..... moves to amend S.F. No. 3656, the second engrossment, the Article 24 Health Coverage delete everything amendment (A18-0939), in conference committee, as follows:

Page 400, delete article 24 and insert:

"ARTICLE 1

HEALTH COVERAGE

Section 1. Minnesota Statutes 2016, section 62A.30, is amended by adding a subdivision to read:

Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive mammogram screening shall include digital breast tomosynthesis for enrollees at risk for breast cancer, and shall be covered as a preventive item or service, as described under section 62Q.46.

(b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:

(1) having a family history with one or more first- or second-degree relatives with breast cancer;

(2) testing positive for BRCA1 or BRCA2 mutations;

(3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(4) having a previous diagnosis of breast cancer.

(c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L.

(d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2019.

(e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.

EFFECTIVE DATE. This section is effective January 1, 2019, and applies to health plans issued, sold, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2016, 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~~ than 12 months;

(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~~ may be renewed for only one additional period meeting the requirements of clause (1); and

(3) does not cover any preexisting conditions for the first six months of coverage, 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. 3. **[62J.824] FACILITY FEE DISCLOSURE.**

(a) Prior to the delivery of nonemergency services, a provider-based clinic that charges a facility fee shall provide notice to any patient stating that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense.

(b) Each health care facility must post prominently in locations easily accessible to and visible by patients, including its Web site, a statement that the provider-based clinic is part of a hospital and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense.

(c) This section does not apply to laboratory services, imaging services, or other ancillary health services that are provided by staff who are not employed by the health care facility or clinic.

(d) For purposes of this section:

(1) "facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses; and

(2) "provider-based clinic" means the site of an off-campus clinic or provider office located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144, and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

Sec. 4. **[62Q.48] POINT OF SALE ALLOWABLE COST.**

(a) No health plan company or pharmacy benefits manager shall require an enrollee to make a payment at the point of sale for a prescription drug that is covered under the enrollee's health plan in an amount greater than the allowable cost to consumers.

(b) For purposes of this section:

(1) "allowable cost to consumers" means the lowest of:

(i) the applicable co-payment for the prescription drug under the enrollee's health plan; or

(ii) the amount an individual would pay for the prescription drug if the individual purchased the prescription drug without using a health plan benefit; and

(2) "pharmacy benefit manager" has the meaning provided in section 151.71, subdivision 1.

Sec. 5. Minnesota Statutes 2016, section 151.214, subdivision 2, is amended to read:

Subd. 2. **No prohibition on disclosure.** No contracting agreement between an employer-sponsored health plan or health plan company, or its contracted pharmacy benefit manager, and a resident or nonresident pharmacy ~~registered~~ licensed under this chapter, may prohibit ~~the~~:

(1) a pharmacy from disclosing to patients information a pharmacy is required or given the option to provide under subdivision 1; or

(2) a pharmacist from informing a patient when the amount the patient is required to pay under the patient's health plan for a particular drug is greater than the amount the patient would be required to pay for the same drug if purchased out-of-pocket at the pharmacy's usual and customary price.

Sec. 6. **[151.555] PRESCRIPTION DRUG REPOSITORY PROGRAM.**

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

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility registered under chapter 144D where there is centralized storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47; or

(6) a drug manufacturer licensed under section 151.252.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription and nonprescription medical supply needed to administer a prescription drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

Subd. 2. **Establishment.** By January 1, 2019, the Board of Pharmacy shall establish a drug repository program, through which donors may donate a drug or medical supply for use by an individual who meets the eligibility criteria specified under subdivision 5. The board shall contract with a central repository that meets the requirements of subdivision 3 to implement and administer the prescription drug repository program.

Subd. 3. **Central repository requirements.** (a) The board shall publish a request for proposal for participants who meet the requirements of this subdivision and are interested in acting as the central repository for the drug repository program. The board shall follow all applicable state procurement procedures in the selection process.

