ARTICLE 9

ONECARE

Section 1. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

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

(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(e) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(f) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(g) "Electronic prescription drug program" means a program that provides for e-prescribing.

(h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6~~.~~, excluding state and federal health care programs under chapters 256B, 256L, and 256T.

(i) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(j) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(l) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(m) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

(n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(p) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(q) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 2. [62V.12] ADVANCED PAYMENT OF STATE-BASED HEALTH INSURANCE PREMIUM TAX CREDIT.

Subdivision 1. **Determination of eligibility for advanced payment of state-based health insurance premium tax credit.** (a) The Board of Directors of MNsure shall assess an individual's eligibility for an advanced payment of the state-based health insurance tax credit under section 290.0693 when an individual applies for an eligibility determination through MNsure, basing the eligibility determination upon income for the relevant tax year as projected by the individual. MNsure shall equally divide the value of the potential state-based tax credit across the monthly premiums to be charged to the individual. If the individual selects a plan through MNsure, MNsure shall notify the relevant health carrier of the amount of the advanced payment of the state-based insurance premium tax credit amount and direct the health carrier to deduct the amount from the eligible individual's premiums.

(b) An individual is eligible for an advanced payment of the state-based health insurance premium tax credit if they are a Minnesota resident who:

(1) had at least one month of coverage by a qualified health plan offered through MNsure during the tax year;

(2) was not enrolled in public program coverage under section 256B.055 or 256L.04 during the months of coverage by the qualified health plan; and

(3) is eligible for the health insurance tax credit in section 290.0693.

(c) To be eligible for an advanced payment of the state-based health insurance premium tax credit, the individual must attest that the individual will file a state tax return in order to reconcile any advanced payment of the credit and will file a joint tax return with their spouse, if married.

(d) An individual is not eligible for an advanced payment of the state-based health insurance premium tax credit for the taxable year if MNsure is notified by the commissioner of revenue that the individual received an advanced payment in a prior tax year and has not filed a tax return for the relevant tax year and has not fully paid any amount necessary to reconcile the advanced payment.

Subd. 2. **Payments to health carriers.** The board shall make payments to health carriers equal to the amount of the advance state-based health insurance premium tax credit amounts provided to eligible individuals effectuating coverage for the months in which the individual has paid the net premium amount to the health carrier.

Subd. 3. **Health carrier responsibilities.** A health carrier that receives notice from MNsure that an individual enrolled in the health carrier's qualified health plan is eligible for an advanced payment of the state-based health insurance premium tax credit shall:

(1) reduce the portion of the premium charged to the individual for the applicable months by the amount of the state-based health insurance tax credit determined by MNsure;

(2) include the amount of advanced state-based health insurance premium tax credit determined by MNsure on each billing statement for which an advanced state-based health insurance tax credit has been applied; and

(3) reconcile advanced payments of state-based health insurance premium tax credits with MNsure at least once a month.

Subd. 4. **Appeals.** MNsure appeals are available for Minnesota residents for initial determinations and redeterminations made by MNsure of eligibility for and level of an advanced payment of the state-based health insurance premium tax credit. The appeals must follow the procedures enumerated in Minnesota Rules, chapter 7700.

Subd. 5. **Data practices.** The data classifications in section 62V.06, subdivision 3, apply to data on individuals applying for or receiving a state-based health insurance tax credit pursuant to this subdivision.

Subd. 6. **Data sharing.** Notwithstanding any law to the contrary, the board is permitted to share or disseminate data in subdivision 5 as described in section 62V.06, subdivision 5.

Subd. 7. **Appropriations.** Beginning in fiscal year 2021 and each fiscal year thereafter, an amount sufficient to make advanced payments of the state-based health insurance tax

credit is appropriated from the health care access fund to the board for payment of advanced state-based health insurance premium tax credits under this section.

EFFECTIVE DATE. This section is effective for advanced payment of the state-based health insurance premium tax credit applied to premiums for plan years 2021 and beyond.

Sec. 3. [62V.13] DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 62V.13 to 62V.133, the following terms have the meanings given.

Subd. 2. **Board.** "Board" means the board of directors of MNsure specified in section 62V.04.

Subd. 3. **Eligible individual.** "Eligible individual" means a Minnesota resident who:

(1) is determined not eligible to receive an advance credit payment under Code of Federal Regulations, title 26, section 1.36B-1(j), of the premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, for a given month of coverage;

(2) is not enrolled in public program coverage under section 256B.055 or 256L.04; and

(3) purchased a qualified health plan through MNsure.

Subd. 4. **Gross premium.** "Gross premium" means the amount billed for a qualified health plan purchased by an eligible individual prior to a premium subsidy or advanced state-based tax credit being applied in a calendar year.

Subd. 5. **Health carrier.** "Health carrier" has the meaning given in section 62A.011, subdivision 2.

Subd. 6. **MNsure.** "MNsure" means the state health benefit exchange as described in section 1311 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, and chapter 62V.

Subd. 7. **Net premium.** "Net premium" means the gross premium less the premium subsidy.

Subd. 8. **Premium subsidy.** "Premium subsidy":

(1) is a rebate payment to discount the cost of insurance for the promotion of general welfare, and is not compensation for any services;

(2) is equal to 20 percent of the monthly gross premium otherwise paid by or on behalf of the eligible individual for qualified health plan coverage purchased through MNsure that covers the eligible individual and the eligible individual's covered spouse and covered dependents; and

(3) is excluded from any calculation used to determine eligibility within any of the Department of Human Services programs.

Subd. 9. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in section 1301(a) of the Affordable Care Act, Public Law 111-148, and has been certified by the board in accordance with section 62V.05, subdivision 5, to be offered through MNsure.

