ARTICLE 5
HEALTH INSURANCE

Section 1. Minnesota Statutes 2016, section 62A.04, subdivision 1, is amended to read:

Subdivision 1. **Reference.** Any reference to "standard provisions" which may appear in other sections and which refer to accident and sickness or accident and health insurance shall hereinafter be construed as referring to accident and sickness policy provisions. The provisions of subdivision 2, clauses (4), (5), (6), (7), (8), (9), (10), and (12); subdivision 3, clauses (1), (3), (4), (5), (6), and (7); subdivision 6; and subdivision 10 do not apply to accident and sickness or accident and health insurance that are health plans defined in section 62A.011, subdivision 3.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 2. Minnesota Statutes 2016, section 62A.21, subdivision 2a, is amended to read:

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's ~~former spouse and~~ dependent children ~~upon~~ as defined in section 62Q.01, subdivision 2a, and former spouse, who was covered on the day before entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) the date the insured's former spouse becomes covered under any other group health plan; or

(b) the date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Upon request by the insured's ~~former spouse or~~ dependent ~~child~~ children and former spouse, who was covered on the day before entry of a valid decree of dissolution, a health

carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 3. Minnesota Statutes 2016, section 62A.3075, is amended to read:

62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.

(a) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells than what the health plan requires for an intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health plan company.

(b) A health plan company must not achieve compliance with this section by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent covered under the health plan.

(c) Nothing in this section shall be interpreted to prohibit a health plan company from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for any chemotherapy.

(d) A plan offered by the commissioner of management and budget under section 43A.23 is deemed to be at parity and in compliance with this section.

(e) A health plan company is in compliance with this section if it does not include orally administered anticancer medication in the fourth tier of its pharmacy benefit.

(f) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment must indicate the level of coverage for orally administered anticancer medication within its pharmacy benefit filing with the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2016, section 62D.105, subdivision 1, is amended to read:

Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to covering the enrollee also provides coverage to the ~~spouse and~~ dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, of the enrollee and spouse who

was covered on the day before entry of a valid decree of dissolution shall: (1) permit the spouse and dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, to elect to continue coverage when the enrollee becomes enrolled for benefits under title XVIII of the Social Security Act (Medicare); and (2) permit the dependent children to continue coverage when they cease to be dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, under the generally applicable requirement of the plan.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 5. Minnesota Statutes 2016, section 62D.105, subdivision 2, is amended to read:

Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be continued until the earlier of the following dates:

(1) the date coverage would otherwise terminate under the contract;

(2) 36 months after continuation by the spouse or dependent was elected; or

(3) the date the spouse or dependent children become covered under another group health plan or Medicare.

If coverage is provided under a group policy, any required fees for the coverage shall be paid by the enrollee on a monthly basis to the group contract holder for remittance to the health maintenance organization. In no event shall the fee charged exceed 102 percent of the cost to the plan for such coverage for other similarly situated spouse and dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 6. Minnesota Statutes 2016, section 62E.04, subdivision 11, is amended to read:

Subd. 11. ~~**Essential health benefits package**~~ **Affordable Care Act compliant plans.** For ~~individual or small group health plans that include the essential health benefits package and are~~ any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, ~~2014~~ 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 7. Minnesota Statutes 2016, section 62E.05, subdivision 1, is amended to read:

Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All plans of health coverage, except Medicare supplement policies, shall be labeled as "qualified" or "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified plans shall indicate whether they are number one, two, or three coverage plans. For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 8. Minnesota Statutes 2016, section 62E.06, is amended by adding a subdivision to read:

Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 9. **[62K.16] COVERAGE TERMINATION NOTIFICATION.**

(a) All individual health carriers issuing individual health plans must permit enrollees to terminate their individual health plan coverage by directly contacting either the health carrier or MNsure, if the enrollee purchased the coverage through MNsure. If an enrollee terminates coverage by contacting the health carrier directly, the health carrier must inform MNsure of the termination request.

(b) Health plan companies and MNsure shall develop a form that can be accessed by an enrollee through either the health plan company's Web site or MNsure's Web site for the purpose of terminating coverage online.

