the insurance company's or nonprofit health service plan corporation's enrollment growth;

(2) a three-year projected statutory balance sheet, income statements, and cash flow statements for the current year and the subsequent two years;

(3) the key assumptions impacting the projections and the sensitivity of the projections to the assumptions; and

(4) a description of anticipated issues associated with the insurance company's or nonprofit health service plan corporation's business, including but not limited to (i) assets, (ii) anticipated business growth and associated surplus strain, (iii) significant change in risk profile, (iv) mix of business, and (v) reinsurance use, if any, in each case.

(b) If the information reported under paragraph (a) raises a concern with respect to an insurance company's or nonprofit health service plan corporation's business on a prospective basis due to anticipated business growth, including but not limited to anticipated business growth, strain on surplus, increased exposure to risk, or an imbalanced mix of business, the commissioner may issue a corrective order specifying corrective actions the commissioner

determines are required. A corrective order issued under this paragraph is subject to review under chapter 14.

Sec. 2. Minnesota Statutes 2024, section 60A.50, subdivision 1, is amended to read:

Subdivision 1. **Scope.** For purposes of sections 60A.50 to ~~60A.592~~ 60A.593, the terms in subdivisions 2 to 13 have the meanings given ~~them~~.

Sec. 3. Minnesota Statutes 2024, section 60A.50, subdivision 3, is amended to read:

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of commerce ~~or the commissioner of health, whichever commissioner otherwise regulates the health organization~~.

Sec. 4. **[60A.593] PROHIBITED ACTIVITIES.**

A domestic health organization that has a total adjusted capital equal to or less than the domestic health organization's company action level RBC is prohibited from, without receiving advance approval from the commissioner: (1) increasing the salary or benefits of an officer or director, or (2) making preferential payment of bonuses, dividends, or other payments the commissioner determines are preferential.

Sec. 5. Minnesota Statutes 2024, section 60A.951, subdivision 3, is amended to read:

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of commerce ~~for insurers regulated by the commissioner of commerce, and means the commissioner of health for insurers regulated by the commissioner of health~~.

Sec. 6. Minnesota Statutes 2024, section 60A.985, subdivision 8, is amended to read:

Subd. 8. **Licensee.** "Licensee" means any person licensed, authorized to operate, or registered, or required to be licensed, authorized, or registered by the Department of Commerce ~~or the Department of Health~~ under chapters 59A to 62M, 62Q to 62V, and 64B to 79A.

Sec. 7. Minnesota Statutes 2024, section 60A.9853, subdivision 1, is amended to read:

Subdivision 1. **Notification to the commissioner.** Each licensee shall notify the commissioner of commerce ~~or commissioner of health, whichever commissioner otherwise regulates the licensee,~~ without unreasonable delay but in no event later than five business days from a determination that a cybersecurity event has occurred when either of the following criteria has been met:

(1) this state is the licensee's state of domicile, in the case of an insurer, or this state is the licensee's home state, in the case of a producer, as those terms are defined in chapter 60K and the cybersecurity event has a reasonable likelihood of materially harming:

(i) any consumer residing in this state; or

(ii) any part of the normal operations of the licensee; or

(2) the licensee reasonably believes that the nonpublic information involved is of 250 or more consumers residing in this state and that is either of the following:

(i) a cybersecurity event impacting the licensee of which notice is required to be provided to any government body, self-regulatory agency, or any other supervisory body pursuant to any state or federal law; or

(ii) a cybersecurity event that has a reasonable likelihood of materially harming:

(A) any consumer residing in this state; or

(B) any part of the normal operations of the licensee.

Sec. 8. Minnesota Statutes 2024, section 60A.9854, is amended to read:

60A.9854 POWER OF COMMISSIONER.

(a) The commissioner of commerce ~~or commissioner of health, whichever commissioner otherwise regulates the licensee, shall have~~ has power to examine and investigate into the affairs of any licensee to determine whether the licensee has been or is engaged in any conduct in violation of sections 60A.985 to 60A.9857. This power is in addition to the powers which the commissioner has under section 60A.031. Any such investigation or examination shall be conducted pursuant to section 60A.031.

(b) Whenever the commissioner of commerce ~~or commissioner of health~~ has reason to believe that a licensee has been or is engaged in conduct in this state which violates sections 60A.985 to 60A.9857, the commissioner of commerce ~~or commissioner of health~~ may take action that is necessary or appropriate to enforce those sections.

Sec. 9. Minnesota Statutes 2024, section 60B.03, subdivision 2, is amended to read:

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce ~~of the state of Minnesota~~ and, in that commissioner's absence or disability, a deputy or other person duly designated to act in that commissioner's place. ~~In the context of rehabilitation or liquidation of a health maintenance organization, "commissioner" means the commissioner~~

~~of health of the state of Minnesota and, in that commissioner's absence or disability, a deputy or other person duly designated to act in that commissioner's place.~~

Sec. 10. Minnesota Statutes 2024, section 60G.01, subdivision 2, is amended to read:

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce~~, except that "commissioner" means the commissioner of health for administrative supervision of health maintenance organizations~~.

Sec. 11. Minnesota Statutes 2024, section 60G.01, subdivision 4, is amended to read:

Subd. 4. **Department.** "Department" means the Department of Commerce~~, except that "department" means the Department of Health for administrative supervision of health maintenance organizations~~.

Sec. 12. Minnesota Statutes 2024, section 62A.02, subdivision 8, is amended to read:

Subd. 8. **Filing by health carriers for purposes of complying with the certification requirements of MNsure.** No qualified health plan shall be offered through MNsure until its form and the premium rates pertaining to the form have been approved by the commissioner of commerce ~~or health, as appropriate,~~ and the health plan has been determined to comply with the certification requirements of MNsure in accordance with an agreement between the commissioners of commerce and health and MNsure.

Sec. 13. Minnesota Statutes 2024, section 62A.021, subdivision 1, is amended to read:

Subdivision 1. **Loss ratio standards.** (a) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, and except as otherwise authorized by section 62A.02, subdivision 3a, for individual policies or certificates, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health

maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and all types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1, 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

(b) All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

(c) A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner

shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

(d) Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

(e)(1) For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(2) For purposes of this section, (i) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (ii) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

(f) The loss ratio phase-in as described in paragraph (a) does not apply to individual policies and small employer policies issued by a health plan company that is assessed less than three percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. These policies must meet a 68 percent loss ratio for individual policies, a 71 percent loss ratio for small employer policies with fewer than ten employees, and a 75 percent loss ratio for all other small employer policies.

(g) Notwithstanding paragraphs (a) and (f), the loss ratio shall be 60 percent for a health plan as defined in section 62A.011, offered by an insurance company licensed under chapter 60A that is assessed less than ten percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. For purposes of the percentage calculation of the association's assessments, an insurance company's assessments include those of its affiliates.

