ARTICLE 3

HEALTH INSURANCE

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

Subdivision 1. **Notice required.** (a) No later than April 15 each year, an insurance company that issues health plans, as defined in section 62A.011, and is licensed under this chapter to offer, sell, or issue a policy of accident and sickness insurance, as defined in section 62A.01, subdivision 1, or that is a nonprofit health service plan corporation operating under chapter 62C must notify the commissioner if, for an insurance company or nonprofit health service plan corporation with at least 25,000 enrollees, the insurance company or nonprofit health service plan corporation:

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

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

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

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

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

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

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

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

(b) If the information reported under paragraph (a) raises a concern with respect to an insurance company's or nonprofit health service plan corporation's business on a prospective basis due to anticipated business growth, including but not limited to anticipated business growth, strain on surplus, increased exposure to risk, or an imbalanced mix of business, the commissioner may issue a corrective order specifying corrective actions the commissioner determines are required. A corrective order issued under this paragraph is subject to review under chapter 14.

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

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

Sec. 3. **[60A.593] PROHIBITED ACTIVITIES.**

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

Sec. 4. Minnesota Statutes 2025 Supplement, section 62A.31, subdivision 1u, is amended to read:

Subd. 1u. **Guaranteed issue for eligible persons.** (a)(1) Eligible persons are those individuals described in paragraph (b) who seek to enroll under the policy during the period specified in paragraph (c) and who submit evidence of the date of termination or disenrollment described in paragraph (b), or of the date of Medicare Part D enrollment, with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not: deny or condition the issuance or effectiveness of a Medicare supplement policy described in paragraph (c) that is offered and is available for issuance to new enrollees by the issuer; discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, medical condition, or age; or impose an exclusion of benefits based upon a preexisting condition under such a Medicare supplement policy.

(b) An eligible person is an individual described in any of the following:

(1) the individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(2) the individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the federal Social Security Act, and there are circumstances similar to those described in this clause that would permit

discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:

(i) the organization's or plan's certification under Medicare Part C has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(ii) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, United States Code, title 42, section 1395w-21(g)(3)(b) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the federal Social Security Act, United States Code, title 42, section 1395w-26), or the plan is terminated for all individuals within a residence area;

(iii) the individual demonstrates, in accordance with guidelines established by the Secretary, that:

(A) the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(B) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(iv) the individual meets such other exceptional conditions as the secretary may provide;

(3)(i) the individual is enrolled with:

(A) an eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) an organization under an agreement under section 1833(a)(1)(A) of the federal Social Security Act, United States Code, title 42, section 1395l(a)(1)(A) (health care prepayment plan); or

(D) an organization under a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under clause (2);

(4) the individual is enrolled under a Medicare supplement policy, and the enrollment ceases because:

(i)(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(B) of other involuntary termination of coverage or enrollment under the policy;

(ii) the issuer of the policy substantially violated a material provision of the policy; or

(iii) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5)(i) the individual was enrolled under a Medicare supplement policy and terminates that enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C; any eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost); any similar organization operating under demonstration project authority; any PACE provider under section 1894 of the federal Social Security Act, or a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the subsequent enrollment under item (i) is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the federal Social Security Act;

(6) the individual, upon first enrolling for benefits under Medicare Part B, enrolls in a Medicare Advantage plan under Medicare Part C, or with a PACE provider under section 1894 of the federal Social Security Act, and disenrolls from the plan by not later than 12 months after the effective date of enrollment;

(7) the individual enrolls in a Medicare Part D plan during the initial Part D enrollment period, as defined under United States Code, title 42, section 1395ss(v)(6)(D), and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (e), clause (4);

(8) the individual was enrolled in a state public program and is losing coverage due to the unwinding of the Medicaid continuous enrollment conditions, as provided by Code of Federal Regulations, title 45, section 155.420 (d)(9) and (d)(1), and Public Law 117-328, section 5131 (2022); or

(9) the individual meets the requirements under subdivision 1r, paragraph (c), and enrolls during the open enrollment period.

(c)(1) In the case of an individual described in paragraph (b), clause (1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination

or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation; or (ii) the date that the applicable coverage terminates or ceases; and ends 63 days after the later of those two dates.

(2) In the case of an individual described in paragraph (b), clause (2), (3), (5), or (6), whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in paragraph (b), clause (4), item (i), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (ii) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in paragraph (b), clause (2), (4), (5), or (6), who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(5) In the case of an individual described in paragraph (b), clause (7), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in paragraph (b) but not described in this paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(7) For an individual described in paragraph (b), clause (9), the guarantee issue period is the open enrollment period.