(b) To be eligible to act as the central repository, the participant must be a wholesale drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance with all applicable federal and state statutes, rules, and regulations.

(c) The central repository shall be subject to inspection by the board pursuant to section 151.06, subdivision 1.

Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the drug repository program, a health care facility must agree to comply with all applicable federal and state laws, rules, and regulations pertaining to the drug repository program, drug storage, and dispensing. The facility must also agree to maintain in good standing any required state license or registration that may apply to the facility.

(b) A local repository may elect to participate in the program by submitting the following information to the central repository on a form developed by the board and made available on the board's Web site:

(1) the name, street address, and telephone number of the health care facility and any state-issued license or registration number issued to the facility, including the issuing state agency;

(2) the name and telephone number of a responsible pharmacist or practitioner who is employed by or under contract with the health care facility; and

(3) a statement signed and dated by the responsible pharmacist or practitioner indicating that the health care facility meets the eligibility requirements under this section and agrees to comply with this section.

(c) Participation in the drug repository program is voluntary. A local repository may withdraw from participation in the drug repository program at any time by providing written notice to the central repository on a form developed by the board and made available on the board's Web site. The central repository shall provide the board with a copy of the withdrawal notice within ten business days from the date of receipt of the withdrawal notice.

Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for the drug repository program, an individual must submit to a local repository an intake application form that is signed by the individual and attests that the individual:

(1) is a resident of Minnesota;

(2) is uninsured, has no prescription drug coverage, or is underinsured;

(3) acknowledges that the drugs or medical supplies to be received through the program may have been donated; and

(4) consents to a waiver of the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

(b) Upon determining that an individual is eligible for the program, the local repository shall furnish the individual with an identification card. The card shall be valid for one year

from the date of issuance and may be used at any local repository. A new identification card may be issued upon expiration once the individual submits a new application form.

(c) The local repository shall send a copy of the intake application form to the central repository by regular mail, facsimile, or secured e-mail within ten days from the date the application is approved by the local repository.

(d) The board shall develop and make available on the board's Web site an application form and the format for the identification card.

Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a) A donor may donate prescription drugs or medical supplies to the central repository or a local repository if the drug or supply meets the requirements of this section as determined by a pharmacist or practitioner who is employed by or under contract with the central repository or a local repository.

(b) A prescription drug is eligible for donation under the drug repository program if the following requirements are met:

(1) the donation is accompanied by a drug repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d);

(2) the drug's expiration date is at least six months after the date the drug was donated. If a donated drug bears an expiration date that is less than six months from the donation date, the drug may be accepted and distributed if the drug is in high demand and can be dispensed for use by a patient before the drug's expiration date;

(3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging is unopened;

(4) the drug or the packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity, or adulteration;

(5) the drug does not require storage temperatures other than normal room temperature as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located in Minnesota; and

(6) the prescription drug is not a controlled substance.

(c) A medical supply is eligible for donation under the drug repository program if the following requirements are met:

(1) the supply has no physical signs of tampering, misbranding, or alteration and there is no reason to believe it has been adulterated, tampered with, or misbranded;

(2) the supply is in its original, unopened, sealed packaging;

(3) the donation is accompanied by a drug repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d); and

(4) if the supply bears an expiration date, the date is at least six months later than the date the supply was donated. If the donated supply bears an expiration date that is less than six months from the date the supply was donated, the supply may be accepted and distributed if the supply is in high demand and can be dispensed for use by a patient before the supply's expiration date.

(d) The board shall develop the drug repository donor form and make it available on the board's Web site. The form must state that to the best of the donor's knowledge the donated drug or supply has been properly stored and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded.

(e) Donated drugs and supplies may be shipped or delivered to the premises of the central repository or a local repository, and shall be inspected by a pharmacist or an authorized practitioner who is employed by or under contract with the repository and who has been designated by the repository to accept donations. A drop box must not be used to deliver or accept donations.