(h) The ~~commissioners~~ commissioner of commerce ~~and health shall each~~ must annually issue a public report listing, by health plan company, the actual loss ratios experienced in

the individual and small employer markets in this state ~~by the health plan companies that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day~~. The report or reports shall be released no later than June 1 for loss ratios experienced for the preceding calendar year. Health plan companies shall provide to the ~~commissioners~~ commissioner any information requested by the ~~commissioners~~ commissioner for purposes of this paragraph.

Sec. 14. Minnesota Statutes 2024, section 62A.61, is amended to read:

62A.61 DISCLOSURE OF METHODS USED BY HEALTH CARRIERS TO DETERMINE USUAL AND CUSTOMARY FEES.

(a) A health carrier that bases reimbursement to health care providers upon a usual and customary fee must maintain in its office a copy of a description of the methodology used to calculate fees including at least the following:

(1) the frequency of the determination of usual and customary fees;

(2) a general description of the methodology used to determine usual and customary fees; and

(3) the percentile of usual and customary fees that determines the maximum allowable reimbursement.

(b) A health carrier must provide a copy of the information described in paragraph (a) to the commissioner of health or the commissioner of commerce, upon request.

(c) The ~~commissioner of health or the~~ commissioner of commerce~~, as appropriate,~~ may use ~~to enforce this section~~ any enforcement powers otherwise available to the commissioner with respect to the health carrier to enforce this section. The commissioner of ~~health or~~ commerce~~, as appropriate,~~ may require health carriers to provide the information required under this section and may use any powers granted under other laws relating to the regulation of health carriers to enforce compliance.

(d) For purposes of this section, "health carrier" has the meaning given in section 62A.011.

(e) "Usual and customary" means the normal charge, in the absence of insurance, of the provider for a service or article, but not more than the prevailing charge in the area for like service or article. A "like service" is the same nature and duration, requires the same skill, and is performed by a provider of similar training and experience. A "like article" is one

that is identically or substantially equivalent. "Area" means the municipality or, in the case of a large city, a subdivision of the city, in which the service or article is actually provided or a greater area as is necessary to obtain a representative cross-section of charges for like service or article.

Sec. 15. Minnesota Statutes 2024, section 62A.65, subdivision 7, is amended to read:

Subd. 7. **Short-term coverage.** (a) For purposes of this section, "short-term coverage" means an individual health plan that:

(1) is issued to provide coverage for a period of 185 days or less, except that the health plan may permit coverage to continue until the end of a period of hospitalization for a condition for which the covered person was hospitalized on the day that coverage would otherwise have ended;

(2) is nonrenewable, provided that the health carrier may provide coverage for one or more subsequent periods that satisfy clause (1), if the total of the periods of coverage do not exceed a total of 365 days out of any 555-day period, plus any additional days covered as a result of hospitalization on the day that a period of coverage would otherwise have ended;

(3) does not cover any preexisting conditions, including ones that originated during a previous identical policy or contract with the same health carrier where coverage was continuous between the previous and the current policy or contract; and

(4) is available with an immediate effective date without underwriting upon receipt of a completed application indicating eligibility under the health carrier's eligibility requirements, provided that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(b) Short-term coverage is not subject to subdivisions 2 and 5. Short-term coverage may exclude as a preexisting condition any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the coverage, but dependent children born or placed for adoption during the policy period must not be subject to this provision.

(c) Notwithstanding subdivision 3, and section 62A.021, a health carrier may combine short-term coverage with its most commonly sold individual qualified plan, as defined in section 62E.02, other than short-term coverage, for purposes of complying with the loss ratio requirement.

(d) The 365-day coverage limitation provided in paragraph (a) applies to the total number of days of short-term coverage that covers a person, regardless of the number of policies, contracts, or health carriers that provide the coverage. A written application for short-term coverage must ask the applicant whether the applicant has been covered by short-term coverage by any health carrier within the 555 days immediately preceding the effective date of the coverage being applied for. Short-term coverage issued in violation of the 365-day limitation is valid until the end of its term and does not lose its status as short-term coverage, in spite of the violation. A health carrier that knowingly issues short-term coverage in violation of the 365-day limitation is subject to the administrative penalties otherwise available to the commissioner of commerce ~~or the commissioner of health, as appropriate~~.

Sec. 16. Minnesota Statutes 2024, section 62A.65, subdivision 8, is amended to read:

Subd. 8. **Cessation of individual business.** Notwithstanding the provisions of subdivisions 1 to 7, a health carrier may elect to cease doing business in the individual health plan market in this state if it complies with the requirements of this subdivision. For purposes of this section, "cease doing business" means to discontinue issuing new individual health plans and to refuse to renew all of the health carrier's existing individual health plans issued in this state whose terms permit refusal to renew under the circumstances specified in this subdivision. This subdivision does not permit cancellation of an individual health plan, unless the terms of the health plan permit cancellation under the circumstances specified in this subdivision. A health carrier electing to cease doing business in the individual health plan market in this state shall notify the commissioner 180 days prior to the effective date of the cessation. Within 30 days after the termination, the health carrier shall submit to the commissioner a complete list of policyholders that have been terminated. The cessation of business does not include the failure of a health carrier to offer or issue new business in the individual health plan market or continue an existing product line in that market, provided that a health carrier does not terminate, cancel, or fail to renew its current individual health plan business. A health carrier electing to cease doing business in the individual health plan market shall provide 120 days' written notice to each policyholder covered by an individual health plan issued by the health carrier. This notice must also inform each policyholder of the existence of the Minnesota Comprehensive Health Association, the requirements for being accepted, the procedures for applying for coverage, and the telephone numbers at the ~~Department of Health and the~~ Department of Commerce for information about private individual or family health coverage. A health carrier that ceases to write new business in the individual health plan market shall continue to be governed by this section with respect to continuing individual health plan business conducted by the health carrier. A health carrier

that ceases to do business in the individual health plan market after July 1, 1994, is prohibited from writing new business in the individual health plan market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the individual health plan market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the individual health plan market in that same service area. The right to refuse to renew an individual health plan under this subdivision does not apply to individual health plans issued on a guaranteed renewable basis that does not permit refusal to renew under the circumstances specified in this subdivision.

Sec. 17. **[62D.015] REGULATORY DUTIES; TRANSFER.**

Subdivision 1. **Transfer and restructuring.** (a) The regulatory oversight with respect to health maintenance organizations transfers from the commissioner of health to the commissioner of commerce on July 1, 2026.

(b) The agency restructuring under this section must be conducted in accordance with sections 15.039 and 43A.045.

Subd. 2. **Succession; employees; liability.** (a) Employees related to the functions assigned to the commissioner of health are transferred to the Department of Commerce 30 days after the date the commissioner of health approves the transfer.

(b) An employee transferred under paragraph (a):

(1) must not have the employee's employment status or job classification altered as a result of the transfer;

(2) if represented by an exclusive representative before the transfer, remains represented by the same exclusive representative after the transfer occurs;

(3) if an applicable collective bargaining agreement with an exclusive representative was effective before the transfer, remains subject to the collective bargaining agreement for the remainder of the agreement's term; and

(4) if employed in a temporary unclassified position, the total length of time that the employee has served in the appointment includes all time served in the appointment at the transferring agency and the time served in the appointment at the department. An employee in a temporary unclassified position who was hired by a transferring agency through an open competitive selection process in accordance with a policy enacted by the commissioner

of management and budget is considered to have been hired through an open competitive selection process after the transfer.