(d)(1) In the case of an individual described in paragraph (b), clause (5), or deemed to be so described, pursuant to this paragraph, whose enrollment with an organization or provider described in paragraph (b), clause (5), item (i), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (5).

(2) In the case of an individual described in paragraph (b), clause (6), or deemed to be so described, pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (b), clause (6), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (6).

(3) For purposes of paragraph (b), clauses (5) and (6), no enrollment of an individual with an organization or provider described in paragraph (b), clause (5), item (i), or with a plan or in a program described in paragraph (b), clause (6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with the organization, provider, plan, or program.

(e) The Medicare supplement policy to which eligible persons are entitled under:

(1) paragraph (b), clauses (1) to ~~(4)~~ (3), is any Medicare supplement policy that has a benefit package consisting of the basic Medicare supplement plan described in section 62A.316, paragraph (a), plus any combination of the three optional riders described in section 62A.316, paragraph (b), clauses (1) to (3), offered by any issuer;

(2) paragraph (b), clause (5), is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, any policy described in clause (1) offered by any issuer, except that after December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy to which the individual is entitled under paragraph (b), clause (5), is:

(i) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) at the election of the policyholder, a policy described in clause (4), except that the policy may be one that is offered and available for issuance to new enrollees that is offered by any issuer;

(3) paragraph (b), ~~clause~~ clauses (4) and (6), is any Medicare supplement policy offered by any issuer;

(4) paragraph (b), clause (7), is a Medicare supplement policy that has a benefit package classified as a basic plan under section 62A.316 if the enrollee's existing Medicare supplement policy is a basic plan or, if the enrollee's existing Medicare supplement policy is an extended basic plan under section 62A.315, a basic or extended basic plan at the option of the enrollee, provided that the policy is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. The issuer must permit the enrollee to retain all optional benefits contained in the enrollee's existing coverage, other than outpatient prescription drugs, subject to the provision that the coverage be offered and available for issuance to new enrollees by the same issuer.

(f)(1) At the time of an event described in paragraph (b), because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare

supplement policies under paragraph (a). The notice must be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in paragraph (b), because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated within ten working days of the issuer receiving notification of disenrollment.

(g) Reference in this subdivision to a situation in which, or to a basis upon which, an individual's coverage has been terminated does not provide authority under the laws of this state for the termination in that situation or upon that basis.

(h) An individual's rights under this subdivision are in addition to, and do not modify or limit, the individual's rights under subdivision 1h.

(i) An individual described in paragraph (b), clause (4), whose enrollment ceased between January 1, 2025, and January 1, 2026, is an eligible person beginning for plan year 2027. Individuals under this paragraph are entitled to any Medicare supplement policy offered by any issuer regardless of the individual's health coverage status or health plan after the individual's enrollment ceased and before plan year 2027.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 5. Minnesota Statutes 2024, section 62D.08, is amended by adding a subdivision to read:

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

Sec. 6. **[62D.085] SUBSTANTIAL ENROLLMENT GROWTH; NOTICE.**

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

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

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

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

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

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

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

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

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

(b) If the information reported under paragraph (a) raises a concern with respect to a health maintenance organization's business on a prospective basis due to anticipated business growth, including but not limited to anticipated business growth, strain on surplus, increased exposure to risk, or an imbalanced mix of business, the commissioner may issue a corrective order specifying corrective actions the commissioner determines are required. A corrective order issued under this paragraph is subject to review under chapter 14.

Sec. 7. Minnesota Statutes 2024, section 62J.40, is amended to read:

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

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

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

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

(d) The commissioner may request unique or custom data sets from a state agency in a request under paragraph (c). The state agency may charge the commissioner a fee to provide data sets under paragraph (c) at the same rate the state agency charges another public or private entity for the same data.

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

Sec. 8. Minnesota Statutes 2024, section 62K.07, subdivision 2, is amended to read:

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

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

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

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

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

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

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

(b) The commissioner of commerce must share reported data with the commissioner of health and, in consultation with the commissioner of health, shall release a summary of the information reported in paragraph (a) at the same time as the information required under section 62A.02, subdivision 2, paragraph (c).

Sec. 9. Minnesota Statutes 2024, section 62M.02, is amended by adding a subdivision to read:

Subd. 2a. **Artificial intelligence.** "Artificial intelligence" has the meaning given in United States Code, title 15, section 9401.

Sec. 10. Minnesota Statutes 2024, section 62M.09, subdivision 3, is amended to read:

Subd. 3. **Physician reviewer; adverse determinations.** (a) A physician must review and make the adverse determination under section 62M.05 in all cases in which the utilization review organization has concluded that an adverse determination for clinical reasons is appropriate.