Sec. 4. [62V.131] PAYMENT TO HEALTH CARRIERS ON BEHALF OF ELIGIBLE INDIVIDUALS.

Subdivision 1. **Program established.** The board shall establish and administer the premium subsidy program authorized by this act to help eligible individuals pay for coverage when purchasing qualified health plans through MNsure in plan year 2020 and in each subsequent plan year for which an appropriation is approved.

Subd. 2. **Administration.** MNsure shall determine if an individual applying for coverage through MNsure is an eligible individual. If so, MNsure shall calculate the proper amount of the eligible individual's premium subsidy. MNsure shall notify the relevant health carrier of the premium subsidy amount and direct the health carrier to deduct the premium subsidy amount from the eligible individual's gross premium as a discount to the eligible individual's qualified health plan premium.

Subd. 3. **Payments to health carriers.** (a) The board shall make payments to health carriers equal to the amount of the premium subsidy discounts provided to eligible individuals effectuating coverage for the months in which the individual has paid the net premium amount to the health carrier. Payments to health carriers shall be based on the premium subsidy provided on behalf of eligible individuals, regardless of the cost of coverage purchased.

(b) Health carriers seeking reimbursement from the board must submit an invoice and supporting information to the board using a format and method developed by the board in order to be determined to be eligible for payment.

(c) The board shall consider health carriers as vendors under section 16A.124, subdivision 3, and each monthly invoice shall represent the completed delivery of the service.

Subd. 4. **Data practices.** The data classifications in section 62V.06, subdivision 3, apply to data on individuals applying for or receiving a premium subsidy under this subdivision.

Subd. 5. **Data sharing.** Notwithstanding any law to the contrary, the board is permitted to share or disseminate the data in subdivision 4 as described in section 62V.06, subdivision 5.

Sec. 5. [62V.132] APPEALS.

MNsure appeals are available for Minnesota residents for initial determinations and redeterminations made by MNsure of eligibility for and level of premium subsidy and shall follow the procedures enumerated in Minnesota Rules, chapter 7700.

Sec. 6. [62V.133] APPLICABILITY OF GROSS PREMIUM.

Notwithstanding premium subsidies provided under section 62V.131, the premium base for calculating the amount of any applicable premium taxes under chapter 297I, shall be the gross premium for a qualified health plan purchased by eligible individuals through MNsure.

Sec. 7. [256B.0371] ADMINISTRATION OF DENTAL SERVICES.

(a) Effective January 1, 2022, the commissioner shall contract with a dental administrator to administer dental services for all recipients of medical assistance and MinnesotaCare.

(b) The dental administrator must provide administrative services including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and review for medical necessity of dental services;

(4) dental claims processing;

(5) coordination with other services;

(6) management of fraud and abuse;

(7) monitoring of access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation requirements; and

(10) management of third-party liability requirements.

(c) Payments to contracted dental providers must be at the rates established under section 256B.76.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 8. Minnesota Statutes 2018, section 256B.0644, is amended to read:
256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program and MinnesotaCare as a condition of

participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services. This section does not apply to dental service providers providing dental services outside the seven-county metropolitan area.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers providing dental services in the seven-county metropolitan area, at least ten percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625, subdivision 9a, shall not be considered to be participating in medical assistance or MinnesotaCare for the purpose of this section.

(e) A vendor of medical care, as defined in section 256B.02, subdivision 7, that dispenses outpatient prescription drugs in accordance with chapter 151 must participate as a provider or contractor in the MinnesotaCare program as a condition of participating as a provider in the medical assistance program.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 9. Minnesota Statutes 2018, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude ~~or modify~~ coverage for prescription drugs from the prepaid managed care contracts entered into under this section ~~in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates~~.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 10. Minnesota Statutes 2018, section 256B.69, subdivision 35, is amended to read:

Subd. 35. **Statewide procurement.** (a) For calendar year 2015, the commissioner may extend a demonstration provider's contract under this section for a sixth year after the most recent procurement. For calendar year 2015, section 16B.98, subdivision 5, paragraph (b), and section 16C.05, subdivision 2, paragraph (b), shall not apply to contracts under this section.

(b) For calendar year 2016 contracts under this section, the commissioner shall procure through a statewide procurement, which includes all 87 counties, demonstration providers, and participating entities as defined in section 256L.01, subdivision 7. The commissioner shall publish a request for proposals by January 5, 2015. As part of the procurement process, the commissioner shall:

(1) seek each individual county's input;

(2) organize counties into regional groups, and consider single counties for the largest and most diverse counties; and

(3) seek regional and county input regarding the respondent's ability to fully and adequately deliver required health care services, offer an adequate provider network, provide care coordination with county services, and serve special populations, including enrollees with language and cultural needs.

(c) For calendar year 2021, the commissioner may extend a demonstration provider's contract under this section for a sixth year after the most recent procurement, for the provision of services in the seven-county metropolitan area to families and children under medical assistance and MinnesotaCare. For calendar year 2021, sections 16B.98, subdivision 5, paragraph (b), and 16C.06, subdivision 3b, shall not apply to contracts under this section. For calendar year 2022, the commissioner shall procure services in the seven-county metropolitan area for families and children under medical assistance and MinnesotaCare, from demonstration providers and participating entities as defined in section 256L.01, subdivision 7.

Sec. 11. Minnesota Statutes 2018, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be

designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding appropriated for this purpose. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, through December 31, 2016, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.

(l) Effective for services provided on or after January 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

(m) Effective for services provided on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.

(n) Effective for dental services provided on or after January 1, 2022, the commissioner shall increase payment rates by 54 percent. This rate increase does not apply to state-operated

dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers.