(c) The state must meet and negotiate with the exclusive representatives of transferred employees regarding proposed changes that affect or relate to the transferred employees' terms and conditions of employment to the extent that the proposed changes are not addressed in the applicable collective bargaining agreement.

(d) If the state transfers ownership or control of a department facility, service, or operation to a private or public entity by subcontracting, sale, assignment, lease, or other transfer, the state must require as a written condition of the transfer of ownership or control:

(1) an employee who performs work in the facility, service, or operation must be offered employment with the entity acquiring ownership or control before the entity offers employment to another individual who was not employed by the transferring agency at the time the transfer occurs; and

(2) the entity acquiring ownership or control is prohibited from reducing the transferred employee's wage and benefit standards until the collective bargaining agreement in effect at the time the transfer occurs expires or for a period of two years after the transfer occurs, whichever is longer.

(e) The state of Minnesota and the state's officers or agents are not liable for and are not subject to a cause of action arising from the action or inaction of an entity acquiring ownership or control of a department facility, service, or operation.

Sec. 18. Minnesota Statutes 2024, section 62D.08, subdivision 1, is amended to read:

Subdivision 1. **Notice of changes.** A health maintenance organization shall, unless otherwise provided for by rules adopted by the commissioner of ~~health~~ commerce, file notice with the commissioner of ~~health prior to any modification of~~ commerce before modifying the operations or documents described in the information submitted under section 62D.03, subdivision 4, clauses (a), (b), (e), (f), (g), (i), (j), (l), (m), (n), (o), (p), (q), (r), (s), and (t) ~~of section 62D.03, subdivision 4~~. If the commissioner of ~~health~~ commerce does not disapprove of the filing within 60 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Sec. 19. Minnesota Statutes 2024, section 62D.08, subdivision 2, is amended to read:

Subd. 2. **Annual report required.** Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of ~~health~~ commerce

covering the preceding calendar year. However, utilization data required under subdivision 3, clause (c), shall be filed on or before July 1.

Sec. 20. Minnesota Statutes 2024, section 62D.08, subdivision 3, is amended to read:

Subd. 3. **Report requirements.** ~~Such~~ The report shall be submitted on forms prescribed by the commissioner of ~~health,~~ commerce and shall include:

(a) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) the number of new enrollees enrolled during the year, the number of group enrollees and the number of individual enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) a summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c), in such form as may be required by the commissioner of ~~health~~ commerce;

(d) a report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (c), who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d);

(e) a separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6;

(f) data on the number of complaints received and the category of each complaint as defined by the commissioner. The categories must include access, communication and

behavior, health plan administration, facilities and environment, coordination of care, and technical competence and appropriateness. The commissioner, in consultation with interested stakeholders, shall define complaint categories to be used by each health maintenance organization by July 1, 2017, and the categories must be used by each health maintenance organization beginning calendar year 2018; and

(g) such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of ~~health~~ commerce to carry out the duties under sections 62D.01 to 62D.30.

Sec. 21. Minnesota Statutes 2024, section 62D.08, subdivision 7, is amended to read:

Subd. 7. **Consistent administrative expenses and investment income reporting.** (a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of ~~health~~ commerce.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of ~~health~~ commerce.

Sec. 22. Minnesota Statutes 2024, section 62D.08, is amended by adding a subdivision to read:

Subd. 8. **Information sharing.** The commissioner of commerce must share nonpublic data submitted by health maintenance organizations under this section with (1) the commissioner of health and the commissioner of human services, (2) other state and federal regulatory agencies, and (3) the National Association of Insurance Commissioners, if the requesting recipient under clauses (1) to (3) agrees to maintain the data in a manner consistent with the data's classification under chapter 13. The commissioner of commerce may enter into agreements governing the sharing and use of information, provided the agreements are consistent with this subdivision.

Sec. 23. **[62D.085] SUBSTANTIAL ENROLLMENT GROWTH; NOTICE.**

Subdivision 1. **Notice required.** (a) No later than April 15 each year, a health maintenance organization that is operating under this chapter and that has at least 25,000 enrollees must notify the commissioner if the health maintenance organization:

(1) increases the total number of enrollees, as of April 1 in the current calendar year, by more than 35 percent of the health maintenance organization's total number of enrollees for the immediately preceding calendar year; or

(2) increases the total number of enrollees in a specific line of business or product by a percentage that is greater than the percentage of growth threshold established by the commissioner for the specific line of business or product.

(b) For purposes of this section, the number of enrollees must be calculated in a manner consistent with the health maintenance organization's reported covered lives in the company's National Association of Insurance Commissioners Annual Statement.

Subd. 2. **Additional information.** (a) Upon receiving notice under subdivision 1, the commissioner may request and the health maintenance organization must provide additional information regarding the health maintenance organization's financial readiness to serve the increased enrollment. The additional information requested may include but is not limited to:

(1) the conditions contributing to the health maintenance organization's enrollment growth;

(2) a three-year projected statutory balance sheet, income statements, and cash flow statements for the current year and the subsequent two years;

(3) the key assumptions impacting the projections and the sensitivity of the projections to the assumptions; and

(4) a description of anticipated issues associated with the health maintenance organization's business, including but not limited to (i) assets, (ii) anticipated business growth and associated surplus strain, (iii) significant change in risk profile, (iv) mix of business, and (v) reinsurance use, if any, in each case.

(b) If the information reported under paragraph (a) raises a concern with respect to a health maintenance organization's business on a prospective basis due to anticipated business growth, including but not limited to anticipated business growth, strain on surplus, increased exposure to risk, or an imbalanced mix of business, the commissioner may issue a corrective

order specifying corrective actions the commissioner determines are required. A corrective order issued under this paragraph is subject to review under chapter 14.

Sec. 24. Minnesota Statutes 2024, section 62D.12, subdivision 1, is amended to read:

Subdivision 1. **False representations.** No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Each health maintenance organization ~~shall be~~ is subject to sections 72A.17 to 72A.32~~,~~ ~~relating to the regulation of trade practices, except (a) to the extent that the nature of a health maintenance organization renders such sections clearly inappropriate and (b) that enforcement shall be by the commissioner of health and not by the commissioner of commerce~~. Every health maintenance organization ~~shall be~~ is subject to sections 8.31 and 325F.69.

Sec. 25. Minnesota Statutes 2024, section 62D.124, subdivision 5, is amended to read:

Subd. 5. **Provider networks.** The ~~commissioner of health, the~~ commissioner of commerce~~,~~ and the commissioner of human services shall merge reporting requirements for health maintenance organizations and county-based purchasing plans related to Minnesota Department of ~~Health~~ Commerce oversight of network adequacy under this section and the provider network list reported to the Department of Human Services under Minnesota Rules, part 4685.2100. The commissioners shall work with health maintenance organizations and county-based purchasing plans to ensure that the report merger is done in a manner that simplifies health maintenance organization and county-based purchasing plan reporting processes.