(f) The central repository and local repository shall inventory all drugs and supplies donated to the repository. For each drug, the inventory must include the drug's name, strength, quantity, manufacturer, expiration date, and the date the drug was donated. For each medical supply, the inventory must include a description of the supply, its manufacturer, the date the supply was donated, and, if applicable, the supply's brand name and expiration date.

Subd. 7. **Standards and procedures for inspecting and storing donated prescription drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated prescription drugs and supplies to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing,

and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory. If donated drugs or supplies are not inspected immediately upon receipt, a repository must quarantine the donated drugs or supplies separately from all dispensing stock until the donated drugs or supplies have been inspected and approved for dispensing under the program.

(c) The central repository and local repositories shall dispose of all prescription drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or prescription drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation shall be maintained by the repository for at least five years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies to eligible individuals in the following priority order: (1) individuals who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured. A repository shall dispense donated prescription drugs in compliance with applicable federal and state laws and regulations for dispensing prescription drugs, including all requirements relating to packaging, labeling, record keeping, drug utilization review, and patient counseling.

(b) Before dispensing or administering a drug or supply, the pharmacist or practitioner shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

(c) Before a drug or supply is dispensed or administered to an individual, the individual must sign a drug repository recipient form acknowledging that the individual understands the information stated on the form. The board shall develop the form and make it available on the board's Web site. The form must include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug or supply has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the central repository or local repository, the Board of Pharmacy, and any other participant of the drug repository program cannot guarantee the safety of the drug or medical supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or medical supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each drug or medical supply dispensed or administered by that repository.

(b) A repository that dispenses or administers a drug or medical supply through the drug repository program shall not receive reimbursement under the medical assistance program or the MinnesotaCare program for that dispensed or administered drug or supply.

Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and local repositories may distribute drugs and supplies donated under the drug repository program to other participating repositories for use pursuant to this program.

(b) A local repository that elects not to dispense donated drugs or supplies must transfer all donated drugs and supplies to the central repository. A copy of the donor form that was completed by the original donor under subdivision 6 must be provided to the central repository at the time of transfer.

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's Web site:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) drug repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) drug repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated prescription drugs and medical supplies must be maintained by a repository for a minimum of five years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the drug repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A health care facility participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a drug or medical supply is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug or supply is dispensed and no disciplinary action by a health-related licensing board shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the drug or medical supply.

Subd. 13. **Sunset.** This section expires June 30, 2022.

Sec. 7. Minnesota Statutes 2016, section 151.71, is amended by adding a subdivision to read:

Subd. 3. **Synchronization of refills.** (a) For purposes of this subdivision, "synchronization" means the coordination of prescription drug refills for a patient taking two or more medications for one or more chronic conditions, to allow the patient's medications to be refilled on the same schedule for a given period of time.

(b) A contract between a pharmacy benefit manager and a pharmacy must allow for synchronization of prescription drug refills for a patient on at least one occasion per year, if the following criteria are met:

(1) the prescription drugs are covered under the patient's health plan or have been approved by a formulary exceptions process;

(2) the prescription drugs are maintenance medications as defined by the health plan and have one or more refills available at the time of synchronization;

(3) the prescription drugs are not Schedule II, III, or IV controlled substances;

(4) the patient meets all utilization management criteria relevant to the prescription drug at the time of synchronization;

(5) the prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization; and

(6) the prescription drugs do not have special handling or sourcing needs that require a single, designated pharmacy to fill or refill the prescription.

(c) When necessary to permit synchronization, the pharmacy benefit manager shall apply a prorated, daily patient cost-sharing rate to any prescription drug dispensed by a pharmacy under this subdivision. The dispensing fee shall not be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

Sec. 8. **TESTIMONY ON USE OF DIGITAL BREAST TOMOSYNTHESIS BY MEMBERS OF THE STATE EMPLOYEE GROUP INSURANCE PROGRAM.**

The director of the state employee group insurance program must prepare and submit written testimony to the house of representatives and senate committees with jurisdiction over health and human services and state government finance regarding the impact of Minnesota Statutes, section 62A.30, subdivision 4. The director must provide data on actual utilization of the coverage under Minnesota Statutes, section 62A.30, subdivision 4, by members of the state employee group insurance program from January 1, 2019, to December 31, 2019. The director may make recommendations for legislation addressing any issues relating to the coverage required by Minnesota Statutes, section 62A.30, subdivision 4. The testimony required under this section is due by March 1, 2020.