Sec. 12. Minnesota Statutes 2018, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2016, through December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

(c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

Sec. 13. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision to read:

Subd. 7. **Outpatient prescription drugs.** Outpatient prescription drugs are covered according to section 256L.30. This subdivision applies to all individuals enrolled in the MinnesotaCare program.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 14. Minnesota Statutes 2018, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized minimum essential coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage that is affordable and provides minimum value as defined in Code of Federal Regulations, title 26, section 1.36B-2.

(b) Notwithstanding paragraph (a), an individual who has access to subsidized health coverage through a spouse's or parent's employer that is deemed minimum essential coverage under Code of Federal Regulations, title 26, section 1.36B-2, is eligible for MinnesotaCare if the portion of the annual premium the employee pays for employee and dependent coverage exceeds the required contribution percentage as described in Code of Federal Regulations,

title 26, section 1.36B-2, and the individual meets all other eligibility requirements of this chapter.

~~(b)~~ (c) This subdivision does not apply to a family or individual who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2018, section 256L.07, is amended by adding a subdivision to read:

Subd. 2b. **Federal waiver.** The commissioner of human services, in consultation with the Board of Directors of MNsure, shall apply for a federal waiver to allow the state to permit a person who has access to employer-sponsored health insurance through a spouse or parent that is deemed minimum essential coverage under Code of Federal Regulations, title 26, section 1.36B-2, and the portion of the annual premium the person pays for employee and dependent coverage exceeds the required contribution percentage in Code of Federal Regulations, title 26, section 1.36B-2, to:

(1) enroll in the MinnesotaCare program, if the person meets all eligibility requirements, except for section 256L.07, subdivision 2, paragraph (a);

(2) qualify for advanced premium tax credits under Code of Federal Regulations, title 26, section 1.36B-2, and cost sharing reductions under Code of Federal Regulations, title 45, section 155.305(g), if the person meets all eligibility requirements, except for the affordability requirement described in Code of Federal Regulations, title 26, section 1.36B-2 (c)(3)(v)(A)(2); and

(3) qualify to purchase coverage in the OneCare Buy-In pursuant to section 256T.03, if the person meets all eligibility requirements.

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

Sec. 16. Minnesota Statutes 2018, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 20 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 17. [256L.30] OUTPATIENT PRESCRIPTION DRUGS.

Subdivision 1. **Establishment of program.** The commissioner shall administer and oversee the outpatient prescription drug program for MinnesotaCare. The commissioner shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

Subd. 2. **Covered outpatient prescription drugs.** (a) In consultation with the Drug Formulary Committee under section 256B.0625, subdivision 13d, the commissioner shall establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the requirements for an essential health benefit under Code of Federal Regulations, title 45, section 156.122. The commissioner may modify the formulary after consulting with the Drug Formulary Committee and providing public notice and the opportunity for public comment. The commissioner is exempt from the rulemaking requirements of chapter 14 to establish the drug formulary, and section 14.386 does not apply. The commissioner shall make the drug formulary available to the public on the agency website.

(b) The MinnesotaCare formulary must contain at least one drug in every United States Pharmacopeia category and class or the same number of prescription drugs in each category and class as the essential health benefit benchmark plan, whichever is greater.

(c) The commissioner may negotiate drug rebates or discounts directly with a drug manufacturer to place a drug on the formulary. The commissioner may also negotiate drug rebates, or discounts, with a drug manufacturer through a contract with a vendor. The commissioner, beginning January 15, 2022, and each January 15 thereafter, shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance of the rebates and discounts negotiated, their aggregate dollar value, and how the department applied these savings, including the extent to which these savings were passed on to enrollees.

(d) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Drug Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Drug Formulary Committee review a drug for prior authorization.

(e) Before the commissioner requires prior authorization for a drug:

(1) the commissioner must provide the Drug Formulary Committee with information on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs and information regarding whether the drug is subject to clinical abuse or misuse if such data is available; and

(2) the Drug Formulary Committee must hold a public forum and receive public comment for an additional 15 days from the date of the public forum.

(f) Notwithstanding paragraph (e), the commissioner may automatically require prior authorization for a period not to exceed 180 days for any drug that is approved by the United States Food and Drug Administration after July 1, 2019. The 180-day period begins no later

than the first day that a drug is available for shipment to pharmacies within the state. The Drug Formulary Committee shall recommend to the commissioner general criteria to use for determining prior authorization of the drugs, but the Drug Formulary Committee is not required to review each individual drug.

(g) The commissioner may also require prior authorization before nonformulary drugs are eligible for payment.

(h) Prior authorization requests must be processed in accordance with Code of Federal Regulations, title 45, section 156.122.

Subd. 3. **Pharmacy provider participation.** (a) A pharmacy enrolled to dispense prescription drugs to medical assistance enrollees under section 256B.0625 must participate as a provider in the MinnesotaCare outpatient prescription drug program.

(b) A pharmacy that is enrolled to dispense prescription drugs to MinnesotaCare enrollees is not permitted to refuse service to an enrollee unless:

(1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug in time to treat the enrollee's medical condition;

(2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the drug is dispensed;

(3) after performing drug utilization review, the pharmacist identifies the prescription drug as being a therapeutic duplication, having a drug-disease contraindication, having a drug-drug interaction, having been prescribed for the incorrect dosage or duration of treatment, having a drug-allergy interaction, or having issues related to clinical abuse or misuse by the enrollee;

(4) the prescription drug is not covered by MinnesotaCare; or

(5) dispensing the drug would violate a provision of chapter 151.

Subd. 4. **Covered outpatient prescription drug reimbursement rate.** (a) The basis for determining the amount of payment shall be the lowest of the National Average Drug Acquisition Cost, plus a fixed dispensing fee; the maximum allowable cost established under section 256B.0625, subdivision 13e, plus a fixed dispensing fee; or the usual and customary price. The fixed dispensing fee shall be $1.50 for covered outpatient prescription drugs.