(b) The physician conducting the review and making the adverse determination must:

(1) hold a current, unrestricted license to practice medicine in this state; and

(2) have the same or similar medical specialty as a provider that typically treats or manages the condition for which the health care service has been requested.

This paragraph does not apply to reviews conducted in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.

(c) The physician should be reasonably available by telephone to discuss the determination with the attending health care professional.

(d) Notwithstanding paragraph (a), a review of an adverse determination involving a prescription drug must be conducted by a licensed pharmacist or physician who is competent to evaluate the specific clinical issues presented in the review.

(e) This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

(f) A utilization review organization is prohibited from using an algorithm or artificial intelligence alone without a clinician review by an appropriate health professional, as required under this section, when making an adverse determination.

EFFECTIVE DATE. This section is effective January 1, 2027, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 11. Minnesota Statutes 2024, section 62Q.47, is amended to read:

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

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

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

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

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

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

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

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing

and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

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

(1) 99492;

(2) 99493;

(3) 99494;

(4) G2214; and

(5) G0512.

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

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

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

(1) care directed by the primary care team;

(2) structured care management;

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

(4) modification of treatment as appropriate.

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

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

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

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

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

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

(l) Health plans must reimburse all alcoholism, mental health, and chemical dependency services provided by clinical trainees, pursuant to section 245I.04, subdivision 6, at a rate at least equal to 100 percent of the rate that would be paid to an independently licensed mental health professional performing the same services. This paragraph does not apply if the service provided by the clinical trainee:

(1) is not within the clinical trainee's scope of practice under section 245I.04, subdivision 7; or

(2) is not a covered service if performed by an independently licensed mental health professional at the same clinic.

EFFECTIVE DATE. This section is effective January 1, 2027, for health plans offered, issued, sold, or renewed on or after that date.

Sec. 12. Minnesota Statutes 2024, section 62Q.545, is amended to read:

62Q.545 COVERAGE OF HOME CARE NURSING.

(a) Home care nursing services, as provided under section 256B.0625, subdivision 7, with the exception of section 256B.0654, subdivision 4, shall be covered under a health plan for persons who are concurrently covered by both the health plan and enrolled in medical assistance under chapter 256B.

(b) For purposes of this section, a period of home care nursing services may be subject to the co-payment, coinsurance, deductible, or other enrollee cost-sharing requirements that apply under the health plan. Cost-sharing requirements for home care nursing services must

not place a greater financial burden on the insured or enrollee than those requirements applied by the health plan to other similar services or benefits. Nothing in this section is intended to prevent a health plan company from requiring prior authorization by the health plan company for such services as required by section 256B.0625, subdivision 7, or use of contracted providers under the applicable provisions of the health plan.

(c) Notwithstanding section 62J.26, a health plan must not impose any quantity limitation on the coverage under this section.

(d) Notwithstanding section 62J.26, a health plan must refer to all services meeting the definition of home care nursing services in paragraph (e) as home care nursing services in the health plan's policy, certificate, contract, or other evidence of coverage and related documents, including but not limited to utilization review policies, claims forms, instructions, and communications to enrollees and providers.

(e) For purposes of this section, "home care nursing services" means ongoing, individual, and continuous nursing services that are:

(1) ordered by a physician, advanced practice registered nurse, or physician assistant;

(2) provided by a registered nurse or licensed practical nurse acting within the provider's scope of practice;

(3) medically necessary to maintain, stabilize, or restore the recipient's health due to medical complexity or the need for sustained skilled nursing assessment, intervention, or monitoring; and

(4) required for a duration or frequency that cannot be safely or effectively met through intermittent, episodic, or visit-based nursing services.

EFFECTIVE DATE. Paragraph (c) is effective January 1, 2026, and applies to policies issued, offered, or renewed and causes of action accruing on or after that date. Paragraphs (d) and (e) are effective August 1, 2026.

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

Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The commissioner or the commissioner's designee shall make the data submitted under subdivisions 4, 5, 5a, and 5b, including data classified as private or nonpublic, available to: (1) individuals and organizations engaged in research on, or efforts to effect transformation in, health care outcomes, access, quality, disparities, or spending, provided the use of the data serves a public benefit; and (2) the commissioner of commerce, subject to the data use requirements under subdivision 11, paragraph (b), to perform health insurance oversight duties.

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

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

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

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

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

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

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

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

Sec. 14. Minnesota Statutes 2024, section 62W.06, is amended by adding a subdivision to read:

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