(c) Termination of coverage shall be effective the first day of the month following the month in which the enrollee notified either the health carrier or MNsure.

Sec. 10. Minnesota Statutes 2016, section 62M.07, is amended to read:

62M.07 PRIOR AUTHORIZATION OF SERVICES.

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(c) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This paragraph does not apply to dental service covered under MinnesotaCare or medical assistance.

(d) Any prior authorization for a prescription drug must remain valid for the duration of an enrollee's contract term. These requirements related to the validity of prior authorization apply only if:

(1) the drug continues to be prescribed for a patient with a condition that requires ongoing medication therapy;

(2) the drug has not otherwise been deemed unsafe by the Food and Drug Administration;

(3) the drug has not been withdrawn by the manufacturer or the Food and Drug Administration;

(4) there is no evidence of the enrollee's abuse or misuse of the prescription drug; and

(5) no independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

This paragraph does not apply to individuals enrolled in a public health care program under chapter 256B or 256L; or assigned to the restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

Sec. 11. **[62Q.575] ACCESS TO PRIMARY CARE PROVIDERS.**

Subdivision 1. **Provider network.** (a) No health plan company offering an individual health plan that is not a grandfathered plan shall deny a primary care provider the right to contract with the health plan company as an in-network provider if the primary care provider meets one of the following criteria:

(1) is certified as a health care home by the commissioner of health under section 256B.0751. To remain eligible for in-network status under this section, the primary care provider must maintain certification as a health care home; or

(2) is in the process of becoming certified as a health care home under section 256B.0751. To remain eligible for in-network status under this subdivision, the primary care provider must complete the certification process within six months to remain an in-network provider.

(b) A health plan company may require the primary care provider to meet reasonable data, utilization review, and quality assurance requirements on the same basis as other in-network providers.

(c) The primary care provider must agree to serve all enrollees of the health care company who select or designate the primary care provider, if designation is required.

(d) The primary care provider and health plan company may negotiate the payment rate for covered services provided by the primary care provider. The rate must not be less than the rate paid by the health plan company to the provider under a different category of coverage or health product, or other arrangement within a category of coverage.

Subd. 2. **Cost-sharing or other conditions.** No health plan company shall impose a co-payment, fee, or other cost-sharing requirement for selecting or designating a primary care provider of the enrollee's choosing or impose other conditions that limit the enrollee's ability to utilize a primary care provider of the enrollee's choosing, unless the health plan company imposes the same cost-sharing requirements, fees, conditions, or limits upon an enrollee's selection or designation of any of the health plan company's in-network primary care providers.

Subd. 3. **Care coordination.** (a) As part of the provider contract with primary care providers that are certified health care homes, the contract must include a care coordination payment for providing care coordination services. The care coordination payment under this subdivision must be a per enrollee, per month payment and must be in addition to the payment rate for the covered services provided by the primary care provider.

(b) The care coordination payment may vary based on care complexity, but must at least be equal to the payment amounts established under section 256B.0753.

(c) The health plan company shall not impose a co-payment, fee, or other cost-sharing requirement for care coordination services.

Subd. 4. **Notice.** The health plan company shall provide notice to enrollees of the provisions of this section.

Subd. 5. **Definition.** For purposes of this section, "primary care provider" means a physician licensed under chapter 147 or an advanced practice registered nurse licensed under chapter 148 who specializes in the practice of family medicine, general internal medicine, obstetrics and gynecology, or general pediatrics; or a health care clinic that specializes in the above-mentioned areas and utilizes a primary care team that includes physicians, physician assistants, or advanced practice registered nurses.

Subd. 6. **Limitations.** (a) This section does not apply to enrollees who are enrolled in a public health care program under chapter 256B or 256L, or the Minnesota restricted recipient program pursuant to Minnesota Rules, part 9505.2238.

(b) This section does not waive any exclusions of coverage under the terms and conditions of the enrollee's health plan.

(c) This section only applies to individual health plans.

Subd. 7. **Enforcement.** The commissioner of health shall enforce this section.

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to any individual health plan offered, sold, issued, or renewed on or after that date.

Sec. 12. **[62Q.678] NETWORK OFFERINGS.**

(a) In counties where a health plan company actively markets an individual health plan, the health plan company must offer, in those counties, at least one individual health plan with a provider network that includes in-network access to more than a single health care provider system or a health plan that includes more than one primary care location in a county. This section is applicable only for the plan year in which the health plan company actively markets an individual health plan.

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

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to any health plan offered, sold, issued, or renewed on or after that date.

Sec. 13. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

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

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract year" means the 12-month term during which benefits associated with health plan company products are in effect.

(d) "Formulary" means a list of prescription drugs that have been developed by clinical and pharmacy experts and represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company. For purposes of this definition, "pharmacy benefits management" means the administration

or management of prescription drug benefits provided by the health plan company for the benefit of its enrollees and may include, but is not limited to, procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make its formulary and related benefit information available by electronic means and, upon request, in writing, at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's (USP) Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract year:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract year upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract year.

(d) A health plan company may remove any drugs from its formulary that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either

the Food and Drug Administration or the product manufacturer, or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

Subd. 4. **Exclusions.** This section does not apply to individuals enrolled in a public health care program under chapter 256B or 256L, or assigned to the restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

Sec. 14. Minnesota Statutes 2016, section 317A.811, subdivision 1, is amended to read:

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

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

(2) a health maintenance organization operating under chapter 62D;

(3) a service plan corporation operating under chapter 62C; or

~~(2)~~ (4) a corporation that is exempt under section 501(c)(3) of the Internal Revenue Code of 1986, or any successor section.

(b) The notice must include:

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

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

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

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

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

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

(7) a list of persons to whom assets will be transferred, if known;

(8) the purposes of persons receiving the assets; and

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

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

Sec. 15. Minnesota Statutes 2016, section 317A.811, is amended by adding a subdivision to read:

Subd. 1a. **Nonprofit health care entity; notice and approval required.** A corporation that is a health maintenance organization or a service plan corporation is subject to notice and approval requirements for certain transactions under section 317A.814.

Sec. 16. **[317A.814] NONPROFIT HEALTH CARE ENTITY CONVERSIONS.**

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

(b) "Commissioner" means the commissioner of commerce if the nonprofit health care entity at issue is a service plan corporation operating under chapter 62C, and the commissioner of health if the nonprofit health care entity at issue is a health maintenance organization operating under chapter 62D.

(c) "Conversion benefit entity" means a foundation, corporation, limited liability company, trust, partnership, or other entity that receives public benefit assets, or their value, in connection with a conversion transaction.

(d) "Conversion transaction" or "transaction" means a transaction in which a nonprofit health care entity merges, consolidates, converts, or transfers all or a substantial portion of its assets to an entity that is not a nonprofit corporation organized under this chapter that is also exempt under United States Code, title 26, section 501(c)(3). The substitution of a new corporate member that transfers the control, responsibility for, or governance of a nonprofit health care entity is also considered a transaction for purposes of this section.

(e) "Family member" means a spouse, parent, or child or other legal dependent.

(f) "Nonprofit health care entity" means a service plan corporation operating under chapter 62C and a health maintenance organization operating under chapter 62D.

(g) "Public benefit assets" means the entirety of a nonprofit health care entity's assets, whether tangible or intangible.

(h) "Related organization" has the meaning given in section 317A.011.

Subd. 2. **Private inurement.** A nonprofit health care entity must not enter into a conversion transaction if a person who has been an officer, director, or other executive of the nonprofit health care entity, or of a related organization, or a family member of that person:

(1) has or will receive any compensation or other financial benefit, directly or indirectly, in connection with the conversion transaction;

(2) has held or will hold, regardless of whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in, or receive any type of compensation or other financial benefit from, any entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction; or

(3) has held or will hold, regardless of whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in, or receive any type of compensation or other financial benefit from, any entity that has or will have a business relationship with any entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction.

Subd. 3. **Attorney general notice and approval required.** (a) Before entering into a conversion transaction, the nonprofit health care entity must notify the attorney general as specified under section 317A.811, subdivision 1. The notice required by this subdivision also must include an itemization of the nonprofit health care entity's public benefit assets and the valuation that the entity attributes to those assets, a proposed plan for distribution of the value of those assets to a conversion benefit entity that meets the requirements of subdivision 5, and other information from the health maintenance organization or the proposed conversion benefit entity that the attorney general reasonably considers necessary for review of the proposed transaction.

(b) A copy of the notice and other information required under this subdivision must be given to the commissioner.

Subd. 4. **Review elements.** (a) The attorney general may approve, conditionally approve, or not approve a conversion transaction under this section. In making a decision whether to approve, conditionally approve, or not approve a proposed transaction, the attorney general, in consultation with the commissioner, shall consider any factors the attorney general considers relevant, including whether:

(1) the proposed transaction complies with this chapter and chapter 501B and other applicable laws;

(2) the proposed transaction involves or constitutes a breach of charitable trust;

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

(4) the full and fair value of the public benefit assets to be transferred has been manipulated in a manner that causes or has caused the value of the assets to decrease;

(5) the proceeds of the proposed transaction will be used consistent with the public benefit for which the assets are held by the nonprofit health care entity;

(6) the proposed transaction will result in a breach of fiduciary duty, as determined by the attorney general, including whether:

(i) conflicts of interest exist related to payments to or benefits conferred upon officers, directors, board members, and executives of the nonprofit health care entity or a related organization;

(ii) the nonprofit health care entity's board of directors exercised reasonable care and due diligence in deciding to pursue the transaction, in selecting the entity with which to pursue the transaction, and in negotiating the terms and conditions of the transaction; and

(iii) the nonprofit health care entity's board of directors considered all reasonably viable alternatives, including any competing offers for its public benefit assets, or alternative transactions;

(7) the transaction will result in private inurement to any person, including owners, stakeholders, or directors, officers, or key staff of the nonprofit health care entity or entity to which the nonprofit health care entity proposes to transfer public benefit assets;

(8) the conversion benefit entity meets the requirements of subdivision 5; and

(9) the attorney general and the commissioner have been provided with sufficient information by the nonprofit health care entity to adequately evaluate the proposed transaction and the effects on the public, provided the attorney general or the commissioner has notified the nonprofit health care entity or the proposed conversion benefit entity of any inadequacy of the information and has provided a reasonable opportunity to remedy that inadequacy.

In addition, the attorney general shall consider the public comments received regarding the proposed conversion transaction and the proposed transaction's likely effect on the availability, accessibility, and affordability of health care services to the public.

(b) The attorney general must consult with the commissioner in making a decision whether to approve or disapprove a transaction.

Subd. 5. **Conversion benefit entity requirements.** (a) A conversion benefit entity must be an existing or new domestic nonprofit corporation organized under this chapter and also be exempt under United States Code, title 26, section 501(c)(3).

(b) The conversion benefit entity must be completely independent of any influence or control by the nonprofit health care entity and related organizations, all entities to which the nonprofit health care entity transfers any public benefit assets in connection with a conversion transaction, and the directors, officers, and other executives of those organizations or entities.

(c) The conversion benefit entity must have in place procedures and policies to prohibit conflicts of interest, including but not limited to prohibiting conflicts of interests relating to any grant-making activities that may benefit:

(1) the directors, officers, or other executives of the conversion benefit entity;

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

(3) any directors, officers, or other executives of any entity to which the nonprofit health care entity transfers any public benefit assets in connection with a conversion transaction.

(d) The charitable purpose and grant-making functions of the conversion benefit entity must be dedicated to meeting the health care needs of the people of this state.

Subd. 6. **Public comment.** Before issuing a decision under subdivision 7, the attorney general may solicit public comment regarding the proposed conversion transaction. The attorney general may hold one or more public meetings or solicit written or electronic correspondence. If a meeting is held, notice of the meeting must be published in a qualified newspaper of general circulation in this state at least seven days before the meeting.

Subd. 7. **Period for approval or disapproval; extension.** (a) Within 150 days of receiving notice of a proposed transaction, the attorney general shall notify the nonprofit health care entity in writing of its decision to approve, conditionally approve, or disapprove the transaction. If the transaction is not approved, the notice must include the reason for the decision. If the transaction is conditionally approved, the notice must specify the conditions that must be met. The attorney general may extend this period for an additional 90 days if necessary to obtain additional information.

(b) The time periods under this subdivision are suspended during the time when a request from the attorney general for additional information is outstanding.

Subd. 8. **Transfer of value of assets required.** If a proposed conversion transaction is approved or conditionally approved by the attorney general, the nonprofit health care entity shall transfer the entirety of the full and fair value of its public benefit assets to one or more conversion benefit entities as part of the transaction.

Subd. 9. **Assessment of costs.** The nonprofit health care entity or the conversion benefit entity must reimburse the attorney general or a state agency for all reasonable and actual costs incurred by the attorney general or a state agency in reviewing a proposed conversion transaction, including attorney fees at the billing rate used by the attorney general for state agencies and the costs for retention of actuarial, valuation, or other experts or consultants, and administrative costs.

Subd. 10. **Annual report by conversion benefit entity.** A conversion benefit entity must submit an annual report to the attorney general that contains a detailed description of its charitable activities related to the use of the public benefit assets received under a transaction that is approved under this section.

Subd. 11. **Penalties; remedies.** A conversion transaction entered into in violation of this section is null and void. The attorney general is authorized to bring an action to unwind a conversion transaction entered into in violation of this section and to recover the amount of any private inurement received or held in violation of subdivision 2. In addition to this recovery, the officers, directors, and other executives of each entity that is a party to and materially participated in a conversion transaction entered into in violation of this section may be subject to a civil penalty of up to the greater of either the entirety of any financial benefit each one derived from the transaction, or $1,000,000, as determined by the court. The attorney general is authorized to enforce this section pursuant to section 8.31.

Subd. 12. **Relation to other law.** (a) This section is in addition to, and does not affect or limit any power, remedy, or responsibility of a health maintenance organization, service plan corporation, a conversion benefit entity, the attorney general, or the commissioner under this chapter, chapter 62C, 62D, 501B, or other law.

(b) Nothing in this section authorizes a nonprofit health care entity to enter into a conversion transaction not otherwise permitted under this chapter.

Sec. 17. Laws 2017, chapter 2, article 1, section 1, subdivision 3, is amended to read:

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

(1) is not receiving ~~a~~ an advanced premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, ~~as of the date their coverage is effectuated~~ in a month in which their coverage is effective;

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

(3) purchased an individual health plan from a health carrier in the individual market.

Sec. 18. Laws 2017, chapter 2, article 1, section 2, subdivision 4, is amended to read:

Subd. 4. **Data practices.** (a) The definitions in Minnesota Statutes, section 13.02, apply to this subdivision.

(b) Government data on an enrollee or health carrier under this section are private data on individuals or nonpublic data, except that the total reimbursement requested by a health carrier and the total state payment to the health carrier are public data.

(c) Notwithstanding Minnesota Statutes, section 138.17, not public government data on an enrollee or health carrier collected under this section must be destroyed by June 30, 2018, or upon completion by the legislative auditor of the audits required by section 3, whichever is later, except to the extent the legislative auditor maintains data for a longer period of time in order to comply with generally accepted government auditing standards.

Sec. 19. Laws 2017, chapter 2, article 1, section 2, is amended by adding a subdivision to read:

Subd. 5. **Data sharing.** (a) Notwithstanding any law to the contrary, the commissioner of human services and the executive director of MNsure must disclose to the commissioner of management and budget data on public program coverage enrollment under Minnesota Statutes, sections 256B.055 and 256L.04, data on an enrollee's receipt of an advanced premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2.

(b) Notwithstanding any law to the contrary, the commissioner of management and budget must disclose data to health carriers on enrollees' enrollment in public program coverage under Minnesota Statutes, section 256B.055 or 256L.04, to the extent that the commissioner determines the disclosure is necessary for purposes of determining eligibility for the premium subsidy program authorized by this act.

(c) Data disclosed under this subdivision may be used only for the purpose of administration of the premium subsidy program under this act and may not be further disclosed to any other person, except as otherwise provided by law.

Sec. 20. Laws 2017, chapter 2, article 1, section 3, is amended to read:

Sec. 3. **AUDITS.**

(a) The legislative auditor shall conduct audits of the health carriers' supporting data, as prescribed by the commissioner, to determine whether payments align with criteria established in sections 1 and 2. The commissioner of human services shall provide data as necessary to the legislative auditor to complete the audit. The commissioner shall withhold or charge back payments to the health carriers to the extent they do not align with the criteria established in sections 1 and 2, as determined by the audit.

(b) The legislative auditor shall audit the extent to which health carriers provided premium subsidies to persons meeting the residency and other eligibility requirements specified in section 1, subdivision 3. The legislative auditor shall report to the commissioner the amount of premium subsidies provided by each health carrier to persons not eligible for a premium subsidy. The commissioner, in consultation with the commissioners of commerce ~~and~~, health, and human services shall develop and implement a process to recover from health carriers the amount of premium subsidies received for enrollees determined to be ineligible for premium subsidies by the legislative auditor. The legislative auditor, when conducting the required audit, and the commissioner, when determining the amount of premium subsidy to be recovered, may take into account the extent to which a health carrier makes use of the Minnesota eligibility system, as defined in Minnesota Statutes, section 62V.055, subdivision 1.

Sec. 21. Laws 2017, chapter 2, article 1, section 5, is amended to read:

Sec. 5. **SUNSET.**

This article ~~sunsets June 30~~, other than section 2, subdivision 5, and section 3, sunsets August 31, 2018.

Sec. 22. Laws 2017, chapter 2, article 1, section 7, is amended to read:

Sec. 7. **APPROPRIATIONS.**

(a) $311,788,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of management and budget for premium assistance under section 2. This appropriation is onetime and is available through ~~June 30~~ August 31, 2018.

(b) $157,000 in fiscal year 2017 is appropriated from the general fund to the legislative auditor for purposes of section 3. This appropriation is onetime.

(c) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018, shall be transferred ~~on July 1~~ no later than August 31, 2018, from the general fund to the budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

Sec. 23. Laws 2017, chapter 2, article 2, section 13, is amended to read:

Sec. 13. **62Q.556 UNAUTHORIZED PROVIDER SERVICES.**

Subdivision 1. **Unauthorized provider services.** (a) Except as provided in paragraph (c), unauthorized provider services occur when an enrollee receives services:

(1) from a nonparticipating provider at a participating hospital or ambulatory surgical center, when the services are rendered:

(i) due to the unavailability of a participating provider;

(ii) by a nonparticipating provider without the enrollee's knowledge; or

(iii) due to the need for unforeseen services arising at the time the services are being rendered; or

(2) from a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility.

(b) Unauthorized provider services do not include emergency services as defined in section 62Q.55, subdivision 3.

(c) The services described in paragraph (a), clause (2), are not unauthorized provider services if the enrollee gives advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan.

Subd. 2. **Prohibition.** (a) An enrollee's financial responsibility for the unauthorized provider services shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services

with the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the health care services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties.

(c) The commissioner of health, in consultation with the commissioner of the Bureau of Mediation Services, must develop a list of professionals qualified in arbitration, for the purpose of resolving disputes between a health plan company and nonparticipating provider arising from the payment for unauthorized provider services. The commissioner of health shall publish the list on the department of health's Web Site, and update the list as appropriate.

(d) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.

Subd. 3. **Scope.** This section does not apply to services provided under chapter 256B or 256L.

Sec. 24. Laws 2017, chapter 2, article 2, section 13, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~90 days following final enactment~~ January 1, 2019, and applies to provider services provided on or after that date.

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

Sec. 25. **WAIVER.**

MNsure shall seek any federal waivers necessary to permit enrollees to contact health carriers directly to terminate individual health plan coverage according to Minnesota Statutes, section 62K.16, when the individual purchased the coverage through MNsure.

EFFECTIVE DATE. This section is effective January 1, 2018, or upon federal approval if required, whichever is later.