(b) The basis for determining the amount of payment for a pharmacy that acquires drugs through the federal 340B Drug Pricing Program shall be the lowest of:

(1) the National Average Drug Acquisition Cost minus 30 percent;

(2) the maximum allowable cost established under section 256B.0625, subdivision 13e, minus 30 percent, plus a fixed dispensing fee; or

(3) the usual and customary price. The fixed dispensing fee shall be $1.50 for covered outpatient prescription drugs.

(c) For purposes of this subdivision, the usual and customary price is the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes the prices the pharmacy charges to customers enrolled in a prescription savings club or prescription discount club administered by the pharmacy, pharmacy chain, or contractor to the provider.

Subd. 5. **Prescription drug benefit consumer protections.** The prescription drug benefit shall include the protections required under Code of Federal Regulations, title 45, section 156.122, including a standard formulary exception request, expedited exception request, external exception request, and application of coverage appeals laws.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 18. [256T.01] DEFINITIONS.

Subdivision 1. **Application.** For purposes of this chapter, the terms in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Department.** "Department" means the Department of Human Services.

Subd. 4. **Essential health benefits.** "Essential health benefits" has the meaning given in section 62Q.81, subdivision 4.

Subd. 5. **Health plan.** "Health plan" has the meaning given in section 62A.011, subdivision 3.

Subd. 6. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 7. **MNsure website.** "MNsure website" has the meaning given in section 62V.02, subdivision 13.

Subd. 8. **Qualified health plan.** "Qualified health plan" has the meaning given in section 62A.011, subdivision 7.

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

Sec. 19. [256T.02] ONECARE BUY-IN.

Subdivision 1. **Establishment.** (a) The commissioner shall establish a program consistent with this section to offer products developed for the OneCare Buy-In through the MNsure website.

(b) The commissioner, in collaboration with the commissioner of commerce and the MNsure Board, shall:

(1) establish a cost allocation methodology to reimburse MNsure operations in lieu of the premium withhold for qualified health plans under section 62V.05;

(2) implement mechanisms to ensure the long-term financial sustainability of Minnesota's public health care programs and mitigate any adverse financial impacts to the state and MNsure. These mechanisms must minimize adverse selection, state financial risk and contribution, and negative impacts to premiums in the individual and group health insurance markets; and

(3) coordinate eligibility, coverage, and provider networks to ensure that persons, to the extent possible, transitioning between medical assistance, MinnesotaCare, and the OneCare Buy-In have continuity of care.

(c) The OneCare Buy-In shall be considered:

(1) a public health care program for purposes of chapter 62V; and

(2) the MinnesotaCare program for purposes of requirements for health maintenance organizations under section 62D.04, subdivision 5, and providers under section 256B.0644.

(d) The Department of Human Services is deemed to meet and receive certification and authority under section 62D.03 and be in compliance with sections 62D.01 to 62D.30. The commissioner has the authority to accept and expend all federal funds made available under this chapter upon federal approval.

(e) Unless otherwise specified under this chapter, health plans offered under the OneCare Buy-In program must meet all requirements of chapters 62A, 62D, 62K, 62M, 62Q, and 62V determined to be applicable by the regulating authority and premiums shall be subject to the gross premiums tax under section 297I.05, subdivision 5.

Subd. 2. **Premium administration and payment.** (a) The commissioner shall establish annually a per-enrollee monthly premium rate.

(b) OneCare Buy-In premium administration shall be consistent with requirements under the federal Affordable Care Act for qualified health plan premium administration. Premium rates shall be established in accordance with section 62A.65, subdivision 3.

Subd. 3. **Rates to providers.** The commissioner shall establish rates for provider payments that are targeted to the current rates established under chapter 256L, plus the aggregate difference between those rates and Medicare rates. The aggregate must not consider services that receive a Medicare encounter payment.

Subd. 4. **Reserve and other financial requirements.** (a) A OneCare Buy-In reserve account is established in the state treasury. Enrollee premiums collected under subdivision 2 shall be deposited into the reserve account. The reserve account shall be used to cover

expenditures related to operation of the OneCare Buy-In, including the payment of claims and all other accrued liabilities. No other account within the state treasury shall be used to finance the reserve account except as otherwise specified in state law.

(b) Beginning January 1, 2023, enrollee premiums shall be set at a level sufficient to fund all ongoing claims costs and all ongoing costs necessary to manage the program and support ongoing maintenance of information technology systems and operational and administrative functions of the OneCare Buy-In program.

(c) The commissioner is prohibited from expending state dollars beyond what is specifically appropriated in law, or transferring funds from other accounts, in order to fund the reserve account, fund claims costs, or support ongoing administration and operation of the program and its information technology systems.

Subd. 5. **Covered benefits.** Each health plan established under this chapter must include the essential health benefits package required under section 1302(a) of the Affordable Care Act and as described in section 62Q.81; dental services described in section 256B.0625, subdivision 9, paragraphs (b) and (c); and vision services described in Minnesota Rules, part 9505.0277, and may include other services under section 256L.03, subdivision 1.

Subd. 6. **Third-party administrator.** (a) The commissioner may enter into a contract with a third-party administrator to perform the operational management of the OneCare Buy-In. Duties of the third-party administrator include but are not limited to the following:

(1) development and distribution of plan materials for potential enrollees;

(2) receipt and processing of electronic enrollment files sent from the state;

(3) creation and distribution of plan enrollee materials including identification cards, certificates of coverage, a plan formulary, a provider directory, and premium billing statements;

(4) processing premium payments and sending termination notices for nonpayment to enrollees and the state;

(5) payment and adjudication of claims;

(6) utilization management;

(7) coordination of benefits;

(8) grievance and appeals activities; and

(9) fraud, waste, and abuse prevention activities.