Sec. 26. Minnesota Statutes 2025 Supplement, section 62D.21, is amended to read:

62D.21 FEES.

Every health maintenance organization subject to sections 62D.01 to 62D.30 shall pay to the commissioner of ~~health~~ commerce the following fees:

(1) filing an application for a certificate of authority: $10,000;

(2) filing an amendment to a certificate of authority: $125;

(3) filing each annual report: $400;

(4) filing each quarterly report: $200; and

(5) filing annual plan review documents, amendments to plan documents, and quality plans: $125.

Sec. 27. Minnesota Statutes 2025 Supplement, section 62D.211, is amended to read:

62D.211 RENEWAL FEE.

Each health maintenance organization subject to sections 62D.01 to 62D.30 shall submit to the commissioner of ~~health~~ commerce each year before June 15 a certificate of authority renewal fee in the amount of $30,000 each plus 88 cents per person enrolled in the health maintenance organization on December 31 of the preceding year.

Sec. 28. **[62D.212] HEALTH MAINTENANCE ORGANIZATION REGULATION ACCOUNT.**

(a) A health maintenance organization regulation account is established as a separate account in the special revenue fund in the state treasury. The commissioner of commerce must credit to the account filing fees and renewal fees collected under sections 62D.21 and 62D.211, appropriations and transfers, and other revenue related to the activities identified in paragraph (b). Earnings, including interest, dividends, other earnings arising from the account's assets, and remaining money from fiscal years occurring before July 1, 2026, must be credited to the account. The commissioner of commerce must manage the account.

(b) Money in the account is appropriated to the commissioner of commerce to administer this chapter and to reimburse the department's costs incurred to administer this section.

Sec. 29. Minnesota Statutes 2024, section 62D.221, subdivision 1, is amended to read:

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

Sec. 30. Minnesota Statutes 2024, section 62D.221, subdivision 2, is amended to read:

Subd. 2. **Statement.** In addition to the conditions in section 60D.17, subdivision 1, subjecting a health maintenance organization to filing requirements, no person other than the issuer shall acquire all or substantially all of the assets of a domestic nonprofit health maintenance organization through any means unless at the time the offer, request, or

invitation is made or the agreement is entered into the person has filed with the commissioner and has sent to the health maintenance organization a statement containing the information required in section 60D.17 and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner of ~~health~~ commerce in the manner prescribed in section 60D.17.

Sec. 31. Minnesota Statutes 2024, section 62E.11, subdivision 9, is amended to read:

Subd. 9. **Special assessment upon termination of individual health coverage.** (a) Each contributing member that terminates individual health coverage for reasons other than ~~(a)~~ (1) nonpayment of premium; ~~(b)~~ (2) failure to make co-payments; ~~(c)~~ (3) enrollee moving out of the area served; or ~~(d)~~ (4) a materially false statement or misrepresentation by the enrollee in the application for membership; and does not provide or arrange for replacement coverage that meets the requirements of section 62D.121; shall pay a special assessment to the state plan based upon the number of terminated individuals who join the comprehensive health insurance plan as authorized under section 62E.14, subdivisions 1, paragraph (d), and 6. Such a contributing member shall pay the association an amount equal to the average cost of an enrollee in the state plan in the year in which the member terminated enrollees multiplied by the total number of terminated enrollees who enroll in the state plan.

(b) The average cost of an enrollee in the state comprehensive health insurance plan shall be determined by dividing the state plan's total annual losses by the total number of enrollees from that year. This cost will be assessed to the contributing member who has terminated health coverage before the association makes the annual determination of each contributing member's liability as required under this section.

(c) In the event that the contributing member is terminating health coverage because of a loss of health care providers, the commissioner may review whether or not the special assessment established under this subdivision will have an adverse impact on the contributing member or its enrollees or insureds, including but not limited to causing the contributing member to fall below statutory net worth requirements. If the commissioner determines that the special assessment would have an adverse impact on the contributing member or its enrollees or insureds, the commissioner may adjust the amount of the special assessment, or establish alternative payment arrangements to the state plan. For health maintenance organizations regulated under chapter 62D, the commissioner of ~~health~~ commerce shall make the determination regarding any adjustment in the special assessment ~~and shall transmit that determination to the commissioner of commerce~~.

Sec. 32. Minnesota Statutes 2024, section 62E.11, subdivision 13, is amended to read:

Subd. 13. **State funding; effect on premium rates of members.** In approving the premium rates as required in sections 62A.65, subdivision 3; and 62L.08, subdivision 8, the ~~commissioners~~ commissioner of ~~health and~~ commerce shall ensure that any appropriation to reduce the annual assessment made on the contributing members to cover the costs of the Minnesota comprehensive health insurance plan as required under this section is reflected in the premium rates charged by each contributing member.

Sec. 33. Minnesota Statutes 2024, section 62J.40, is amended to read:

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

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

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

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

(d) The commissioner of commerce may request unique or custom data sets from a state agency in a request under paragraph (c). The state agency may charge the commissioner of

commerce a fee to provide data sets under paragraph (c) at the same rate the state agency charges another public or private entity for the same data.

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

Sec. 34. Minnesota Statutes 2024, section 62J.60, subdivision 5, is amended to read:

Subd. 5. **Annual reporting.** As part of an annual filing made with the commissioner of ~~health or~~ commerce ~~on or after January 1, 2003~~, a group purchaser shall certify compliance with this section and shall submit to the commissioner of ~~health or~~ commerce a copy of the Minnesota uniform health care identification card used by the group purchaser.

Sec. 35. Minnesota Statutes 2024, section 62K.07, subdivision 2, is amended to read:

Subd. 2. **Prescription drug costs.** (a) Each health carrier that offers a prescription drug benefit in its individual health plans or small group health plans shall include in the applicable rate filing required under section 62A.02 the following information about covered prescription drugs:

(1) the 25 most frequently prescribed drugs in the previous plan year;

(2) the 25 most costly prescription drugs as a portion of the individual health plan's or small group health plan's total annual expenditures in the previous plan year;

(3) the 25 prescription drugs that have caused the greatest increase in total individual health plan or small group health plan spending in the previous plan year;

(4) the projected impact of the cost of prescription drugs on premium rates;

(5) if any health plan offered by the health carrier requires enrollees to pay cost-sharing on any covered prescription drugs including deductibles, co-payments, or coinsurance in an amount that is greater than the amount the enrollee's health plan would pay for the drug absent the applicable enrollee cost-sharing and after accounting for any rebate amount; and

(6) if the health carrier prohibits third-party payments including manufacturer drug discounts or coupons that cover all or a portion of an enrollee's cost-sharing requirements including deductibles, co-payments, or coinsurance from applying toward the enrollee's cost-sharing obligations under the enrollee's health plan.

(b) The commissioner of commerce must share reported data with the commissioner of health and, in consultation with the commissioner of health, shall release a summary of the

information reported in paragraph (a) at the same time as the information required under section 62A.02, subdivision 2, paragraph (c).

Sec. 36. Minnesota Statutes 2024, section 62L.02, subdivision 8, is amended to read:

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of commerce ~~for health carriers subject to the jurisdiction of the Department of Commerce or the commissioner of health for health carriers subject to the jurisdiction of the Department of Health, or the relevant commissioner's designated representative. For purposes of sections 62L.13 to 62L.22, "commissioner" means the commissioner of commerce or that commissioner's designated representative~~.

Sec. 37. Minnesota Statutes 2024, section 62L.08, subdivision 11, is amended to read:

Subd. 11. **Loss ratio standards.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, each policy or contract form used with respect to a health benefit plan offered, or issued in the small employer market, is subject, beginning July 1, 1993, to section 62A.021. ~~The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.~~

Sec. 38. Minnesota Statutes 2024, section 62L.09, subdivision 3, is amended to read:

Subd. 3. **Reentry prohibition.** (a) Except as otherwise provided in paragraph (b), a health carrier that ceases to do business in the small employer market after July 1, 1993, is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the small employer market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the small employer market in that same service area.

(b) The commissioner of commerce ~~or the commissioner of health~~ may permit a health carrier that ceases to do business in the small employer market in this state after July 1, 1993, to begin writing new business in the small employer market if:

(1) since the carrier ceased doing business in the small employer market, legislative action has occurred that has significantly changed the effect on the carrier of its decision to cease doing business in the small employer market; and

(2) the commissioner deems it appropriate.

Sec. 39. Minnesota Statutes 2024, section 62L.10, subdivision 4, is amended to read:

Subd. 4. **Review of premium rates.** The commissioner shall regulate premium rates charged or proposed to be charged by all health carriers in the small employer market under section 62A.02. ~~The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.~~

Sec. 40. Minnesota Statutes 2024, section 62L.11, subdivision 2, is amended to read:

Subd. 2. **Enforcement powers.** The ~~commissioners~~ commissioner of ~~health and~~ commerce ~~each~~ has, for purposes of this chapter, all of ~~each~~ the commissioner's ~~respective~~ powers under other chapters that are applicable to ~~their respective~~ the commissioner's duties under this chapter.

Sec. 41. Minnesota Statutes 2024, section 62M.11, is amended to read:

62M.11 COMPLAINTS TO COMMERCE ~~OR HEALTH~~.

Notwithstanding the provisions of this chapter, an enrollee may file a complaint regarding an adverse determination directly to the commissioner ~~responsible for regulating the utilization review organization~~ of commerce.

Sec. 42. Minnesota Statutes 2024, section 62Q.01, subdivision 2, is amended to read:

Subd. 2. **Commissioner.** "Commissioner" means ~~the commissioner of health for purposes of regulating health maintenance organizations, and community integrated service networks, or~~ the commissioner of commerce for purposes of regulating ~~all other~~ health plan companies. For all other purposes, "commissioner" means the commissioner of health.

Sec. 43. Minnesota Statutes 2024, section 62Q.106, is amended to read:

62Q.106 DISPUTE RESOLUTION BY COMMISSIONER.

(a) A complainant may at any time submit a complaint to the ~~appropriate~~ commissioner to investigate. After investigating a complaint, or reviewing a company's decision, the ~~appropriate~~ commissioner may order a remedy as authorized under chapter 45, 60A, or 62D.

(b) In investigating a complaint filed against a health maintenance organization regarding a vulnerable adult, upon request, the commissioner of ~~health~~ commerce must interview at least one family member of the complainant or the subject of the complaint. If the

complainant or the subject of the complaint does not want any family members to be interviewed, this information will be included in the investigative file.

Sec. 44. Minnesota Statutes 2024, section 62Q.188, subdivision 2, is amended to read:

Subd. 2. **Flexible benefits plan.** Notwithstanding any provision of this chapter, chapter 363A, or any other law to the contrary, a health plan company may offer, sell, issue, and renew a health plan that is a flexible benefits plan under this section if the following requirements are satisfied:

(1) the health plan must be offered in compliance with the laws of this state, except as otherwise permitted in this section;

(2) the health plan must be designed to enable covered persons to better manage costs and coverage options through the use of co-pays, deductibles, and other cost-sharing arrangements;

(3) the health plan may modify or exclude any or all coverages of benefits that would otherwise be required by law, except for maternity benefits and other benefits required under federal law;

(4) each health plan and plan's premiums must be approved by the commissioner of ~~health or~~ commerce, ~~whichever is appropriate under section 62Q.01, subdivision 2,~~ but ~~neither~~ the commissioner may not disapprove a plan on the grounds of a modification or exclusion permitted under clause (3); and

(5) prior to the sale of the health plan, the purchaser must be given a written list of the coverages otherwise required by law that are modified or excluded in the health plan. The list must include a description of each coverage in the list and indicate whether the coverage is modified or excluded. If coverage is modified, the list must describe the modification. The list may, but is not required to, also list any or all coverages otherwise required by law that are included in the health plan and indicate that they are included. The health plan company must require that a copy of this written list be provided, prior to the effective date of the health plan, to each enrollee or employee who is eligible for health coverage under the plan.

Sec. 45. Minnesota Statutes 2024, section 62Q.37, subdivision 2, is amended to read:

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

(b) "Commissioner" means the commissioner of ~~health for purposes of regulating health maintenance organizations and community integrated service networks, the commissioner of~~ commerce for purposes of regulating health maintenance organizations and nonprofit health service plan corporations, or the commissioner of human services for the purpose of contracting with managed care organizations serving persons enrolled in programs under chapter 256B or 256L.

(c) "Health plan company" means (1) a nonprofit health service plan corporation operating under chapter 62C; (2) a health maintenance organization operating under chapter 62D; (3) a community integrated service network operating under chapter 62N; or (4) a managed care organization operating under chapter 256B or 256L.

(d) "Nationally recognized independent organization" means (1) an organization that sets specific national standards governing health care quality assurance processes, utilization review, provider credentialing, marketing, and other topics covered by this chapter and other chapters and audits and provides accreditation to those health plan companies that meet those standards. The American Accreditation Health Care Commission (URAC), the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Accreditation Association for Ambulatory Health Care (AAAHC) are, at a minimum, defined as nationally recognized independent organizations; and (2) the Centers for Medicare and Medicaid Services for purposes of reviews or audits conducted of health plan companies under Part C of Title XVIII of the Social Security Act or under section 1876 of the Social Security Act.

(e) "Performance standard" means those standards relating to quality management and improvement, access and availability of service, utilization review, provider selection, provider credentialing, marketing, member rights and responsibilities, complaints, appeals, grievance systems, enrollee information and materials, enrollment and disenrollment, subcontractual relationships and delegation, confidentiality, continuity and coordination of care, assurance of adequate capacity and services, coverage and authorization of services, practice guidelines, health information systems, and financial solvency.

Sec. 46. Minnesota Statutes 2024, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons seeking chemical dependency services under section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health services, psychiatric residential treatment facility services, and inpatient hospital and residential chemical dependency and alcoholism services, except for persons seeking chemical dependency services under section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) All health plan companies offering health plans that provide coverage for alcoholism, mental health, or chemical dependency benefits shall provide reimbursement for the benefits delivered through the psychiatric Collaborative Care Model, which must include the following Current Procedural Terminology or Healthcare Common Procedure Coding System billing codes:

(1) 99492;

(2) 99493;

(3) 99494;

(4) G2214; and

(5) G0512.

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

(i) The commissioner of commerce shall update the list of codes in paragraph (h) if any alterations or additions to the billing codes for the psychiatric Collaborative Care Model are made.

(j) "Psychiatric Collaborative Care Model" means the evidence-based, integrated behavioral health service delivery method described at Federal Register, volume 81, page 80230, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes but is not limited to the following elements:

(1) care directed by the primary care team;

(2) structured care management;

(3) regular assessments of clinical status using validated tools; and

(4) modification of treatment as appropriate.

(k) By June 1 of each year~~, beginning June 1, 2021~~, the commissioner of commerce~~, in consultation with the commissioner of health,~~ shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section, section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

Sec. 47. Minnesota Statutes 2024, section 62Q.51, subdivision 3, is amended to read:

Subd. 3. **Rate approval.** The premium rates and cost sharing requirements for each option must be submitted to ~~the commissioner of health or~~ the commissioner of commerce as required by law. A health plan that includes lower enrollee cost sharing for services provided by network providers than for services provided by out-of-network providers, or lower enrollee cost sharing for services provided with prior authorization or second opinion than for services provided without prior authorization or second opinion, qualifies as a point-of-service option.

Sec. 48. Minnesota Statutes 2024, section 62Q.556, subdivision 3, is amended to read:

Subd. 3. **Annual data reporting.** (a) Beginning April 1, 2024, a health plan company must report annually to the commissioner of ~~health~~ commerce:

(1) the total number of claims and total billed and paid amounts for nonparticipating provider services, by service and provider type, submitted to the health plan in the prior calendar year; and

(2) the total number of enrollee complaints received regarding the rights and protections established by the No Surprises Act in the prior calendar year.

(b) The ~~commissioners~~ commissioner of commerce ~~and health~~ shall develop the form and manner for health plan companies to comply with paragraph (a).

Sec. 49. Minnesota Statutes 2024, section 62Q.556, subdivision 4, is amended to read:

Subd. 4. **Enforcement.** (a) Any provider or facility, including a health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to the relevant provisions of the No Surprises Act is subject to the requirements of this section and section 62J.811.

(b) The commissioner of commerce ~~or health~~ shall enforce this section.

(c) If a health-related licensing board has cause to believe that a provider has violated this section, it may further investigate and enforce the provisions of this section pursuant to chapter 214.

Sec. 50. Minnesota Statutes 2024, section 62Q.69, subdivision 2, is amended to read:

Subd. 2. **Procedures for filing a complaint.** (a) A complainant may submit a complaint to a health plan company either by telephone or in writing. If a complaint is submitted orally and the resolution of the complaint, as determined by the complainant, is partially or wholly adverse to the complainant, or the oral complaint is not resolved to the satisfaction of the complainant, by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing. The health plan company must also offer to provide the complainant with any assistance needed to submit a written complaint, including an offer to complete the complaint form for a complaint that was previously submitted orally and promptly mail the completed form to the complainant for the complainant's signature. At the complainant's request, the health plan company must provide the assistance requested by the complainant. The complaint form must include the following information:

(1) the telephone number of the health plan company member services or other departments or persons equipped to advise complainants on complaint resolution;

(2) the address to which the form must be sent;

(3) a description of the health plan company's internal complaint procedure and the applicable time limits; and

(4) the toll-free telephone number of ~~either~~ the commissioner of ~~health or~~ commerce and notification that the complainant has the right to submit the complaint at any time to the ~~appropriate~~ commissioner for investigation.

(b) Upon receipt of a written complaint, the health plan company must notify the complainant within ten business days that the complaint was received, unless the complaint is resolved to the satisfaction of the complainant within the ten business days.

(c) Each health plan company must provide, in the member handbook, subscriber contract, or certification of coverage, a clear and concise description of how to submit a complaint and a statement that, upon request, assistance in submitting a written complaint is available from the health plan company.

Sec. 51. Minnesota Statutes 2024, section 62Q.69, subdivision 3, is amended to read:

Subd. 3. **Notification of complaint decisions.** (a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint. If the health plan company cannot make a decision within 30 days due to circumstances outside the control of the health plan company, the health plan company may take up to 14 additional days to notify the complainant of its decision. If the health plan company takes any additional days beyond the initial 30-day period to make its decision, it must inform the complainant, in advance, of the extension and the reasons for the extension.

(b) For group health plans, if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.

(c) For individual health plans, if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to submit the complaint decision to the external review process described in section 62Q.73 and the procedure for initiating the external review process. Notwithstanding the provisions in this subdivision, a health plan company offering individual coverage may instead follow the process for group health plans outlined in paragraph (b).

(d) The notification must also inform the complainant of the right to submit the complaint at any time to ~~either~~ the commissioner of ~~health or~~ commerce for investigation and the toll-free telephone number of the ~~appropriate~~ commissioner.

Sec. 52. Minnesota Statutes 2024, section 62Q.71, is amended to read:

62Q.71 NOTICE TO ENROLLEES.

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain authorization for health care services;

(3) how to request an appeal either through the procedures described in section 62Q.70, if applicable, or through the procedures described in chapter 62M;

(4) of the right to file a complaint with ~~either~~ the commissioner of ~~health or~~ commerce at any time during the complaint and appeal process;

(5) of the toll-free telephone number of the ~~appropriate~~ commissioner; and

(6) of the right, for individual and group coverage, to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised, including that under most circumstances an enrollee must exhaust the internal complaint or appeal process prior to external review. However, an enrollee may proceed to external review without exhausting the internal complaint or appeal process under the following circumstances:

(i) the health plan company waives the exhaustion requirement;

(ii) the health plan company is considered to have waived the exhaustion requirement by failing to substantially comply with any requirements including, but not limited to, time limits for internal complaints or appeals; or

(iii) the enrollee has applied for an expedited external review at the same time the enrollee has applied for internal review under chapter 62M.

Sec. 53. Minnesota Statutes 2024, section 62Q.73, subdivision 3, is amended to read:

Subd. 3. **Right to external review.** (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination, if applicable under section 62Q.68, subdivision 1, or 62M.06, ~~to the commissioner of health if the request involves a health plan company regulated by that commissioner or~~ to the commissioner of commerce ~~if the request involves a health plan company regulated by that commissioner~~. Notification of the enrollee's right to external review must accompany the denial issued by the insurer.

(b) Nothing in this section requires the commissioner of ~~health or~~ commerce to independently investigate an adverse determination referred for independent external review.

(c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review must be borne by the health plan company.

(d) The enrollee must request external review within six months from the date of the adverse determination.

Sec. 54. Minnesota Statutes 2024, section 62Q.73, subdivision 10, is amended to read:

Subd. 10. **Data reporting.** The ~~commissioners~~ commissioner of commerce shall make available to the public, upon request, summary data on the decisions rendered under this section, including the number of reviews heard and decided and the final outcomes. Any data released to the public must not individually identify the enrollee initiating the request for external review.

Sec. 55. Minnesota Statutes 2024, section 62Q.81, subdivision 7, is amended to read:

Subd. 7. **Standard plans.** (a) A health plan company that offers individual health plans must ensure that no less than one individual health plan at each level of coverage described in subdivision 1, paragraph (b), clause (3), that the health plan company offers in each geographic rating area the health plan company serves conforms to the standard plan parameters determined by the commissioner under paragraph (e).

(b) An individual health plan offered under this subdivision must be:

(1) clearly and appropriately labeled as standard plans to aid the purchaser in the selection process;

(2) marketed as standard plans and in the same manner as other individual health plans offered by the health plan company; and

(3) offered for purchase to any individual.

(c) This subdivision does not apply to catastrophic plans, grandfathered plans, small group health plans, large group health plans, health savings accounts, qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(d) Health plan companies must meet the requirements in this subdivision separately for plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

(e) The commissioner of commerce~~, in consultation with the commissioner of health,~~ must annually determine standard plan parameters, including but not limited to cost-sharing structure and covered benefits, that comprise a standard plan in Minnesota.

(f) Notwithstanding section 62A.65, subdivision 2, a health plan company may discontinue offering a health plan under this subdivision if, three years after the date the plan is initially offered, the plan has fewer than 75 enrollees. A health plan company discontinuing a health plan under this paragraph may discontinue a health plan that has fewer than 75 enrollees if it:

(1) provides notice of the plan's discontinuation in writing, in a form prescribed by the commissioner, to each enrollee of the plan at least 90 calendar days before the date the coverage is discontinued;

(2) offers on a guaranteed issue basis to each enrollee the option to purchase an individual health plan currently being offered by the health plan company for individuals in that geographic rating area. An enrollee who does not select an option shall be automatically enrolled in the individual health plan closest in actuarial value to the enrollee's current plan; and

(3) acts uniformly without regard to any health status-related factor of an enrollee or an enrollee's dependents who may become eligible for coverage.

Sec. 56. Minnesota Statutes 2024, section 62U.04, subdivision 13, is amended to read:

Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The commissioner or the commissioner's designee shall make the data submitted under subdivisions 4, 5, 5a, and 5b, including data classified as private or nonpublic, available to: (1) individuals and organizations engaged in research on, or efforts to effect transformation

in, health care outcomes, access, quality, disparities, or spending, provided the use of the data serves a public benefit; and (2) the commissioner of commerce, subject to the data use requirements under subdivision 11, paragraph (b), to perform health insurance oversight duties.

(b) Data made available under this subdivision may not be used to:

(1) create an unfair market advantage for any participant in the health care market in Minnesota, including health plan companies, payers, and providers;

(2) reidentify or attempt to reidentify an individual in the data; or

(3) publicly report contract details between a health plan company and provider and derived from the data.

~~(b)~~ (c) To implement ~~paragraph~~ paragraphs (a) and (b), the commissioner shall:

(1) establish detailed requirements for data access; a process for data users to apply to access and use the data; legally enforceable data use agreements to which data users must consent; a clear and robust oversight process for data access and use, including a data management plan, that ensures compliance with state and federal data privacy laws; agreements for state agencies and the University of Minnesota to ensure proper and efficient use and security of data; and technical assistance for users of the data and for stakeholders;

(2) develop a fee schedule to support the cost of expanded access to and use of the data, provided the fees charged under the schedule do not create a barrier to access or use for those most affected by disparities; and

(3) create a research advisory group to advise the commissioner on applications for data use under this subdivision, including an examination of the rigor of the research approach, the technical capabilities of the proposed user, and the ability of the proposed user to successfully safeguard the data.

Sec. 57. Minnesota Statutes 2024, section 62W.06, is amended by adding a subdivision to read:

Subd. 4. **Data sharing.** Notwithstanding subdivision 2, paragraph (d), the commissioner must provide the data under subdivision 2, paragraph (a), to the commissioner of health. The commissioner of health must maintain data received under this section in a manner consistent with the data's classification under subdivision 2, paragraph (d).

Sec. 58. **REVISOR INSTRUCTION.**

(a) Except as otherwise provided in this act, the revisor of statutes shall substitute the term "commissioner of commerce" for the term "commissioner of health" wherever the term appears in (1) Minnesota Statutes, chapters 62D, except section 62D.02, subdivision 12; 62L; and 62Q, except sections 62Q.19 and 62Q.33; (2) Minnesota Statutes, sections 60B.15, 60B.191, 60B.20, 62K.09, 62K.10, 62K.105, 62K.12, 62K.13, 62K.14, 62W.05, 256B.69, and 256B.692; (3) Minnesota Rules, chapters 4685, 2740, 4688; and (4) Minnesota Rules, part 9510.2020, subparts 3 and 8, item (C). The revisor shall also make any necessary grammatical changes to verbs or other words to conform with this substitution.

(b) The revisor of statutes shall remove the term "commissioner of health" wherever the term appears in Minnesota Rules, chapter 2730.

ARTICLE 5
REINSURANCE

Section 1. Minnesota Statutes 2024, section 62E.23, subdivision 1, is amended to read:

Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes. Nothing in this paragraph prohibits the association from providing technical assistance or information regarding the association of the Minnesota premium security plan.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) ~~By August 15 of the year following the applicable benefit year, the association must disburse all applicable reinsurance payments to an eligible health carrier.~~ For benefit year 2027, the commissioner must transfer the total amount of money necessary for the association to pay all applicable reinsurance payments to each eligible health carrier by August 15, 2028.

(h) For benefit year 2027, the association must disburse applicable reinsurance payments to an eligible health carrier no later than August 31, 2028.

Sec. 2. Minnesota Statutes 2025 Supplement, section 62E.23, subdivision 1a, is amended to read:

Subd. 1a. **2028 assessment on group health carriers.** (a) An assessment is imposed in calendar year 2028 on group health carriers operating ~~under the~~ in Minnesota ~~premium security plan in~~ during benefit year 2027. This is a onetime assessment.

(b) By May 1, 2028, the association must provide each group health carrier with an estimate of the carrier's assessment under paragraph (a).

(c) By June 30, 2028, the association must ~~notify each group health carrier of the carrier's assessment amount under paragraph (a). The association must determine~~ propose each carrier's assessment amount, in consultation with the commissioner, based on the group health carrier's portion of the total premiums for group health plans written in Minnesota for benefit year 2027. The commissioner must approve the carrier's assessment amount. The ~~association must establish the~~ final assessment amount for each group health plan ~~so~~ must ensure that the aggregate assessment amount collected from group health plans under this subdivision equals the amount necessary for the appropriations and transfers under section 62E.25, subdivision 1. By July 25, 2028, the association must notify each group health carrier of the carrier's proposed assessment amount under paragraph (a).

(d) Subject to paragraph (e), each group health carrier must pay the assessment under paragraph (a) to the ~~association~~ commissioner by August ~~1~~ 29, 2028, for deposit in the premium security plan account created under section 62E.25. A group health plan must pay the assessment in the manner determined by the commissioner.

(e) A group health carrier may apply to the commissioner to defer all or part of the assessment imposed under paragraph (a). The application must be submitted to the commissioner by May 15, 2028. The commissioner may defer all or part of the assessment if the commissioner determines the payment of the assessment places the group health carrier in a financially impaired condition. The commissioner may deny an application for deferral under this paragraph. No later than June 15, 2028, the commissioner must notify the association and the group health carrier whether the assessment deferral is approved or denied. If the commissioner approves the deferral request, the notice must include the amount of and due date for the deferred portion of the assessment. If all or part of the assessment is deferred, the association must include the amount deferred in the other group health carriers' assessments in a proportionate manner consistent with this subdivision. ~~The~~ A group health carrier that receives a deferral is liable to the ~~association~~ commissioner for the amount deferred and is prohibited from receiving or becoming entitled to a reinsurance payment under the Minnesota premium security plan until the group health carrier has paid the deferred assessment.

(f) If the association determines the assessment imposed under paragraph (a) exceeds or is less than the amount necessary to operate and administer the Minnesota premium security plan and issue reinsurance payments, the association must require group health carriers to pay an additional amount or the association must issue a refund to the group health carriers. The association must determine the accuracy of the assessment by ~~May 30~~ March 15, 2029.

~~(g) By August 15, 2028, the association must remit the assessments collected under this subdivision to the commissioner for deposit in the premium security plan account created under section 62E.25.~~

Sec. 3. Minnesota Statutes 2025 Supplement, section 62E.23, subdivision 2, is amended to read:

Subd. 2. **Payment parameters.** (a) The board must design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market;

(2) will increase participation in the individual market;

(3) will improve access to health care providers and services for those in the individual market;

(4) mitigate the impact high-risk individuals have on premium rates in the individual market;

(5) take into account any federal funding available for the plan;

(6) for benefit year 2027, take into account the assessment under subdivision 1a;

(7) ensure the premium security plan account created under section 62E.25, subdivision 1, has sufficient money to ensure MNsure's stable operation after taking into account the Minnesota premium security plan's effect on MNsure's funding; and

(8) take into account the total amount available to fund the plan.

(b) The attachment point for the plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the board at $50,000 or more, but not exceeding the reinsurance cap.

(c) The coinsurance rate for the plan is the rate at which the association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board at a rate between 50 and 80 percent.

(d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board at $250,000 or less.

(e) The board may adjust the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8.

(f) For purposes of paragraph (a), clause (7), the ~~association~~ commissioner must consult with the commissioner of management and budget and the board of directors of MNsure to determine the amount of funding necessary to ensure MNsure's stable operation.

Sec. 4. Minnesota Statutes 2025 Supplement, section 297I.20, subdivision 7, is amended to read:

Subd. 7. **Reinsurance credit.** Beginning with taxable years after December 31, 2028, a taxpayer may claim a credit against the premiums tax imposed under this chapter equal to the amount of the assessment paid by the taxpayer under section 62E.23 in the immediately

preceding calendar year. If the amount of the credit exceeds the liability for tax under this chapter, the commissioner must refund the excess to the ~~insurance company~~ taxpayer. An amount sufficient to pay the refunds under this section is appropriated to the commissioner from the general fund. The credit under this subdivision does not affect the calculation of fire state aid under section 477B.03 and police state aid under section 477C.03. The commissioner of commerce must annually provide to the commissioner a list of assessments paid by taxpayers under section 62E.23 by March 1 of the calendar year following the assessment.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2028.

APPENDIX
Article locations for 26-08197

ARTICLE 1 COMMERCE FINANCE..... Page.Ln 2.2
ARTICLE 2 PRESCRIPTION DRUG AFFORDABILITY ADVISORY COUNCIL. Page.Ln 2.15
ARTICLE 3 NON-DEPOSITORY INSTITUTIONS..... Page.Ln 4.20
ARTICLE 4 HEALTH PLAN REGULATORY ALIGNMENT..... Page.Ln 18.24
ARTICLE 5 REINSURANCE..... Page.Ln 51.12

56.08 ANNUAL LICENSE FEE.

Every licensee shall, on or before the 20th day of each December, pay to the commissioner the sum of $150 as an annual license fee for the next succeeding calendar year.

62J.86 DEFINITIONS.

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

62J.88 PRESCRIPTION DRUG AFFORDABILITY ADVISORY COUNCIL.

Subdivision 1. **Establishment.** The governor shall appoint a 18-member stakeholder advisory council to provide advice to the board on drug cost issues and to represent stakeholders' views. The governor shall appoint the members of the advisory council based on the members' knowledge and demonstrated expertise in one or more of the following areas: the pharmaceutical business; practice of medicine; patient perspectives; health care cost trends and drivers; clinical and health services research; and the health care marketplace.

Subd. 2. **Membership.** The council's membership shall consist of the following:

(1) two members representing patients and health care consumers;

(2) two members representing health care providers;

(3) one member representing health plan companies;

(4) two members representing employers, with one member representing large employers and one member representing small employers;

(5) one member representing government employee benefit plans;

(6) one member representing pharmaceutical manufacturers;

(7) one member who is a health services clinical researcher;

(8) one member who is a pharmacologist;

(9) one member representing the commissioner of health with expertise in health economics;

(10) one member representing pharmaceutical wholesalers;

(11) one member representing pharmacy benefit managers;

(12) one member from the Rare Disease Advisory Council;

(13) one member representing generic drug manufacturers;

(14) one member representing pharmaceutical distributors; and

(15) one member who is an oncologist who is not employed by, under contract with, or otherwise affiliated with a hospital.

Subd. 3. **Terms.** (a) The initial appointments to the advisory council must be made by January 1, 2024. 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, the 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, except that those advisory council members designated in subdivision 2, clauses (10) to (15), must not be compensated.

Subd. 5. **Meetings.** Meetings of the advisory council are subject to chapter 13D. The advisory council shall meet publicly at least every three months to advise the board on drug cost issues related to the prescription drug product information submitted to the board under section 62J.90.

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

332A.02 DEFINITIONS.

Subd. 2. **Accreditation.** "Accreditation" means certification as an accredited credit counseling provider by the Council on Accreditation, the Bureau Veritas Certification North America, Inc., or BSI Management Systems America, Inc.

332B.02 DEFINITIONS.

Subd. 2. **Accreditation.** "Accreditation" means certification as an accredited credit counseling provider by the Council on Accreditation, the Bureau Veritas Certification North America, Inc., or BSI Management Systems America, Inc.