Sec. 9. **STUDY AND REPORT ON DISPARITIES BETWEEN GEOGRAPHIC RATING AREAS IN INDIVIDUAL AND SMALL GROUP MARKET HEALTH INSURANCE RATES.**

Subdivision 1. **Study and recommendations.** (a) As permitted by the availability of resources, the legislative auditor is requested to study disparities between Minnesota's nine geographic rating areas in individual and small group market health insurance rates and recommend ways to reduce or eliminate rate disparities between the geographic rating areas and provide for stability of the individual and small group health insurance markets in the state. In the study, if conducted, the legislative auditor shall:

(1) identify the factors that cause higher individual and small group market health insurance rates in certain geographic rating areas, and determine the extent to which each identified factor contributes to the higher rates;

(2) identify the impact of referral centers on individual and small group market health insurance rates in southeastern Minnesota, and identify ways to reduce the rate disparity between southeastern Minnesota and the metropolitan area, taking into consideration the patterns of referral center usage by patients in those regions;

(3) determine the extent to which individuals and small employers located in a geographic rating area with higher health insurance rates than surrounding geographic rating areas have obtained health insurance in a lower-cost geographic rating area, identify the strategies that individuals and small employers use to obtain health insurance in a lower-cost geographic rating area, and measure the effects of this practice on the rates of the individuals and small employers remaining in the geographic rating area with higher health insurance rates; and

(4) develop proposals to redraw the boundaries of Minnesota's geographic rating areas, and calculate the effect each proposal would have on rates in each of the proposed rating areas. The legislative auditor shall examine at least three options for redrawing the boundaries of Minnesota's geographic rating areas, at least one of which must reduce the number of geographic rating areas. All options for redrawing Minnesota's geographic rating areas considered by the legislative auditor must be designed:

(i) with the purposes of reducing or eliminating rate disparities between geographic rating areas and providing for stability of the individual and small group health insurance markets in the state;

(ii) with consideration of the composition of existing provider networks and referral patterns in regions of the state; and

(iii) in compliance with the requirements for geographic rating areas in Code of Federal Regulations, title 45, section 147.102(b), and other applicable federal law and guidance.

(b) The legislative auditor may secure de-identified data necessary to complete the study and recommendations according to this subdivision directly from health carriers. For purposes of this paragraph "de-identified" means a process to remove all identifiable information regarding an individual or group from data. Data classified as nonpublic data or private data on individuals, as defined in Minnesota Statutes, section 13.02, subdivisions 9 and 12, remains classified as such.

(c) The legislative auditor may recommend one or more proposals for redrawing Minnesota's geographic rating areas if the legislative auditor determines that the proposal would reduce or eliminate individual and small group market health insurance rate disparities between the geographic rating areas and provide for stability of the individual and small group health insurance markets in the state.

Subd. 2. **Contract.** The legislative auditor may contract with another entity for technical assistance in conducting the study and developing recommendations according to subdivision 1.

Subd. 3. **Report.** The legislative auditor is requested to complete the study and recommendations by January 1, 2019, and to submit a report on the study and recommendations by that date to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and health insurance.

Sec. 10. **MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY WORK GROUP.**

Subdivision 1. **Establishment; membership.** (a) A mental health and substance use disorder parity work group is established and shall include the following members:

(1) two members representing health plan companies that offer health plans in the individual market, appointed by the commissioner of commerce;

(2) two members representing health plan companies that offer health plans in the group markets, appointed by the commissioner of commerce;

(3) the commissioner of health or a designee;

(4) the commissioner of commerce or a designee;

(5) the commissioner of management and budget or a designee;

(6) two members representing employers, appointed by the commissioner of commerce;

(7) two members who are providers representing the mental health and substance use disorder community, appointed by the commissioner of commerce; and

(8) two members who are advocates representing the mental health and substance use disorder community, appointed by the commissioner of commerce.