(b) Any solicitation of vendors to serve as the third-party administrator is subject to the requirements under section 16C.06.

Subd. 7. **Eligibility.** (a) To be eligible for the OneCare Buy-In, a person must:

(1) be a resident of Minnesota; and

(2) not be enrolled in government-sponsored programs as defined in United States Code, title 26, section 5000A(f)(1)(A). For purposes of this subdivision, an applicant who is enrolled in Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered enrolled in government-sponsored programs. An applicant shall not refuse to apply for or enroll in Medicare coverage to establish eligibility for the OneCare Buy-In.

(b) A person who is determined eligible for enrollment in a qualified health plan with or without advance payments of the premium tax credit and with or without cost-sharing reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), is eligible to purchase and enroll in the OneCare Buy-In instead of purchasing a qualified health plan as defined under section 62V.02.

Subd. 8. **Enrollment.** (a) A person may apply for the OneCare Buy-In during the annual open and special enrollment periods established for MNsure as defined in Code of Federal Regulations, title 45, sections 155.410 and 155.420, through the MNsure website.

(b) A person must annually reenroll for the OneCare Buy-In during open and special enrollment periods.

Subd. 9. **Premium tax credits, cost-sharing reductions, and subsidies.** A person who is eligible under this chapter, and whose income is less than or equal to 400 percent of the federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing reductions under Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), to purchase a health plan established under this chapter.

Subd. 10. **Covered benefits and payment rate modifications.** The commissioner, after providing public notice and an opportunity for public comment, may modify the covered benefits and payment rates to carry out this chapter.

Subd. 11. **Provider tax.** Section 295.582, subdivision 1, applies to health plans offered under the OneCare Buy-In program.

Subd. 12. **Hospital financial reimbursement fund.** The commissioner shall establish and administer a hospital financial reimbursement fund, to provide grants or supplemental payments to hospitals, to mitigate the financial effects of uncompensated care caused by high-deductible health plans.

Subd. 13. **Request for federal authority.** The commissioner shall seek all necessary federal waivers to establish the OneCare Buy-In under this chapter.

EFFECTIVE DATE. (a) Subdivisions 1 to 12 are effective January 1, 2023.

(b) Subdivision 13 is effective the day following final enactment.

Sec. 20. [256T.03] ONECARE BUY-IN PRODUCTS.

Subdivision 1. **Platinum product.** The commissioner of human services shall establish a OneCare Buy-In coverage option that provides platinum level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option. This product must be made available in all rating areas in the state.

Subd. 2. **Silver and gold products.** (a) If any rating area lacks an affordable or comprehensive health care coverage option according to standards developed by the commissioner of health, the following year the commissioner of human services shall offer silver and gold products established under paragraph (b) in the rating area for a five-year period.

(b) The commissioner shall establish the following OneCare Buy-In coverage options: one coverage option shall provide silver level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option, and one coverage option shall provide gold level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option.

Subd. 3. **Qualified health plan rules.** (a) The coverage options developed under this section are subject to the process under section 62K.06. The coverage options developed under this section shall meet requirements of chapters 62A, 62K, and 62V that apply to qualified health plans.

(b) The Department of Human Services is not an insurance company for purposes of this chapter.

Subd. 4. **Actuarial value.** Determination of the actuarial value of coverage options under this section must be calculated in accordance with Code of Federal Regulations, title 45, section 156.135.

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

Sec. 21. [256T.04] OUTPATIENT PRESCRIPTION DRUGS.

Subdivision 1. **Establishment of program.** The commissioner shall administer and oversee the outpatient prescription drug program for the OneCare Buy-In program. The commissioner shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

Subd. 2. **Covered outpatient prescription drugs.** Outpatient prescription drugs are covered in accordance with chapter 256L.

Subd. 3. **Pharmacy provider participation.** Pharmacy provider participation shall be governed by section 256L.30, subdivision 3.

Subd. 4. **Reimbursement rate.** The commissioner shall establish outpatient prescription drug reimbursement rates according to chapter 256L.

Subd. 5. **Prescription drug benefit consumer protections.** Prescription drug benefit consumer protections shall be in accordance with section 256L.30, subdivision 5.

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

Sec. 22. Minnesota Statutes 2018, section 270B.12, is amended by adding a subdivision to read:

Subd. 15. **Board of Directors of MNsure.** The commissioner may disclose return information to the extent necessary to the Board of Directors of MNsure to determine eligibility under section 62V.12, subdivision 1.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2020.

Sec. 23. Minnesota Statutes 2018, section 290.0131, is amended by adding a subdivision to read:

Subd. 15. **Health insurance premiums.** The amount of health insurance premiums deducted on the taxpayer's federal return, to the extent used to calculate the credit under section 290.0693, is an addition.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2020.

Sec. 24. [290.0693] HEALTH INSURANCE PREMIUM CREDIT.

Subdivision 1. **Credit allowed.** (a) An individual who is a resident of Minnesota is allowed a credit against the tax due under this chapter if the individual would be allowed a credit under section 36B of the Internal Revenue Code, except that the individual's household income, as defined in section 36B(d)(2) of the Internal Revenue Code, exceeds 400 percent of the poverty line for the individual's family size as defined in section 36B(d)(3) of the Internal Revenue Code.

(b) In the determination of "coverage month" under section 36B(c)(2) of the Internal Revenue Code, section 36B(c)(2)(B) and (C) must not apply.

(c) The credit is equal to what the credit would have been under section 36B of the Internal Revenue Code, except the applicable percentage for purposes of section 36B(b)(2)(B)(ii) of the Internal Revenue Code is the highest premium percentage in section 36B(b)(3)(A) of the Internal Revenue Code.

(d) The amount of monthly premiums taken into account under section 36B(b)(2)(A) of the Internal Revenue Code must be reduced by the amount of premium subsidy made by MNsure and applied to the gross premium.

Subd. 2. **Advanced payment of credit.** (a) An individual may claim the credit on the individual's tax return or have the credit paid in advance pursuant to section 62V.12.

(b) If an individual elects to have the credit paid in advance, the credit claimed under subdivision 1 must be reduced by the amount of the advanced payments. If the amount of the advance payments exceeds the amount of credit the individual is eligible for, the tax imposed by this chapter for the taxable year must be increased by the amount of the excess.

(c) If the amount of credit that the individual is allowed under subdivision 1, after subtracting any advanced payments, exceeds the individual's tax liability under this chapter, the commissioner shall refund the excess to the individual.

(d) By January 31 of each year, the Board of Directors of MNsure must provide to each individual who applied for assistance and enrolled in a qualified health plan and to the commissioner a statement containing information on the preceding year necessary to reconcile the credit with the advance payments. The Board of Directors of MNsure and the commissioner must consult to develop the form and manner of the report.

(e) Each year, 60 days prior to MNsure's open enrollment, the commissioner shall provide information to MNsure about which individuals received an advanced payment of the state-based health insurance tax credit under section 62V.12 in a prior taxable year and did not file a return and reconcile the payments for that taxable year.

Subd. 3. **Reporting requirements.** (a) If the individual has a change in eligibility status determination by MNsure, after the taxable year is complete, the individual and MNsure must notify the commissioner of the change in eligibility within six months of the change.

(b) Notwithstanding any law to the contrary, the commissioner may recompute the tax due based on the determination of eligibility.

Subd. 4. **Appropriation.** (a) An amount sufficient to pay the refunds required by this section is appropriated to the commissioner from the health care access fund.

(b) $1,037,000 in fiscal year 2022 and $880,000 in each fiscal year thereafter are the base from the health care access fund to the commissioner of revenue for administering this section.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2020.

Sec. 25. Minnesota Statutes 2018, section 295.51, subdivision 1a, is amended to read:

Subd. 1a. **Nexus in Minnesota.** (a) To the extent allowed by the United States Constitution and the laws of the United States, a person who is a wholesale drug distributor

~~has nexus in Minnesota if its contacts with or presence in Minnesota is sufficient to satisfy the requirements of the United States Constitution.~~, a person who receives legend drugs for resale or use in Minnesota other than from a wholesale drug distributor that is subject to tax, or a person who sells or repairs hearing aids and related equipment or prescription eyewear is subject to the taxes imposed by this chapter if the person:

(1) has or maintains within this state, directly or by a subsidiary or an affiliate, an office, place of distribution, sales, storage, or sample room or place, warehouse, or other place of business, including the employment of a resident of this state who works from a home office in this state;

(2) has a representative, including but not limited to an employee, affiliate, agent, salesperson, canvasser, solicitor, independent contractor, or other third party operating in this state under the person's authority or the authority of the person's subsidiary, for any purpose, including the repairing, selling, delivering, installing, facilitating sales, processing sales, or soliciting of orders for the person's goods or services, or the leasing of tangible personal property located in this state, whether the place of business or the agent, representative, affiliate, salesperson, canvasser, or solicitor is located in the state permanently or temporarily, or whether or not the person, subsidiary, or affiliate is authorized to do business in this state;

(3) owns or leases real property that is located in this state; or

(4) owns or leases tangible personal property that is present in this state, including but not limited to mobile property.

(b) To the extent allowed by the United States Constitution and the laws of the United States, a person who is a wholesale drug distributor, or a person who receives legend drugs for resale or use in Minnesota other than from a wholesale drug distributor that is subject to tax, is subject to the taxes imposed by this chapter if the person:

(1) conducts a trade or business not described in paragraph (a) and sells, delivers, or distributes legend drugs from outside this state to a destination within this state by common carrier or otherwise; and

(2) meets one of the following thresholds:

(i) makes 100 or more sales, deliveries, or distributions described in clause (1) during any taxable year;

(ii) the gross revenues of a wholesale drug distributor that sells or distributes legend drugs as described in clause (1) totals more than $100,000 during any taxable year; or

(iii) the price paid by a person who receives legend drugs for resale or use in Minnesota other than from a wholesale drug distributor that is subject to tax for legend drugs as described in clause (1) totals more than $100,000 during any taxable year.

(c) To the extent allowed by the United States Constitution and the laws of the United States, a person who sells or repairs hearing aids and related equipment or prescription eyewear is subject to the taxes imposed by this chapter if the person:

(1) conducts a trade or business not described in paragraph (a) and:

(i) sells, delivers, or distributes hearing aids or prescription eyewear from outside of this state to a destination within this state by common carrier or otherwise; or

(ii) repairs hearing aids or prescription eyewear outside of this state and delivers or distributes the hearing aids or prescription eyewear to a destination within this state by common carrier or otherwise; and

(2) meets one of the following thresholds:

(i) makes 100 or more sales, deliveries, distributions, or repairs described in clause (1) during any taxable year; or

(ii) the gross revenues of the person who sells, delivers, distributes, or repairs hearing aids or prescription eyewear described in clause (1) totals more than $100,000 during any taxable year.

(d) Once a taxpayer has established nexus with Minnesota under paragraph (b) or (c), the taxpayer must continue to file an annual return and remit taxes for subsequent years. A taxpayer who has established nexus under paragraph (b) or (c) is no longer required to file an annual return and remit taxes if the taxpayer:

(1) ceases to engage in the activities, or no longer meets any of the applicable thresholds, in paragraph (b) or (c) for an entire taxable year; and

(2) notifies the commissioner by March 15 of the following calendar year, in a manner prescribed by the commissioner, that the taxpayer no longer engages in any of the activities, or no longer meets any of the applicable thresholds, in paragraph (b) or (c).

(e) If, after notifying the commissioner pursuant to paragraph (d), the taxpayer subsequently engages in any of the activities, and meets any of the applicable thresholds, in paragraph (b) or (c), the taxpayer shall again comply with the applicable requirements of paragraphs (b), (c), and (d).

EFFECTIVE DATE; APPLICATION. (a) This section is effective the day following final enactment.

(b) In enacting this section, the legislature confirms that the United States Supreme Court decision in South Dakota v. Wayfair, Inc. et al., Dkt. No. 17-494 (June 21, 2018); 138 S. Ct. 2080 (2018), applied upon the date of that decision to provide Minnesota with jurisdiction over persons described in paragraphs (b) and (c) for purposes of imposing tax under chapter 295 to the extent allowed by the United States Constitution and the laws of the United States.

Sec. 26. Minnesota Statutes 2018, section 295.57, subdivision 3, is amended to read:

Subd. 3. **Interest on overpayments.** Interest must be paid on an overpayment refunded or credited to the taxpayer ~~from the date of payment of the tax until the date the refund is paid or credited. For purposes of this subdivision, the date of payment is the due date of the return or the date of actual payment of the tax, whichever is later~~ in the manner provided in section 289A.56, subdivision 2.

EFFECTIVE DATE. This section is effective for overpayments made on or after January 1, 2020.

Sec. 27. Minnesota Statutes 2018, section 295.582, subdivision 1, is amended to read:

Subdivision 1. **Tax expense transfer.** (a) A hospital, surgical center, or health care provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor, may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. Nothing shall prohibit a pharmacy from transferring the additional expense generated under section 295.52 to a pharmacy benefits manager. The additional expense transferred to the third-party purchaser or a pharmacy benefits manager must not exceed the tax percentage specified in section 295.52 multiplied against the gross revenues received under the third-party contract, and the tax percentage specified in section 295.52 multiplied against co-payments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, ~~or~~ 79A, or 256T, or under section 471.61 or 471.617, and pharmacy benefits managers must pay the transferred expense in addition to any payments due under existing contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. A third-party purchaser of health care services includes, but is not limited to, a health carrier or community integrated service network that pays for health care services on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures patients for health care services. For purposes of this section, a pharmacy benefits manager means an entity that performs pharmacy benefits management. A third-party purchaser or pharmacy benefits manager shall comply with this section regardless of whether the third-party purchaser or pharmacy benefits manager is a for-profit, not-for-profit, or nonprofit entity. A wholesale drug distributor may transfer additional expense generated by section 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay the additional expense. Nothing in this section limits the ability of a hospital, surgical center, pharmacy, wholesale drug distributor, or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

(b) Any hospital, surgical center, or health care provider subject to a tax under section 295.52 or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor may file a complaint with the commissioner responsible for

regulating the third-party purchaser if at any time the third-party purchaser fails to comply with paragraph (a).

(c) If the commissioner responsible for regulating the third-party purchaser finds at any time that the third-party purchaser has not complied with paragraph (a), the commissioner may take enforcement action against a third-party purchaser which is subject to the commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center, pharmacy, or provider to pass-through the tax. The commissioner may by order fine or censure the third-party purchaser or revoke or suspend the certificate of authority or license of the third-party purchaser to do business in this state if the commissioner finds that the third-party purchaser has not complied with this section. The third-party purchaser may appeal the commissioner's order through a contested case hearing in accordance with chapter 14.

Sec. 28. Minnesota Statutes 2018, section 297I.05, subdivision 5, is amended to read:

Subd. 5. **Health maintenance organizations, nonprofit health service plan corporations, OneCare Buy-In plans, and community integrated service networks.** (a) A tax is imposed on health maintenance organizations, community integrated service networks, OneCare Buy-In plans established under chapter 256T, and nonprofit health care service plan corporations. The rate of tax is equal to one percent of gross premiums less return premiums on all direct business received by the organization, network, plan, or corporation or its agents in Minnesota, in cash or otherwise, in the calendar year.

(b) The commissioner shall deposit all revenues, including penalties and interest, collected under this chapter from health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations in the health care access fund and shall deposit all revenues collected from OneCare Buy-In plans in the hospital financial reimbursement fund established under section 256T.02, subdivision 12. Refunds of overpayments of tax imposed by this subdivision must be paid from the health care access fund. There is annually appropriated from the health care access fund to the commissioner the amount necessary to make any refunds of the tax imposed under this subdivision.

EFFECTIVE DATE. This section is effective for premiums received on or after January 1, 2023.

Sec. 29. **DIRECTION TO COMMISSIONER; STATE-BASED RISK ADJUSTMENT ANALYSIS.**

The commissioner of commerce, in consultation with the commissioner of health, shall conduct a study on the design and implementation of a state-based risk adjustment program. The commissioner shall report on the findings of the study and any recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over the individual health insurance market by February 15, 2021.

Sec. 30. **STUDY OF COST OF PROVIDING DENTAL SERVICES.**

The commissioner of human services shall contract with a vendor to conduct a survey of the cost to Minnesota dental providers of delivering dental services to medical assistance and MinnesotaCare enrollees under both fee-for-service and managed care. The commissioner of human services shall ensure that the vendor has prior experience in conducting surveys of the cost of providing health care services. Each dental provider enrolled with the department must respond to the cost of service survey. The commissioner of human services may sanction a dental provider under Minnesota Statutes, section 256B.064, for failure to respond. The commissioner of human services shall require the vendor to measure statewide and regional costs for both fee-for-service and managed care, by major dental service category and for the most common dental services. The commissioner of human services shall post a copy of the final survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and the survey must be repeated every three years. The commissioner of human services shall provide a summary of the results of each cost of dental services survey and provide recommendations for any changes to dental payment rates to the chairs and ranking members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 31. **OUTPATIENT PHARMACY BENEFIT FOR ENROLLEES OF HEALTH PLAN COMPANIES.**

(a) The commissioner of human services shall develop a plan for an outpatient pharmacy benefit to be administered by the commissioner of human services for enrollees of health plan companies. The plan must:

(1) provide prescription drug coverage, beginning January 1, 2022, to the enrollees of health plan companies that choose to participate in the pharmacy benefit program;

(2) provide coverage and reimbursement for outpatient prescription drugs in accordance with Minnesota Statutes, chapter 256L;

(3) require the commissioner to annually determine and publish the monthly premium per enrollee for prescription drug coverage by August 1 of each year, for coverage taking effect the following January 1;

(4) establish different co-payments for each of the following categories: preferred generic drugs; preferred branded drugs; nonpreferred generic drugs; nonpreferred branded drugs; and specialty drugs; and

(5) require a health plan company that enters into a contract with the commissioner to participate in the program to pay the commissioner for all costs incurred in providing a prescription drug benefit, including costs related to benefit administration and the purchasing of prescription drugs.

(b) The commissioner shall present the plan to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and health insurance by December 15, 2019.

Sec. 32. **BENEFIT AND COST ANALYSIS OF A UNIFIED HEALTH CARE FINANCING SYSTEM.**

Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall contract with the University of Minnesota School of Public Health to conduct an analysis of the current health care financing environment and evaluate whether a unified health care financing system would provide better access to care, reduce or slow the rate of increase in total health care spending, and provide other benefits to individuals, businesses, and the state economy, relative to the current health care financing environment.

Subd. 2. **Proposal.** The analysis shall include recommendations for a framework for a unified health care financing system designed to:

(1) ensure all Minnesotans have access to all necessary primary and specialty care, including dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term, and home care;

(2) maximize the ability for patients to choose doctors, hospitals, and other providers; and

(3) incentivize a focus on preventative care and public health, including social determinants of health and care coordination.

Subd. 3. **Proposal analysis.** (a) The analysis must forecast over a ten-year or longer period determined to be sufficient to capture all benefits and costs of the unified health care financing system. The analysis must compare and contrast the impact of the proposed health care financing system and the current health care financing environment on:

(1) the number of people covered versus the number of people who continue to lack access to health care because of financial or other barriers, if any;

(2) the completeness of the coverage and the number of people lacking coverage for dental, long-term care, medical equipment or supplies, vision and hearing, or other health services that are not covered, if any;

(3) the adequacy of the coverage, the level of underinsured in the state, and whether people with coverage can afford the care they need or whether cost prevents them from accessing care;

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

(5) total public and private health care spending in Minnesota under the current health care financing environment versus a unified health care financing system, including all spending by individuals, businesses, and government. "Total public and private health care spending" means spending on all medical care including but not limited to dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical

equipment and supplies, long-term care, and home care, whether paid through premiums, co-pays and deductibles, other out-of-pocket payments, or other funding from government, employers, or other sources. Total public and private health care spending also includes the costs associated with administering, delivering, and paying for the care. The costs of administering, delivering, and paying for the care includes all expenses by insurers, providers, employers, individuals, and government to select, negotiate, purchase, and administer insurance and care including but not limited to coverage for health care, dental, prescription drugs, medical expense portions of workers compensation and automobile insurance, and the cost of administering and paying for all health care products and services that are not covered by insurance. The analysis of total health care spending shall examine, to the extent possible given available data and resources, whether there are savings or additional costs under the proposed health care financing system compared to the existing health care financing environment due to:

(i) reduced insurance, billing, underwriting, marketing, evaluation, and other administrative functions including savings from global budgeting for hospitals and institutional care instead of billing for individual services provided;

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

(iii) shortages or excess capacity of medical facilities and equipment;

(iv) changes in utilization, better health outcomes, and reduced time away from work due to prevention, early intervention, and health-promoting activities; and

(v) the impact on state, local, and federal government non-health-care expenditures, such as reduced demand for public services and reduced out-of-home placement costs due to increased access to mental health and chemical dependency services.

(b) The analysis shall assume that operation of the unified health care financing system is not preempted by federal law.

(c) The commissioner shall issue a final report by January 15, 2021, and may provide interim reports and status updates to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 33. **RATE CHANGES AND DENTAL ACCESS.**

The commissioner of human services, in consultation with stakeholders, including the Health Services Policy Committee established in Minnesota Statutes, section 256B.0625, subdivision 3c, shall analyze the impact of the dental rate changes in this article that take effect January 1, 2022, to evaluate the impact on access to dental services for medical assistance and MinnesotaCare program participants. The analysis may recommend changes to payment methodologies. In evaluating access, the analysis shall at a minimum consider distance traveled by enrollees, access to regular and urgent dental care, and the availability

of a dental home. The analysis shall consider the impact of any changes on the providers currently enrolled in the medical assistance and MinnesotaCare programs as well as the potential impact on providers who currently do not participate. Any changes to payment methodologies recommended as part of this analysis must include a comprehensive, uniform rate for the provision of dental services for all recipients of medical assistance and MinnesotaCare, prioritizing access to both preventative and restorative dental services among children under age 21. The commissioner shall provide, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, a preliminary report on the results of the analysis by December 1, 2019, and a final report and any recommendations by December 1, 2020.

Sec. 34. **REPEALER.**

Minnesota Statutes 2018, section 256L.11, subdivision 6a, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2022.