(b) Members of the work group must have expertise in standards for evidence-based care, benefit design, or knowledge relating to the analysis of mental health and substance use disorder parity under federal and state law, including nonquantitative treatment limitations.

Subd. 2. **First appointments; first meeting; chair.** Appointing authorities shall appoint members to the work group by July 1, 2018. The commissioner of commerce or a designee shall convene the first meeting of the work group on or before August 1, 2018. The commissioner of commerce or the commissioner's designee shall act as chair.

Subd. 3. **Duties.** The mental health and substance use disorder parity work group shall:

(1) develop recommendations on the most effective approach to determine and demonstrate mental health and substance use disorder parity, in accordance with state and federal law for individual and group health plans offered in Minnesota; and

(2) report recommendations to the legislature.

Subd. 4. **Report.** (a) By February 15, 2019, the work group shall submit a report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance.

(b) The report must include the following:

(1) a summary of completed state enforcement actions relating to individual and group health plans offered in Minnesota during the preceding 12-month period regarding compliance with parity in mental health and substance use disorders benefits in accordance with state and federal law and a summary of the results of completed state enforcement actions. Data that is protected under state or federal law as nonpublic, private, or confidential shall remain nonpublic, private, or confidential. This 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;

(2) detailed information about any regulatory actions the commissioner of health or commissioner of commerce has taken as a result of a completed state enforcement action pertaining to health plan compliance with Minnesota Statutes, sections 62Q.47 and 62Q.53, and United States Code, title 42, section 18031(j);

(3) a description of the work group's recommendations on educating the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law; and

(4) recommendations on the most effective approach to determine and demonstrate mental health and substance use disorder parity, in accordance with state and federal law for individual and group health plans offered in Minnesota.

(c) In developing the report and recommendations, the work group may consult with the Substance Abuse and Mental Health Services Agency and the National Association of

Insurance Commissioners for the latest developments on evaluation of mental health and substance use disorder parity.

(d) The report must be written in plain language and must be made available to the public by being posted on the Web sites of the Department of Health and Department of Commerce. The work group may make the report publicly available in additional ways, at its discretion.

(e) The report must include any draft legislation necessary to implement the recommendations of the work group.

Subd. 5. **Expiration.** The mental health and substance use disorder parity work group expires February 16, 2019, or the day after submitting the report required in this section, whichever is earlier.

Sec. 11. **PROVIDER GRANTS FOR ADMINISTRATION OF PERIPHERAL NERVE BLOCKS.**

(a) The commissioner of human services, within the limits of funding provided for the substance use disorder provider capacity grant program under Laws 2017 First Special Session chapter 6, article 12, section 4, may design and implement a grant program to assist providers in purchasing devices for administering continuous peripheral nerve blocks to treat, reduce, or prevent substance use disorder for medical assistance enrollees.

(b) If the commissioner implements the grant program, grants shall be distributed between July 1, 2018, and June 30, 2019. The commissioner shall conduct outreach to providers regarding the availability of this grant and ensure a simplified grant application process. The commissioner shall provide technical assistance to assist providers in building operational capacity to treat, reduce, or prevent substance use disorders with devices for administering continuous peripheral nerve blocks. The commissioner, in collaboration with stakeholders, shall: (1) analyze the impact of the grant program; (2) identify actual or perceived barriers to providers accessing and obtaining reimbursement for devices for administering continuous peripheral nerve blocks; and (3) develop recommendations for addressing identified barriers. The commissioner shall provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by September 1, 2019.

Sec. 12. **REPEALER.**

Minnesota Statutes 2016, sections 62A.65, subdivision 7a; and 151.55, are repealed."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly