POUL HAAS
Government Relations

Healthcare
End of Session Summary
2023

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Introduction

The 2023 Legislative Session was ushered in with historic and unexpected wins by the DFL resulting in a legislative trifecta for only the second time in thirty years. Governor Walz easily won re-election and the DFL gained control of the Senate by one seat and held a 34/33 majority, while the House majority continued its reign with a six-seat majority of 70/64. All DFL constitutional officers also prevailed in their elections.

Legislators returned to St. Paul on January 3 with an unprecedented number of new colleagues. Of the 201 legislators 71 members between the House and Senate were brand new. In the House, a total of 47 newly elected members included 25 Republican members and 19 DFL members. In the Senate, a total of 24 newly elected members included 14 DFL members and 10 Republican members. Both House and Senate majority and minority caucuses came into session with newly elected leaders. House Speaker Melissa Hortman was the only leader to continue in her position and the DFL caucus elected Rep. Jaime Long as the Majority Leader and Rep. Athena Hollins as Majority Whip. Republicans elected Rep. Lisa Demuth as Minority Leader and Rep. Paul Torkelson as Deputy Minority Leader. In the Senate, the DFL caucus elected Sen. Kari Dziedzic as Majority Leader and Sen. Bobby Joe Champion as Senate President.

The first year of each biennium is a budget year in Minnesota with the primary goal of the Legislature to create a two-year budget for the state with the new fiscal year beginning July 1. However, this year with pent up demand on key DFL policies and election promises, Legislators got to work on several key items. Within the first six weeks the Legislature passed, and the Governor signed: targeted increases in the Attorney General's Office to add capacity for its criminal division, voter restoration, tax conformity, recognition of Juneteenth as a state holiday, 100% carbon free standards by 2024, and a fundamental right to reproductive health care.

A historic surplus of $17.5 billion dollars greeted legislators in the updated February Forecast and the Legislature made quick work of their new majorities. They set early committee deadlines, agreed on joint budget targets a full two months before the end of session and predicted the possibility of adjournment prior to the May 22 deadline. The budget agreement framework prioritized multi-billions of investments in tax cuts, education and supports for children and families, transportation improvements, housing and infrastructure projects. Other marquee topics that dominated session action included paid family and medical leave, legalizing adult use cannabis, driver's license for all, social security tax elimination, and efforts to pass a robust bonding bill left over from last session.

As the session entered its final weekend eleven budget bills had passed off the House and Senate floors. However, final agreements on the tax, transportation, health and bonding bills held the legislature all the way to its deadline of Monday, May 22nd at midnight. A last minute compromise between democrats and republicans on an additional $300 million dollars for nursing home support helped pave the way for a GO bonding agreement of $1.5 billion, a cash bonding agreement of $1.1 billion and the assurance of orderly floor sessions to complete their work. The last weekend also ushered in final passage of bills to legalize adult use cannabis, approve minimum compensation for Uber and Lyft drivers, and authorize committee-driven nurse-to-patient staffing

ratios as well as a pair of constitutional amendments; one to continue to dedicate a portion of lottery proceeds to protect the environment and one to adopt equality under the law.

Rumors of a possible special session to address the U of M's desire to buy back its hospital following the merger of Fairview and Sandford systems surfaced in the last days of session. However, absent a special session and with arguably the busiest and most accomplished session in recent memory legislators will return home to their districts until February 12, 2024, when the next session is set to reconvene. To date, only one member, Representative Jerry Newton, has declared his intent to not run again. The 2024 session will be a short session with a focus on policy measures, bonding, and it will be an election year for all members of the House of Representatives.

Bills That Passed

Omnibus Health and Human Services Appropriations Bill

S.F. 2995 Senator Wiklund / H.F. 2930 Representative Liebling

The bill did pass.

Chapter 70

The Omnibus Health and Human Services Appropriations bill was the last Conference Committee Reports to pass both chambers. This bill received scrutiny because the final report was released the night before the constitutional adjournment date, many members of the legislature expressed their disapproval of the late release, and lack of Conference Committee review and walkthrough of the report. The final bill is 843 pages. It expands access to MinnesotaCare, and will study the feasibility of MNCare as a public option as well as implementing a universal health care system. The Health Care Affordability Board was dropped, although was replaced by three different entities who will look at healthcare spending market reforms.

MinnesotaCare Expansion

- One of the DFL's priorities was to expand the public option to make healthcare accessible for more Minnesotans. The final bill passed included provisions to expand MinnesotaCare to Deferred Action for Childhood Arrival (DACA) recipients and undocumented Minnesotans.
    - Original versions of the bill significantly expanded eligibility for MinnesotaCare by removing the income limitations—making the only qualifications that the individual is not able to get on Medicare, Medical Assistance, or affordable employer-sponsored coverage
        1. A study was put in place to review the feasibility of the originally proposed plan

Health Care Affordability Board

- The Health Care Affordability Board was ultimately not included in the Omnibus bill, however, three different entities will now look at the healthcare delivery and payment system:
    - A new Center for Health Care Affordability (CHCA) within the Dept. of Health which is charged with conducting research on and analyzing the drivers of health care spending as well as identifying health care market reforms to increase health care affordability
    - The Department of Health which is charged with making recommendations for strategies to reduce the volume and growth of administrative spending by health care organizations (not defined) and group purchasers (defined under 62J.03) and the magnitude of low-value care (also not defined)

- A new Health Subcabinet comprised of the commissioners of heath, commerce, human services and the executive director of MNsure. The Subcabinet is charged with coordinating state agency and private sector efforts to reform the health care delivery and payment systems

Studies

- MinnesotaCare as public option
  - Minnesota is poised to expand its state-funded health insurance program, becoming the latest to add a public option for residents with incomes above 200% of the federal poverty level
  - States like Colorado and Washington state have turned to public option plans to control health costs, but are encountering lackluster interest and resistance from providers
  - In Minnesota, insurers like Cigna and employer groups opposed the proposal, saying it would lead many residents to switch from private to public health plans
  - The Democratic-controlled Legislature passed the new program this week, starting with a study and actuarial analysis due early in 2024
  - The legislation requires Minnesota to apply to the Centers for Medicare and Medicaid Services federal waiver to implement a public option, which would begin in 2027
  - The public option would augment MinnesotaCare, a state health plan offering low premiums and covering people at 200% of the federal poverty level and below
  - Lawmakers also voted to expand health coverage via MinnesotaCare to an estimated more than 50,000 uninsured and undocumented Minnesotans
- Universal Health Care
  - The commissioner of health, in consultation with the commissioners of human services and commerce, shall submit to the contractor for analysis the legislative proposal known as the Minnesota Health Plan, that would establish a universal health care financing system designed to:
    1. ensure all Minnesotans have health care coverage
    2. cover all necessary care
    3. allow patients to choose their doctors, hospitals, and other providers
  - The analysis of total health care spending must examine whether there are savings or additional costs under the universal health care financing system established by the legislative proposal compared to the existing system
  - The Final Report is due January 15, 2026

Price Transparency

- Requiring healthcare providers to make publicly available a list of current standard charges for all items and services
  - This bill requires hospitals, outpatient surgical centers, and certain other medical and dental practices to make available to the public, and to report to the commissioner of health, a list of their current standard charges for items and

services provided by the practice. The commissioner of health must use the data reported to make available to the public, a tool to compare charges for items and services across practices.

- A hospital must comply with this section no later than January 1, 2024. A medical or dental practice that meets the requirements, or an **outpatient surgical center** must comply with this section no later than January 1, 2025.

All Other Provisions

- Imposing provider balance billing requirements
- Creating consumer protections against balance billing, in conformity with the federal No Surprises Act
- Requiring health plans to cover biomarker testing to diagnose, treat, and monitor illness or disease if the test provides clinical utility
- Requiring coverage under medical assistance for biomarker testing to diagnose, treat, and monitor illness or disease
- No cost additional diagnostic services or testing that a healthcare provider determines necessary after a mammogram
- Including audio-only communication between a healthcare provider and patient in the definition of telehealth
- Creating a statewide healthcare provider directory

Notable appropriations in the bill

- $22 million in FY25 to implement a Minnesota public option health care plan
- $1.21 million in FY24 and $1.09 million in FY25 for implementation of the federal No Surprises Act and assessment of feasibility of the statewide provider directory
- $2.75 million in FY24 and $3.99 million in FY25 to establish a Center for Health Care Affordability
- $1.82 million in FY24 and $580,000 in FY25 for an analysis of benefits and costs of a universal health care financing system
- $11.03 million in FY24 and $14.25 million in FY25 to establish a single end-to-end IT system with seamless, real-time interoperability between qualified health plan eligibility and enrollment services
- $17 million in FY25 to the Dept. of Commerce for administrative costs to implement mandated coverage of biomarker testing

Data Reporting and Attorney General Oversight of Healthcare Sales, Mergers, and Acquisitions Bill

H.F. 402 Representative Bierman / S.F. 1681 Senator Wiklund

The bill did pass.

Chapter 66

The Department of Health will now gather information on healthcare transactions, including how many are occurring, analyze potential impacts to access, cost, and quality of health care services and will develop recommendations for the Legislature for future consideration.

The Attorney General will also have expanded oversight of health care transactions and could block them if deemed detrimental to the public or would have reduced health care outcomes. These powers would allow the Attorney General to prohibit a transaction by a healthcare entity if it would substantially lessen competition or tend to create a monopoly or monopsony.

HF 402 analyzes and regulates healthcare transactions in the following ways:

- Basic data reporting for certain healthcare transactions; Starting January 1, 2024, a healthcare entity involved in the transaction that has (or will be projected to have) average revenue between $10 million and $80 million per year must report the following data to MDH at least 30 days prior to the transaction:
    - Entities involved, leadership, ownership structure, board members, partners and officers
    - Services, operating and nonoperating revenue for last 3 years
    - Primary service location and proposed service location
    - Terms of the transaction agreement
    - Relationships between the entities
    - Potential areas of expansion
    - Plans to close facilities or reduce/eliminate jobs
    - Number of employees before and after
- Notice requirements information including document production must be sent to the Attorney General for healthcare transactions that have average revenue of $80 million per year. Information must be provided at least 60 days prior to the transaction, including:
    - Entities involved, leadership, ownership structure, board members, partners, and officers
    - Services, operating and nonoperating revenue for last 3 years
    - Primary service location and proposed service location
    - Terms of the transaction agreement
    - Market synergies and areas of expansion
    - Brokers, consultants used in the transaction
    - Number of employees

- Documents and Additional Information Required:
    - Governing documents
    - Transaction agreement
    - Lease, management, and service contracts
    - Expert consultant reports
    - Projections or modeling
    - Financial and economic analysis/report
    - Impact analysis in communities and workforce
    - Federal regulation submissions
    - Audited and unaudited financial statements and tax filings from 5 previous years
- The Attorney General may bring an action in District Court to prohibit transactions that would substantially lessen competition or tend to create a monopoly or monopsony
- The Attorney General would also be given supplemental authority to protect the "public interest", which could include:
    - Harm to public health
    - Access to affordable and quality care
    - Detrimental impact on health care options
    - Reduce delivery of healthcare to disadvantaged or underserved populations
    - Increase costs or have a negative impact on health insurance or services
    - Negatively impact wages or collective bargaining agreement
- This section would be effective following final enactment and applies to transactions completed after that date
- This legislation would prohibit the U of M's facilities from being owned or controlled by a for profit or out-of-state entity unless the Attorney General determines it is in the public interest
- Study and Recommendations; nonprofit HMO conversion
    - The Commissioner of Health shall study and develop recommendations on the regulation of conversions, mergers, acquisitions, transfer of assets affecting MN domiciled nonprofit HMOs and for-profit HMOs
    - The study shall submit preliminary findings by January 15, 2024, and final report and recommendations by June 30, 2024

Omnibus Jobs, Economic Development, Labor and Industry Appropriations Bill

S.F. 3035 Senator Champion / H.F. 3028 Representative Hassan

The bill did pass.

Chapter 53

The Omnibus Jobs bill provides large-scale employment law reform and massive investments in an effort to address workforce shortages and economic disparities. These efforts are highlighted by a $1.4 billion appropriation dedicated to workforce development, economic competitiveness, and assisting disadvantaged communities.

The policy changes in this legislation will have significant impacts on employers in Minnesota. Employers will take note of the changes that render non-compete agreements unenforceable, prohibit mandatory employer-sponsored meetings, establish additional paystub requirements, and enhance protections for pregnant employees. Employers will have to act relatively quickly to ensure compliance as many provisions of this bill take effect as early as July 1 of this year.

Earned Sick and Safe Time

The bill contains language from the Earned Sick and Safe Time bill, which passed as a stand-alone bill by the House earlier in the session. This allows all workers to accrue paid time off, earning one hour of paid leave for every 30 hours worked. Eligible use of sick leave includes:

- An employee's mental or physical illness, treatment, or preventive care
- Care for a sick family member or a family member in need of preventive care or treatment
- Absence related to domestic abuse, sexual assault, or stalking of an employee or family member
- Closure of an employee's workplace or a family member's school or daycare due to weather or public emergency
- A determination by a health care provider that an employee or family member is at risk of infecting others with a communicable disease
- Effective Date: January 1, 2024

Ergonomics Safety Program

- This legislation will now require all healthcare providers to implement an ergonomics safety program
    - Every licensed health care facility, warehouse distribution center, or meatpacking site in the state shall create and implement an effective written ergonomics program establishing the employer's plan to minimize the risk of its employees developing or aggravating musculoskeletal disorders. The ergonomics program shall focus on eliminating the risk. To the extent risk exists, the ergonomics program must include feasible administrative or engineering controls to reduce the risk.

    - Creates annual evaluation of the program, requirements on employee training, recordkeeping, and availability of records
    - Makes training materials available for employers
    - Establishes an ergonomics grant program
- $2 million for the ergonomics safety program
- Effective Date: January 1, 2024

<u>Ban on Noncompete Agreements</u>

- Under the new law, which passed out of the Minnesota Legislature this week, most noncompete agreements between employers and employees or independent contractors would be banned. If signed by Gov. Walz, the law would go into effect July 1st, but would not be retroactive. The law would not ban non-solicitation agreements or agreements restricting the ability to use client or contact lists or to solicit customers
- Unlike other states that have passed laws that restrict noncompete agreements only with employees earning below a certain salary or income threshold, Minnesota enacted a complete prohibition on noncompete agreements with only two limited exceptions:
    - Those agreements that are greed to during the sale of a business where the agreement prohibits the seller from carrying on a similar business within a reasonable geographic area for a reasonable period of time; or
    - In anticipation of the dissolution of a business in which the dissolving partnership or entity agrees that the partners, members, or shareholders will not carry on a similar business in a reasonable geographic area for a reasonable period of time

Omnibus Commerce Finance Bill

S.F. 2744 Senator Klein / H.F. 2680 Representative Stephenson

The bill did pass.

Chapter 57

The Commerce Conference Committee met minimally in the last few weeks of the session. Both Chairs, Stephenson and Klein, had other conference committees where they played integral roles. Representative Stephenson chaired the Cannabis Conference Committee and Senator Klein was the Vice Chair serving on the Taxes Conference Committee. The Commerce Conference Committee Chairs started the Conference Committee process with two very similar bills, which allowed them to do their work on multiple conference committees at once.

The Omnibus Commerce Finance bill appropriates $834.7 million in the 2024-2025 biennial budget for the Department of Commerce to fund operations and programs of the Department, and institute new consumer protections, including:

Healthcare Related Consumer Protection Provisions:

- Prohibiting excessive price increases of generic or off-patent drugs
- Creating a Prescription Drug Affordability Board to counter excessive price increase by drug companies, and creating a Prescription Drug Affordability Council (18 members)
- Studying existing statutory health benefit mandates
- Requiring health plans to limit patient co-pays to no more than $25 per one-month supply for prescription drugs used to treat chronic diseases
- Creates safety and care requirements for specialty pharmacies that ship clinician-administered drugs to a health care provider or pharmacy
- Feasibility study on a proposal to offer free primary care to Minnesotans

Nurse and Patient Safety Act

S.F. 1384 Murphy / H.F. 1522 Representative Feist

The bill did pass.

Chapter 75

The "Keeping Nurses at the Bedside Act", which was approved by conference committee during the weekend before adjournment, had originally aimed to grapple with working conditions of direct care nurses in hospitals and to address related staffing shortages. However, that deal fell through on the last day of session, and instead, the conference committee report termed the "Nurse and Patient Safety Act" was passed by both bodies. The original proposal had accumulated significant controversy throughout the session, with both hospital administrators and nurse unions in dialogue to come to the agreement during the weekend. This original agreement included an exception for Mayo Clinic to the proposed labor standards, which triggered discontent of the bill from several Senate DFL members. Earlier in May, Mayo Clinic has announced that they would retract millions of dollars in investments out of the state if its health system were to be included in the bill.

The original agreement also included the creation of a nurse staffing committees, which aimed to guide the creation of daily staffing schedules and staffing plans, however, this was ultimately removed from the final agreement.

Anti-retaliation protections for nurses who refuse a patient assignment if it is deemed unsafe for the patient, while still allowed by current statute, was also not included in the final version that passed.

Instead, the Nurse and Patient Safety Act aims to prevent the rising violence against health care workers by requiring incident response action plans and laying out specific criteria for implementation. This would apply to all hospitals in Minnesota, and would not exempt Mayo Clinic. The bill also expands the health professional education loan forgiveness program to include direct care nurses at nonprofit hospitals, as an attempt to increase staffing levels in hospitals, nursing homes, and clinics.

Omnibus Judiciary and Public Safety Appropriations Bill

S.F. 2909 Senator Latz / H.F. 2890 Representative Moller

View the Conference Committee Report here.

The bill did pass.

Chapter 52

Communication Following an Adverse Healthcare Incident

This legislation is modeled after the CANDOR Initiative (Communication and Optimal Resolution), and was adopted as part of the Omnibus Judiciary and Public Safety bill. This effort was led by the Minnesota Medical Association and supported by MNASCA and other healthcare providers.

If a health care adverse incident occurs, a health care provider involved in the health care adverse incident, the health facility involved in the health care adverse incident, or both jointly may provide the patient with written notice of their desire to enter into an open discussion with the patient to discuss potential outcomes following a health care adverse incident.

This legislation will allow healthcare providers and patients to speak openly and candidly to reach a settlement if warranted and to help prevent future incidents from occurring. All communications are privileged and confidential and not subject to discovery.

The patient has a right to medical records and can seek legal counsel throughout the process. The communications are privileged and confidential and not subject to discovery or release. The Health Care provider may investigate the incident, openly communicate steps to prevent future incidents, and also determine whether compensation is warranted. All discussions including offers of compensation are privileged and not subject to disclosure.

This applies to adverse health care incidents that occur on or after August 1, 2023. This section also sunsets on June 30, 2031.

Paid Family Medical Leave

H.F. 2 Representative Richardson / S.F. 2 Senator Mann

The bill did pass.

Chapter 59

This bill creates a program that will provide a number of weeks of partial wage replacement for family and medical leave funded through a payroll tax applied to all employers. The program will be administered by the Department of Employment and Economic Development (DEED). The benefits and premium cost will be effective January 1, 2026. The State of Minnesota will initially fund the program with $668 million to start this initiative.

The program authorizes up to 20 weeks of leave for the combined benefits, for a maximum of 12 weeks for either benefit (8 weeks for the remaining benefit or some other combination not to exceed 12 weeks for one benefit or 20 weeks benefit).

Employers that provide their own paid family and medical leave plan could apply to DEED for approval if the plan meets the same rights, protections, and benefits provided to employees in the bill.

The program will be funded through a payroll tax of .7%. The maximum wage subject to a premium in a calendar year is equal to the maximum earnings subject to social security tax. For reference, the wage cap is $160,700 for 2023.

If an employer is only participating in the medical benefits program with an approved private plan for family benefits the rate would drop to .4%. If the employer is providing family benefits with an approved private plan, the rate would be .3%.

The premium rate adjustments will be made annually depending on program expenditures in the prior year. The annual premium rate cannot exceed 1.2%.

The program defines family as including the following:

- A spouse or domestic partner
- A child, including biological, adopted, foster, stepchild, a child to whom the applicant serves as a legal guardian
    - A sibling
- A parent or spouse's parent
- A grandchild
- A grandparent or spouse's grandparent
- A son-in-law or daughter-in-law

The employers will be required to submit a quarterly wage detail report electronically, including for each employee (name, total wages, hours worked, etc.). Wage reporting will be due starting July 1, 2024.

The new law requires all employers to pay a yearly premium on employee taxable wages, paid quarterly into the insurance account and calculated based on the wage detail report.

The bill will allow employers to deduct up to 50% of the premiums paid by the employer from the employee's wages. The payroll tax is set to begin January 1, 2026.

Legalizing Adult Use Cannabis

H.F. 100 Representative Stephenson / S.F. 73 Senator Port

View the bill summary here: House and Senate

The bill did pass.

After a long journey the adult use cannabis bill finally managed to make it across the finish line. The bill will make Minnesota the 23rd state to enact measures to regulate cannabis for adult non-medical use. Minnesota will be the 11th state to allow its production at home. In addition to allowing adults over the age of 21 to produce, possess, and consume cannabis, the bill also notably allows expunges the records of those with misdemeanor marijuana conviction and allows those with felony marijuana-related convictions to apply for expungement. Other notable provisions of this bill include:

- Establishes a seed to sale regulatory framework comprised of 15 different licenses, ranging from growing and manufacturing to various types of retail locations. The new "Office of Cannabis Management" will issue licenses and be responsible for oversight of the industry
- The possession limit for flowered cannabis will be two ounces in public and two pounds at home
- The sales tax rate for marijuana will be 10% (80% to general fund and 20% to local government cannabis account)
- Creating more than a dozen types of licenses for growing, selling, transporting and testing cannabis
- Establishes an Office of Cannabis Management to regulate cannabis and take enforcement actions
- creating grants to assist individuals entering the legal cannabis market
- Allowing local governments have powers to block cannabis stores from opening near schools and other special locations. They may also choose to enforce a cap on the number of cannabis sellers allowed to do business in their city: one cannabis provider per 12,500 residents
- Medical cannabis providers will not be expected to change their current operations in any significant way, and they may be in both the medical and recreational marijuana businesses simultaneously
- Local governments may place a capacity on the number of medical cannabis stores in their city: one per congressional district
- Selling cannabis will remain illegal in school zones, park zones, and drug treatment facilities
- Funding to support treatment courts including $3,000,000 in the first biennium and $2,500,000 in each year thereafter

Omnibus Taxes Bill

H.F. 1938 Representative Gomez / S.F. 1811 Senator Rest

View the bill summary here: House

The bill did pass.

Chapter 64

Lawmakers passed a sweeping $3 billion tax relief bill along party lines that includes onetime rebates, a credit for low income families, income tested exemption from Minnesota's tax on Social Security benefits, and property tax relief and funding to cities for public safety improvements. The bill will raise $1.034 billion over the biennium from business and high-income households.

Tax Relief Provisions include the following:

- Rebates
  - $260 single filer up to $75,000 income
  - $520 joint filer up to $150,000 income
- Child Tax Credit
  - $260 per dependent (up to 3 children) for a maximum of $1,300
  - $1,750 per child to households making $35,000 per year, phasing out at $96,250
- Social Security Exemption – Exempts Minnesota's state tax on a couples earning up to $100,000 (singles up to $78,000)

Tax Increase Provisions include the following:

- Federal conformity to GILTI with 50% dividend reduction with no selection 250 deduction ($437 million FY24-25)
- Reduced deductions for dividends received from domestic subsidiaries ($125 million FY24-25)
- Modifications to phase out standard itemized deductions for high income earners by adding two new thresholds:
  - 10% of AGI over $300,000
  - 20% AGI over $1 million, up to max of 80% of total deductions
  - $354 million FY24-25
- New 1% tax on all net investment income (interest, dividends, annuities, royalties, etc.) over $1 million ($128 million FY24-25)
- Decouple corporate net operating loss provision, limiting deductions to 70% ($22.5 million FY24-25)

State Aid Provisions

- $80 million for an annual increase to local government aid
- Updated formula factors for local government aid
- $210 million in one-time public safety aid for cities, distributed on a per capita basis. Eligible uses include community violence prevention and intervention programs; community engagement; mental health crisis responses; victim services; training

programs; first responder wellness; equipment related to fire, rescue, and emergency services; or to pay other personnel or equipment costs
- Establishment of a new transition aid for counties, cities, townships, and school districts that lose tax base when an electric generation plant is retired
- Creating an affordable housing aid for local governments located outside the metro that will not receive distributions from the quarter-cent metro area sales tax for housing. Qualifying cities with a population of at least 10,000 will receive a $4.5 million annual distribution in fiscal years 2024-25 and $2 million annual distribution in following years. Cities with populations under 10,000 will be eligible to apply for grants of at least $25,000 from the Minnesota Housing Finance Agency (MHFA). This MHFA aid totals $2.25 million annually for fiscal years 2024-25 and $1 million annually in following years

Property Tax Provisions

- A permanent increase to the Homestead Credit refund to increase the refund for taxpayers that are currently eligible for it
- Converting the Renter's Credit from a property tax refund to an income tax credit, and changing the definition of income to the simpler adjusted gross income
- One-time increases to the Homestead Credit refund, Renter's Credit, and targeted property tax refund
- Increasing the homestead market value exclusion (HMVE) for homes valued up to $517,000
- Lowering the property tax classification rate on 4d property from .75% of the first $100,000 of value to .25%, causing a property tax shift onto other property. The bill also allows for a two-year transition aid for cities whose tax base is at least 2% 4d property
- Increasing the income limit for the senior citizens' property tax deferral from $60,000 to $96,000. The bill also reduces the minimum number of years the homeowner must own and occupy the property to qualify from 15 years to five years

Sales Tax Provisions

- Individual local sales tax authorizations for cities that brought forward requests this year
- Places a two-year moratorium on local sales tax authorizations going through the 2025 legislative session
- Creation of a task force to examine the use of local taxes as a funding mechanism for cities to fund capital projects and other improvement projects. The task force recommendations will be reported to the Legislature by Jan. 15, 2024

Omnibus Transportation Finance and Policy Bill

H.F. 2887 Representative Hornstein / S.F. 3157 Senator Dibble

View the bill summary here: House and Senate

The bill did pass.

Chapter 68

Transportation Chairs Hornstein and Dibble, both from Senate District 61 in Minneapolis, were tasked with putting together the state's transportation budget. The $1.3 billion deal will make historic investments in the state's roads, bridges, and transit, while also creating significant new revenue streams to increase ongoing dedicated funding for the state's transportation system.

The bill increases funding for transportation statewide and includes many new revenue sources including:

- Indexing the gas tax to inflation, resulting in a 5-cent increase over the current rate by fiscal year 2027
- Establishing a new Regional Transportation Sales and Use Tax of .75%
    - 83% of these funds will go to the Met Council for the following uses:
        - 5% for active transportation as determined by the Transportation Advisory Board
        - 95% for the below uses:
            - Improvements to regular route bus service levels
            - Improvements to transit safety
            - Maintenance and improvements to bus accessibility at transit stops and transit centers
            - Transit shelter replacement and improvements
            - Planning and project development for expansion of ABRT lines
            - Operations and capital maintenance of ABRT lines
            - Planning and project development for expansion of highway BRT and bus guideway lines
            - Operations and capital maintenance of highway BRT and bus guideways
            - Zero-emissions bus procurement and associated costs in conformance with the zero-emission and electric transit vehicle transition plan
            - Demand response microtransit service provided by the Council
            - Demand response microtransit service provided by the Suburban Transportation Providers
            - Financial assistance to political subdivisions
            - Wage adjustments for Metro Transit hourly operations employees

        - The Met Council is prohibited from using these funds on Southwest light rail transit.
    - 17% to the metropolitan counties
- Delivery fee of 50 cents for most deliveries to homes that are more than $100
    - Funds deposited into the Transportation Advancement Account
- Increasing the Motor Vehicles Sales Tax from 6.5% to 6.875%
    - New distribution of funds:
        - 60% to Highway User Trust Fund
        - 34.3% to Metropolitan Area Transit Account
        - 5.7% to Greater Minnesota Transit
- Raising the fees to register vehicles, purchase driver's licenses, and documentary fees

Notable transportation appropriations:

- $216,400,000 for Infrastructure Investment and Jobs Act discretionary matches
- $9 million to expand micro transit services for the Suburban Transit Providers:
    - $5.8 million for Minnesota Valley Transit Authority
    - $3 million for SouthWest Transit
    - $200,000 for Maple Grove Transit
- $195 million to support the Northern Lights Express passenger rail service between the Twin Cities and Duluth
- $2 million to fund safety interventions with passengers on the Green and Blue light-rail lines
- Creates $1500 credits for purchasing electric bikes.
- $153 million for Corridors of Commerce

Notable transportation policy provisions:

- Creates a Metropolitan Governance Task Force to review the make-up of the Met Council and whether they should be elected rather than appointed by the Governor
- Creates a Transit Signal Priority System Planning workgroup to perform planning on transit signal priority systems and related transit advantage improvements on high-frequency and high-ridership bus routes in the metropolitan area
- Requires the Met Council to produce a Post-Covid Study on the impacts of Covid on transit ridership
- Establishes a Transit Rider Investment Program (TRIP) which will put transit officials on buses and trains as a means of fare enforcement and to monitor passenger activity
- Creates many new license plate options for Minnesotans to choose from including:
    - Lions Club International Plates
    - Minnesota Professional Sports Team Foundation Plates:
        - Minnesota Vikings
        - Minnesota Timberwolves
        - Minnesota Lynx
        - Minnesota Wild
        - Minnesota Twins

- Minnesota United
- Minnesota Blackout Plates

Minnesota Missing and Murdered Indigenous Relatives Plates

Omnibus Higher Education Finance and Policy Bill

H.F. 2073 Representative Pelowski / S.F. 2075 Senator Fateh

The bill did pass.

Chapter 41

The Omnibus Higher Education Finance and Policy bill aims to address a historic worker shortage, provide free tuition at any public postsecondary institution for students from families making less than $80,000 a year, and fund the Office of Higher Education. Also included in the bill is a $21.1 million increase to boost the state grant program's outlay for students' living and miscellaneous expenses and provides $17.7 million for simplification and federal conformity. Additionally, the Higher Education Omnibus bill includes $1.05 million to help reduce students' out-of-pocket costs by expanding free offerings in course materials and resources. The bill also includes $17 million for an American Indian scholarship program, as well as $8.7 million for dual training competency grants.

The House had hoped to adopt its recommendation for $5.4 million in allied health technician scholarships, but this was not included in the final Conference Committee Report.

The Office of Higher Education would also receive increases of:

- $6.5 million in emergency assistance for post-secondary students
- $6 million for tribal college grants
- $4.2 million to maintain current service levels in agency administration
- $3.2 million for paramedic scholarships
- $3 million for a Next Generation nursing assistant training program
- $2.3 million for the Hunger-Free Schools Program
- $2 million for the Inclusive Higher Education program
- $300,000 for the Competitive Grant Program

Among appropriations for the Minnesota State system, the most significant changes would include:

- $122 million for system stabilization
- $75 million for a tuition freeze
- $50 million in campus one-time support
- $13.5 million for equipment and learning environments
- $13.5 million to develop and expand industry sector programming
- $6.3 million for student support
- $3 million for systemwide technology
- $2 million for open educational resources or the Z-Degree Textbook Program

The most significant increases in funding for the University of Minnesota would be:

- $100 million for core mission support
- $10 million for systemwide safety and security
- $10 million for the health sciences collaboration with CentraCare

- $4 million for the Natural Resources Research Institute

The final bill also included an $896,000 increase in funding for the Mayo Foundation's family medicine and residency programs, which was in both House and Senate versions. The House also recommended an additional $48 million to cover an enrollment tuition shortfall in the university system, however, this was not included in the final bill.

Among other changes, the bill:

- Changes the definition of "student" for purposes of state financial aid programs to include any enrollment of one credit per term or more
- Increases the living and miscellaneous expense allowance from 109% to 115%
- Increases the state grant lifetime eligibility to 180 credits
- Changes the deadline to apply for the state grant to June 30 of the fiscal year
- Establishes a new program to address the needs of expectant and parenting college students
- Establishes the Minnesota Commitment to Higher Education Act

Omnibus Human Services Finance and Policy Bill

S.F. 2934 Senator Hoffman / H.F. 2847 Representative Noor

The bill did pass.

Chapter 61

The Omnibus Human Services Appropriations Bill would appropriate $14.11 billion, $1.35 billion of which in new spending, to the Department of Human Services during the 2024-25 biennium. The COVID-19 Pandemic and subsequent workforce challenges strained nursing home facilities financially for the last few years, and many legislators urged their support for helping these facilities financially and by other means. DFLers stated that the bill would provide the largest increase in funding to nursing homes in state history, and after automatic reimbursement rate adjustments, they expect $847 million to reach the facilities over the next four years. However, the lack of direct nursing home funding in the bill was a point of contention with members. A onetime $100 million appropriation would establish a nursing home facility loan program for financially anguished nursing facilities, but some legislators voiced their preference for a forgivable loan or grant. Other proposed new nursing home spending includes $22.84 million for a 25% rate increase for home care nursing, $1.91 million for critical access nursing facilities, and $680,000 for a nursing facilities rate study.

Additional new spending consists of:

- $122.09 million for elderly waiver increases and consumer-directed community supports parity
- $90 million for long-term workforce incentive grants (including nursing)
- $86.66 million for modifying the inflation adjustments to the disability waiver system
- $46.59 million for disability and elderly waiver homemaker rate alignment
- $18.16 million for safe recovery sites
- $12.1 million for HIV/AIDS support services
- $100,000 to the Commissioner of Human Services for grants for opiate antagonist distribution
- $1.58 million create a multitiered public awareness and educational campaign on substance use disorders
- $250,000 for a grant for collaborative outreach, education, training on opioid use and overdose, and distribution of opiate antagonist kits in East African and Somali communities in Minnesota

Numerous rate increases are included, such as home care services, home and community-based services, and certain disability waiver services. Effective Jan. 1, 2024, intermediate care facilities for persons with developmental disabilities would see a daily rate increase of $40, as well as minimum daily operating payment rates set at $275 for class A facilities and $316 for class B facilities.

Policy changes in the bill included:

- Establishing an opioid treatment program work group
- Requiring school districts, charter schools, and site-based or group housing support settings to maintain a supply of opiate antagonists
- Establishing a voluntary, state-wide opioid overdose surge text message alert system, to caution people during an overdose surge in an area
- Implementing an opioid prescribing improvement program to reduce opioid dependency and substance use

Bonding Bill

H.F. 669 Representative Lee / S.F. 676 Senator Pappas

View the bill summary here: House and Senate

The bill did pass.

Every other year, lawmakers typically passed a capital investment bill – known as a bonding bill. But they failed to get one across the finish line in 2021 and 2022 under divided control in the Legislature. It required a 60% vote in the House and Senate to pass the bill. This bill was the largest bonding bill in Minnesota History costing $2.6 billion for projects across Minnesota included $1.5 billion in General Obligation (GO) bonds and $1.12 billion in cashing funding (H.F. 670 Lee/S.F 677 Pappas). In the last-minute, both parties agreed to invest $300 million in emergency aid for nursing homes in crisis.

Agency funding totals in HF 669 for the next biennium included:

- $381.1 million to the Public Facilities Authority for 47 water and wastewater projects across the state
- $326.3 million to the Department of Transportation, including $146 million from bond proceeds for local roads and bridge
- $233.1 million to the Department of Natural Resources, including $49.7 million for flood hazard mitigation programs
- $108.6 million to the Metropolitan Council, including $72 million for bus rapid transit projects
- $90 million to the Department of Veterans Affairs, including $77.8 million for upgrades at the Hasting Veterans Home Campus
- $130 million to University of Minnesota, including $92.6 million to renovate Fraser Hall into an undergraduate chemistry building and $43.35 million in asset preservation
- $134.7 million to Minnesota State - $90 million for renovations and upgrades at 13 campuses and $44.7 million for asset preservation

Cash Projects HF 670

- Authorized $850.7 million in General Fund spending for more than 190 projects
- $48.6 million to Department of Public Safety (local fire or public safety centers)
- $10 million for a regional training center in Hibbing
- $6.4 million for a Lake Johanna fire station headquarters
- $4.4 million for a fire station in Dilworth
- $21.6 million to renovate facilities at the St. Peter Regional Treatment Center
- $14.5 million for improvements to the wastewater treatment plant in Austin
- $12.8 million to the Pope-Douglas Solid Waste board to switch to single-source recycling
- $7 million to construct a freight rail car storage facility in Lakeville
- $4 million to the Indian Health Board for a medical center in Minneapolis

- $3 million to replace the ice plant and make other improvements to the sports arena and curling club in Chisolm
- $2.2 million to the Ain Dah Yung Center in St. Paul for renovations of its emergency shelter
- $300 million for nursing homes over the next four years

Other Bills That Passed

- Protect Reproductive Options Act (PRO Act)
- Driver's License for All
- Juneteenth
- Clean Energy by 2040
- State Forecast Required to Include the Rate of Inflation
- Restore the Vote
- Competency Attainment and Appropriation
- Catalytic Converter Theft Penalties
- Minnesota Indian Family Protection Act (MIFPA)
- Free School Lunches
- Veteran's Restorative Justice Act (VRJA)
- Minnesota Competitiveness Fund
- Democracy for the People Act
- Omnibus Economic Development Policy Bill
- Prince Rogers Nelson Highway
- Omnibus Housing Finance and Policy Bill
- Omnibus Early Childhood Finance Bill
- Omnibus Education Finance Bill
- Duty Disability
- Omnibus Agriculture, Broadband and Rural Development Appropriations and Policy Bill
- Omnibus Pension Finance Bill
- Omnibus Pension Policy Bill
- Omnibus State and Local Government Appropriations and Policy Bill
- Omnibus Environment, Natural Resources, Climate, and Energy Finance and Policy Bill
- Omnibus Legacy Finance and Policy Bill

Bills That Were Vetoed

Uber/Lyft Company Driver Protections

H.F. 2369 Representative Hassan / S.F. 2319 Senator Fateh

The bill was vetoed by Governor Walz

H.F. 2369, as authored by Representative Hodan Hassan and Senator Omar Fateh, would have set minimum payment levels for drivers and required that more of the amount collected in fees for a late pickup or cancellation be directed toward drivers. It would also have required clearer rules about why a driver could be deactivated, notice in writing if a driver was up for deactivation and give that driver a chance to appeal before removing them from the app. After Uber threatened to stop operating outside of the Twin Cities area and to only offer premium services in the Metro Area, Governor Walz vetoed the bill, his first since taking office in 2019.

Governor Tim Walz issued his first veto of his tenure on May 25, vetoing the bill that would have established protections for transportation company drivers, including those for Uber and Lyft. In vetoing the bill, Governor Walz stated that the bill, if signed into law, would have made "Minnesota one of the most expensive states in the country for rideshare, potentially putting [Minnesota] on par with the cost of rides in New York City and Seattle". Walz also wrote in his veto statement his concern for a lack of Minnesota-specific data regarding riders, drivers, and rideshare companies, and that the bill would have dramatically raised the prices of rideshare services, negatively impacting "low-income Minnesotans, those in the disability community who depend on rideshares for independence, people who use rideshare for medical transportation or to get to work, Minnesotans without cars, and Minnesotans who simply need a safe ride home at night". The Governor also highlighted concerns from disability advocates, anti-violence organizations, and organizations representing seniors, childcare centers, and local governments.

Governor Walz issued Executive Order 23-07, which establishes the Governor's Committee on the Compensation, Wellbeing, and Fair Treatment of Transportation Network Drivers.

The Executive Order:

- Orders the Commissioner of Labor and Industry to commission and oversee a study to obtain and analyze data and information related to the working conditions of transportation network company "TNC" drivers in Minnesota and how potential changes may impact access and cost for riders
- Establishes the Governor's Committee on the Compensation, Wellbeing and Fair Treatment of Transportation Network Company Drivers ("Committee")
    - The Committee's objectives are to:
        a. Provide a forum to engage, collect, and analyze data and information related to working conditions of TNC drivers
        b. Draft recommendations related to compensation and fair treatment of TNC drivers that achieve the following goals:
            i. Ensure TNC drivers receive fair compensation
            ii. Ensure TNCs have established procedures for the deactivation of TNC drivers that provide due process

iii. Limit impact on fares for riders, especially riders in the disability community and low-income communities who rely on these services
iv. Ensure continued operation of TNCs in the state of Minnesota

c. By January 1, 2024, provide recommendations for state policy and legislative changes

- The members of the Committee are:
  a. The Commissioners of the following agencies or their designees:
     i. Department of Commerce
     ii. Department of Labor and Industry
  b. One member of the Minnesota House of Representatives, appointed by the Speaker of the House
  c. One member of the Minnesota Senate, appointed by the Majority Leader of the Senate
  d. The Attorney General or his designee
  e. Ten additional members appointed by the Governor:
     i. Three members representing TNC drivers
     ii. Two members representing TNCs
     iii. Two members of the general public
     iv. One member representing Minnesota cities
     v. One member representing a labor union
     vi. One member from a group that provides services to or advocates on behalf of disabled individuals
- The Commissioners of Labor and Industry and Commerce, or their designees, will serve as the Committee's Co-Chairs.
- The duties of the Committee are as follows:
  a. Meet at least once per month and more often as necessary.
  b. Identify and engage stakeholders who can inform discussion of strategies and plans necessary to achieve the Committee's objectives.
  c. Review the results of the study commissioned pursuant to paragraph 1.
  d. By January 1, 2024, submit a written report to the Governor that sets forth the Committee's recommendations that relate to compensation and fair treatment of TNC drivers.
  e. Communicate recommendations with interested stakeholders.
- The following individuals will provide assistance and resources to the Committee as needed:
  a. Chief Equity Officer
  b. Commissioner of Employment and Economic Development
  c. Commissioner of Transportation

Executive Order 23-07 will become effective June 14, 2023, and will remain in effect until the order is rescinded or through June 1, 2024.

Budget Targets

Net Targets	FY 2023-25
Areas Within Omnibus Bills	
K-12 Educations	$2.2 million
Children and Families Early Education HHS – Children and Families	$1.17 billion $300 million $875 million
Health and Human Services	$775 million
HCAF Financing	$621.6 million
Human Services	$1.3 billion
Higher Education	$650 million
Agriculture	$48 million
Broadband	$100 million
Housing	$1 billion
Environment and Natural Resources	$670 million
Energy and Climate	$255 million
Commerce	$10 million
Workforce Development	$240 million
Economic Development	$250 million
Federal Economic Dev Match	$500 million
Labor	$8 million
State Government	$400 million
Veterans and Military Affairs	$128.4 million
Elections	$10 million
Transportation	$1.07 billion
Judiciary	$230 million
Public Safety	$650 million
Taxes, Aids, and Credits (Net)	$3 billion
Debt Service and Capital Projects	$2.29 billion
Other Items	
Paid Family and Medical Leave	$668.3 million
Stadium (inc. reserve impact)	($340.8 million)
Pensions	$600 million
Earned Safe and Sick Time	$4.8 million
Lead Lines	$240 million
Disaster Relief	$40 million
Claims Bill	$1.5 million
Other Items	$310 million

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Omnibus Health and Human Services Appropriations Bill
H.F. 2930 Representative Liebling / S.F. 2995 Senator Wiklund

Sections of Interest to Healthcare

ARTICLE 1
HEALTH CARE

Sec. 3.
Minnesota Statutes 2022, section 256.9655, is amended by adding a subdivision to read:
Subd. 3.
Prompt payment required.
(a) In paying claims under medical assistance, the commissioner shall comply with Code of Federal Regulations, title 42, section 447.45.
(b) If the commissioner does not pay or deny a clean claim within the period provided in paragraph (a), the commissioner must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date on which the commissioner makes the payment or denies the claim.
(c) The rate of interest paid by the commissioner under this subdivision must be 1.5 percent per month or any part of a month.
EFFECTIVE DATE.
This section is effective the day following final enactment.

Sec. 24.
Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:
Subd. 69.
Biomarker testing.
Medical assistance covers biomarker testing to diagnose, treat, manage, and monitor illness or disease. Medical assistance coverage must meet the requirements that would otherwise apply to a health plan under section 62Q.473.
EFFECTIVE DATE.
This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 39.
Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:
Subd. 5.
Cost-sharing.
(a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.
(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.
(d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.
(e) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.
(f) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

EFFECTIVE DATE.

This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5.

[62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.

Subdivision 1.

Billing requirements.

(a) Each health care provider and health facility shall comply with the federal Consolidated Appropriations Act, 2021, Division BB also known as the "No Surprises Act," including any federal regulations adopted under that act.
(b) For the purposes of this section, "provider" or "facility" means any health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to relevant provisions of the No Surprises Act.

Subd. 2.

Investigations and compliance.

(a) The commissioner shall, to the extent practicable, seek the cooperation of health care providers and facilities, and may provide any support and assistance as available, in obtaining compliance with this section.
(b) The commissioner shall determine the manner and processes for fulfilling any responsibilities and taking any of the actions in paragraphs (c) to (f).
(c) A person who believes a health care provider or facility has not complied with the requirements of the No Surprises Act or this section may file a complaint with the commissioner in the manner determined by the commissioner.
(d) The commissioner shall conduct compliance reviews and investigate complaints filed under this section in the manner determined by the commissioner to ascertain whether health care providers and facilities are complying with this section.
(e) The commissioner may report violations under this section to other relevant federal and state departments and jurisdictions as appropriate, including the attorney general and

relevant licensing boards, and may also coordinate on investigations and enforcement of this section with other relevant federal and state departments and jurisdictions as appropriate, including the attorney general and relevant licensing boards.
(f) A health care provider or facility may contest whether the finding of facts constitute a violation of this section according to the contested case proceeding in sections 14.57 to 14.62, subject to appeal according to sections 14.63 to 14.68.
(g) Any data collected by the commissioner as part of an active investigation or active compliance review under this section are classified (1) if the data is not on individuals, it is classified as protected nonpublic data pursuant to section 13.02 subdivision 13; or (2) if the data is on individuals, it is classified as confidential pursuant to sections 13.02, subdivision 3. Data describing the final disposition of an investigative or compliance review are classified as public.
Subd. 3.
Civil penalty.
(a) The commissioner, in monitoring and enforcing this section, may levy a civil monetary penalty against each health care provider or facility found to be in violation of up to $100 for each violation, but may not exceed $25,000 for identical violations during a calendar year.
(b) No civil monetary penalty shall be imposed under this section for violations that occur prior to January 1, 2024.

ARTICLE 2
HEALTH INSURANCE

Sec. 2.
Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to read:
Subd. 5.
Mammogram; diagnostic services and testing.
If a health care provider determines an enrollee requires additional diagnostic services or testing after a mammogram, a health plan must provide coverage for the additional diagnostic services or testing with no cost-sharing, including co-pay, deductible, or coinsurance.
EFFECTIVE DATE.
This section is effective January 1, 2024, and applies to health plans offered, issued, or sold on or after that date.

Sec. 7.
[62J.826] MEDICAL AND DENTAL PRACTICES; CURRENT STANDARD CHARGES.
Subdivision 1.
Definitions.
(a) The definitions in this subdivision apply to this section.
(b) "CDT code" means a code value drawn from the Code on Dental Procedures and Nomenclature published by the American Dental Association.

(c) "Chargemaster" means the list of all individual items and services maintained by a medical or dental practice for which the medical or dental practice has established a charge.
(d) "Commissioner" means the commissioner of health.
(e) "CPT code" means a code value drawn from the Current Procedural Terminology published by the American Medical Association.
(f) "Dental service" means a service charged using a CDT code.
(g) "Diagnostic laboratory testing" means a service charged using a CPT code within the CPT code range of 80047 to 89398.
(h) "Diagnostic radiology service" means a service charged using a CPT code within the CPT code range of 70010 to 79999 and includes the provision of x-rays, computed tomography scans, positron emission tomography scans, magnetic resonance imaging scans, and mammographies.
(i) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58, but does not include a health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.
(j) "Medical or dental practice" means a business that:
(1) earns revenue by providing medical care or dental services to the public;
(2) issues payment claims to health plan companies and other payers; and
(3) may be identified by its federal tax identification number.
(k) "Outpatient surgical center" means a health care facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.
(l) "Standard charge" means the regular rate established by the medical or dental practice for an item or service provided to a specific group of paying patients. This includes all of the following:
(1) the charge for an individual item or service that is reflected on a medical or dental practice's chargemaster, absent any discounts;
(2) the charge that a medical or dental practice has negotiated with a third-party payer for an item or service;
(3) the lowest charge that a medical or dental practice has negotiated with all third-party payers for an item or service;
(4) the highest charge that a medical or dental practice has negotiated with all third-party payers for an item or service; and
(5) the charge that applies to an individual who pays cash, or cash equivalent, for an item or service.
Subd. 2.
Requirement; current standard charges.
The following medical or dental practices must make available to the public a list of their current standard charges for all items and services, as reflected in the medical or dental practice's chargemaster, provided by the medical or dental practice:
(1) hospitals;
(2) outpatient surgical centers; and
(3) any other medical or dental practice that has revenue of greater than $50,000,000 per year and that derives the majority of its revenue by providing one or more of the following services:

(i) diagnostic radiology services;
(ii) diagnostic laboratory testing;
(iii) orthopedic surgical procedures, including joint arthroplasty procedures within the CPT code range of 26990 to 27899;
(iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT code 66982 or 66984, or refractive correction surgery to improve visual acuity;
(v) anesthesia services commonly provided as an ancillary to services provided at a hospital, outpatient surgical center, or medical practice that provides orthopedic surgical procedures or ophthalmologic surgical procedures;
(vi) oncology services, including radiation oncology treatments within the CPT code range of 77261 to 77799 and drug infusions; or
(vii) dental services.
Subd. 3.
Required file format and content.
(a) A medical or dental practice that is
subject to this section must make available to the public current standard charges using the format and data elements specified in the currently effective version of the Hospital Price Transparency Sample Format (Tall) (CSV) and related data dictionary recommended for hospitals by the Centers for Medicare and Medicaid Services (CMS). If CMS modifies or replaces the specifications for this format, the form of this file must be modified or replaced to conform with the new CMS specifications by the date specified by CMS for compliance with its new specifications. All prices included in the file must be expressed as dollar amounts. The data must be in the form of a comma separated values file which can be directly imported, without further editing or remediation, into a relational database table which has been designed to receive these files. The medical or dental practice must make the file available to the public in a manner specified by the commissioner.
(b) A medical or dental practice must test its file for compliance with paragraph (a) before making the file available to the public.
(c) A hospital must comply with this section no later than January 1, 2024. A medical or dental practice that meets the requirements in subdivision 2, clause (3), or an outpatient surgical center must comply with this section no later than January 1, 2025.

Sec. 25.
[62Q.451] UNRESTRICTED ACCESS TO SERVICES FOR THE DIAGNOSIS, MONITORING, AND TREATMENT OF RARE DISEASES.
Subdivision 1.
Definitions.
(a) For purposes of this section, the following terms have
the meanings given.
(b) "Rare disease or condition" means any disease or condition:
(1) that affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;
(2) that affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb;

(3) that is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or
(4) for which an enrollee:
(i) has received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint;
(ii) has documentation in the enrollee's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and
(iii) had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.
A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.
Subd. 2.
Unrestricted access.
(a) No health plan company may restrict the choice of an
enrollee as to where the enrollee receives services from a licensed health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition, including but not limited to additional restrictions through any prior authorization, preauthorization, prior approval, precertification process, increased fees, or other methods.
(b) Any services provided by, referred for, or ordered by an out-of-network provider for an enrollee who, before receiving and being notified of a definitive diagnosis, satisfied the requirements in subdivision 1, paragraph (b), clause (4), are governed by paragraph (c), even if the subsequent definitive diagnosis does not meet the definition of rare disease or condition in subdivision 1, paragraph (b), clause (1), (2), or (3). Once the enrollee is definitively diagnosed with a disease or condition that does not meet the definition of rare disease or condition in subdivision 1, paragraph (b), clause (1), (2), or (3), and notification of the diagnosis has been provided to both the health plan and the enrollee, or a parent or guardian of a minor enrollee, any services provided by, referred for, or ordered by an out-of-network provider related to the diagnosis are governed by paragraph (c) for up to 60 days, providing time for care to be transferred to a qualified in-network provider and to schedule needed in-network appointments. After this 60-day period, subsequent services provided by, referred for, or ordered by an out-of-network provider related to the diagnosis are no longer governed by paragraph (c).
(c) Cost-sharing requirements and benefit or services limitations for the diagnosis and treatment of a rare disease or condition must not place a greater financial burden on the enrollee or be more restrictive than those requirements for in-network medical treatment.
(d) A health plan company must provide enrollees with written information on the content and application of this section and must train customer service representatives on the content and application of this section.
Subd. 3.
Coverage; prior authorization.
(a) Nothing in this section requires a health
plan company to provide coverage for a medication, procedure or treatment, or laboratory or clinical testing, that is not covered under the enrollee's health plan.

(b) Coverage for a service must not be denied solely on the basis that it was provided by, referred for, or ordered by an out-of-network provider.
(c) Any prior authorization requirements for a service that is provided by, referred for, or ordered by an out-of-network provider must be the same as any prior authorization requirements for a service that is provided by, referred for, or ordered by an in-network provider.
(d) Subject to the requirements of this section and chapter 62W, a health plan may require use of a specialty pharmacy, as defined in section 62W.02, subdivision 20.
Subd. 4.
Payments to out-of-network providers for services provided in this state.
(a)
If a health plan company has an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks, then the provider shall accept the established contractual payment for that service as payment in full.
(b) If a health plan company does not have an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks, then the provider shall accept:
(1) the provider's established rate for uninsured patients for that service as payment in full; or
(2) if the provider does not have an established rate for uninsured patients for that service, then the average commercial insurance rate the health plan company has paid for that service in this state over the past 12 months as payment in full.
(d) If the payment amount is determined under paragraph (b), clause (2), and the health plan company has not paid for that service in this state within the past 12 months, then the health plan company shall pay the lesser of the following:
(1) the average rate in the commercial insurance market the health plan company paid for that service across all states over the past 12 months; or
(2) the provider's standard charge.
(e) This subdivision does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapters 256B or 256L.
Subd. 5.
Payments to out-of-network providers when services are provided outside of the state.
(a) If a health plan company has an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in another state related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks in the state where the service is provided, then the health plan company shall pay the established contractual payment for that service.
(b) If a health plan company does not have an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in another state related to the diagnosis, monitoring, and treatment of a rare disease

or condition, across any of the health plan's networks in the state where the service is provided, then the health plan company shall pay:
(1) the provider's established rate for uninsured patients for that service; or
(2) if the provider does not have an established rate for uninsured patients for that service, then the average commercial insurance rate the health plan company has paid for that service in the state where the service is provided over the past 12 months.
(c) If the payment amount is determined under paragraph (b), clause (2), and the health plan company has not paid for that service in the state where the service is provided within the past 12 months, then the health plan company shall pay the lesser of the following:
(1) the average commercial insurance rate the health plan company has paid for that service across all states over the last 12 months; or
(2) the provider's standard charge.
(d) This subdivision does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.
Subd. 6.
Exclusion.
This section does not apply to medications obtained from a retail pharmacy as defined in section 62W.02, subdivision 18.
EFFECTIVE DATE.
This section is effective January 1, 2024, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 26.
[62Q.473] BIOMARKER TESTING.
Subdivision 1.
Definitions.
(a) For the purposes of this section, the terms defined in this subdivision have the meanings given.
(b) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.
(c) "Biomarker testing" means the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyst tests; multiplex panel tests; protein expression; and whole exome, whole genome, and whole transcriptome sequencing.
(d) "Clinical utility" means a test provides information that is used to formulate a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision.
(e) "Consensus statement" means a statement that: (1) describes optimal clinical care outcomes, based on the best available evidence, for a specific clinical circumstance; and
(2) is developed by an independent, multidisciplinary panel of experts that: (i) uses a rigorous

and validated development process that includes a transparent methodology and reporting structure; and (ii) strictly adheres to the panel's conflict of interest policy.

(f) "Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline that: (1) establishes a standard of care informed by (i) a systematic review of evidence, and (ii) an assessment of the risks and benefits of alternative care options; and (2) is developed by an independent organization or medical professional society that: (i) uses a transparent methodology and reporting structure; and (ii) adheres to a conflict of interest policy. Nationally recognized clinical practice guideline includes recommendations to optimize patient care.

Subd. 2.

Biomarker testing; coverage required.

(a) A health plan must provide coverage for biomarker testing to diagnose, treat, manage, and monitor illness or disease if the test provides clinical utility. For purposes of this section, a test's clinical utility may be demonstrated by medical and scientific evidence, including but not limited to:

(1) nationally recognized clinical practice guidelines as defined in this section;

(2) consensus statements as defined in this section;

(3) labeled indications for a United States Food and Drug Administration (FDA) approved or FDA-cleared test, indicated tests for an FDA-approved drug, or adherence to warnings and precautions on FDA-approved drug labels; or

(4) Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.

(b) Coverage under this section must be provided in a manner that limits disruption of care, including the need for multiple biopsies or biospecimen samples.

(c) Nothing in this section prohibits a health plan company from requiring a prior authorization or imposing other utilization controls when approving coverage for biomarker testing.

EFFECTIVE DATE.

This section is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 30.

Minnesota Statutes 2022, section 62Q.556, is amended to read:

62Q.556 ~~UNAUTHORIZED PROVIDER SERVICES~~ CONSUMER PROTECTIONS AGAINST BALANCE BILLING.

Subdivision 1.

~~Unauthorized provider services~~ Nonparticipating provider balance billing prohibition.

(a) Except as provided in paragraph ~~(c), unauthorized provider services occur~~ (b), balance billing is prohibited when an enrollee receives services from:

(1) ~~from~~ a nonparticipating provider at a participating hospital or ambulatory surgical center, ~~when the services are rendered:~~ as described by the No Surprises Act, including any federal regulations adopted under that act;

~~(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~~.~~; or

(3) a nonparticipating provider or facility providing emergency services as defined in section 62Q.55, subdivision 3, and other services as described in the requirements of the No Surprises Act.

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

~~(c)~~ (b) The services described in paragraph (a), ~~clause (2)~~ clauses (1), (2), and (3), as defined in the No Surprises Act, and any federal regulations adopted under that act, are ~~not unauthorized provider services~~ subject to balance billing if the enrollee ~~gives advance written~~ provides informed consent ~~to~~ prior to receiving services from the nonparticipating provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan. The informed consent must comply with all requirements of the No Surprises Act, including any federal regulations adopted under that act.

Subd. 2.

~~Prohibition~~ Cost-sharing requirements and independent dispute resolution.

(a) An enrollee's financial responsibility for the ~~unauthorized~~ nonparticipating provider services described in subdivision 1, paragraph (a), 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~~ nonparticipating 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~~ nonparticipating provider services with the nonparticipating provider. If ~~a health plan company's and nonparticipating provider's attempts~~ the attempt to negotiate reimbursement for the ~~health care~~ nonparticipating provider services ~~do~~ does 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.~~ either party may initiate the federal independent dispute resolution process pursuant to the No Surprises Act, including any federal regulations adopted under that act.

~~(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 website, 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.

Annual data reporting.

(a) Beginning April 1, 2024, a health plan company must report annually to the commissioner of health:

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

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

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

Subd. 4.

Enforcement.

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

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

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

Sec. 42. **STATEWIDE HEALTH CARE PROVIDER DIRECTORY.**

Subdivision 1.

Definitions.

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

(b) "Health care provider" means a practicing provider that accepts reimbursement from a group purchaser.

(c) "Health care provider directory" means an electronic catalog and index that supports the management of health care provider information, both individual and organizational, in a directory structure for public use to find available providers and networks and support state agency responsibilities.

(d) "Group purchaser" has the meaning given in Minnesota Statutes, section 62J.03, subdivision 6.

Subd. 2.

Health care provider directory.

The commissioner shall assess the feasibility and stakeholder commitment to develop, manage, and maintain a statewide electronic directory of health care providers. The assessment must take into consideration consumer information needs, state agency applications, stakeholder needs, technical requirements, alignment with national standards, governance, operations, legal and policy considerations, and existing directories. The commissioner shall conduct this assessment in consultation with stakeholders, including but not limited to consumers, group purchasers, health care providers, community health boards, and state agencies.

ARTICLE 16
HEALTH CARE AFFORDABILITY AND DELIVERY

Section 1.

[4.047] HEALTH SUBCABINET.

Subdivision 1.

Establishment.

The Health Subcabinet is established.

Subd. 2.

Membership.

The Health Subcabinet shall consist of the commissioners of human services, commerce, management and budget, and health and the executive director of MNsure.

Subd. 3.

Director; staffing and administrative support.

An executive director must be hired to manage the activities of the Health Subcabinet and serve as its chair. The commissioner of management and budget, in coordination with other state agencies and boards, as applicable, must provide staffing and administrative support to the executive director and the subcabinet established in this section.

Subd. 4.

Duties.

The Health Subcabinet shall coordinate state agency and, as applicable, private sector efforts to reform the health care delivery and payment systems; foster sustainability in health care spending; ensure the availability of affordable and comprehensive health care coverage and health care; ensure access to high-quality health care services; and reduce disparities and inequities in the experience or outcomes of health care.

Sec. 2.

Minnesota Statutes 2022, section 62J.03, is amended by adding a subdivision to read:

Subd. 11.

Health care entity.

"Health care entity" includes clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations, integrated provider and plan systems, county-based purchasing plans, health carriers, health care providers as defined under section 62J.03, subdivision 8, and entities required to report under section 62J.84.

Sec. 3.

[62J.0416] IDENTIFY STRATEGIES FOR REDUCTION OF ADMINISTRATIVE SPENDING AND LOW-VALUE CARE.

(a) The commissioner of health shall develop recommendations for strategies to reduce the volume and growth of administrative spending by health care organizations and group purchasers, and the magnitude of low-value care delivered to Minnesota residents. The commissioner shall:

(1) review the availability of data and identify gaps in the data infrastructure to estimate aggregated and disaggregated administrative spending and low-value care;

(2) based on available data, estimate the volume and change over time of administrative spending and low-value care in Minnesota;

(3) conduct an environmental scan and key informant interviews with experts in health care finance, health economics, health care management or administration, and the administration of health insurance benefits to determine drivers of spending growth for spending on administrative services or the provision of low-value care; and

(4) convene a clinical learning community and an employer task force to review the evidence from clauses (1) to (3) and develop a set of actionable strategies to address administrative spending volume and growth and the magnitude of the volume of low-value care.

(b) By March 31, 2025, the commissioner shall deliver the recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy.

Sec. 4.

[62J.0417] PAYMENT MECHANISMS IN RURAL HEALTH CARE.

(a) The commissioner shall develop a plan to assess readiness of rural communities and rural health care providers to adopt value based, global budgeting or alternative payment systems and recommend steps needed to implement them. The commissioner may use the development of case studies and modeling of alternate payment systems to demonstrate value-based payment systems that ensure a baseline level of essential community or regional health services and address population health needs.

(b) The commissioner shall develop recommendations for pilot projects with the aim of ensuring financial viability of rural health care entities in the context of spending growth targets. The commissioner shall include the plan, recommendations, and related findings in the reports required under section 62J.312, subdivision 3.

Sec. 5.

[62J.312] CENTER FOR HEALTH CARE AFFORDABILITY.

Subdivision 1.

Center establishment; research and analysis.

(a) The commissioner shall establish a center for health care affordability within the Minnesota Department of Health. The commissioner, through the center, shall carry out the duties assigned under this section.

(b) The commissioner shall conduct research on and analyze the drivers of health care spending growth in order to increase transparency and identify strategies that help to reduce waste and low-value care; eliminate unproductive administrative spending; enhance the provision of effective, high-value care; consider the sustainability of health care spending growth and the relationship of health care spending growth to health equity; and identify delivery system, payment, and health care market reforms to increase health care affordability.

(c) To perform the duties under paragraph (b), the commissioner shall:

(1) identify additional data needed from health care entities and the level of granularity of required reporting, while limiting additional reporting burdens to the extent possible by ensuring effective use of existing data and reporting mechanisms;

(2) establish the form and manner for data reporting, including but not limited to data specifications, methods of reporting, and reporting schedules;

(3) assist reporting entities in submitting data and information; and

(4) conduct background research and environmental scans, perform qualitative and quantitative analyses, and perform economic modeling.

Subd. 2.

Public input.

(a) The commissioner shall obtain public feedback on the research agenda for the center for health care affordability and on the research activities conducted under this section by consulting with health care entities, licensed physicians and other health care providers, employers and other purchasers, the commissioners of human services and management and budget, patients and patient advocates, individuals with expertise in health care spending or health economics, and other stakeholders. The commissioner may convene an advisory body or bodies to obtain public feedback.

(b) The commissioner shall hold public hearings, at least annually, to share initial and final analyses conducted under this section, solicit community input on strategies to strengthen health care affordability, and hear testimony about experiences and challenges related to health care affordability.

Subd. 3.

Reporting.

The commissioner shall provide periodic reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy describing the analyses conducted under this section and making recommendations for strategies to address unsustainable rates of health care spending growth.

Subd. 4.

Contracting.

In carrying out the duties required by this section, the commissioner may contract with entities with expertise in health economics, health care finance, accounting, and actuarial science.

Subd. 5.

Access to information.

(a) The commissioner may request that a state agency provide data in a usable format as requested by the commissioner at no cost to the commissioner.

(b) The commissioner may also request from a state agency unique or custom data sets. That agency may charge the commissioner for providing the data at the same rate the agency would charge any other public or private entity.

(c) Unless specified elsewhere in statute, any information provided to the commissioner by a state agency must be de-identified. For purposes of this requirement, "de-identified" means that a process was used to prevent the identity of a person from being connected with information and to ensure that all identifiable information has been removed.

(d) Notwithstanding any provisions to the contrary, the commissioner may use data collected and maintained under section 62U.04 to carry out the duties required under this section.

(e) Any health care entity subject to reporting under this section that fails to provide data in the form and manner prescribed by the commissioner is subject to a fine paid to the commissioner of up to $500 for each day the data are past due. The commissioner may grant an extension of the reporting deadlines upon a showing of good cause by the entity. Any fine levied against the entity under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 and 14.69.

(f) Any data submitted to the commissioner must retain their original classification under the Minnesota Data Practices Act under chapter 13.

Subd. 6.

340B covered entity report.

(a) Beginning April 1, 2024, each 340B covered entity, as defined by section 340B(a)(4) of the Public Health Service Act, must report to the commissioner of health by April 1 of each year the following information related to its participation in the federal 340B program for the previous calendar year:

(1) the National Provider Identification (NPI) number;

(2) the name of the 340B covered entity;

(3) the servicing address of the 340B covered entity;

(4) the classification of the 340B covered entity;

(5) the aggregated acquisition cost for prescription drugs obtained under the 340B program;

(6) the aggregated payment amount received for drugs obtained under the 340B program and dispensed to patients;

(7) the aggregated payment made to pharmacies under contract to dispense drugs obtained under the 340B program; and

(8) the number of claims for prescription drugs described in clause (6).

(b) The information required under paragraph (a) must be reported by payer type, including commercial insurance, medical assistance and MinnesotaCare, and Medicare, in the form and manner defined by the commissioner. For covered entities that are hospitals, the information required under paragraph (a), clauses (5) to (8), must also be reported at

the national drug code level for the 50 most frequently dispensed drugs by the facility under the 340B program.

(c) Data submitted under paragraph (a) must include prescription drugs dispensed by outpatient facilities that are identified as child facilities under the federal 340B program based on their inclusion on the hospital's Medicare cost report.

(d) Data submitted to the commissioner under paragraph (a) must be classified as nonpublic data as defined in section 13.02, subdivision 9.

(e) Beginning November 15, 2024, and by November 15 of each year thereafter, the commissioner shall prepare a report that aggregates the data submitted under paragraph (a). The commissioner shall submit this report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy.

Sec. 19. **ANALYSIS OF BENEFITS AND COSTS OF A UNIVERSAL HEALTH CARE FINANCING SYSTEM.**

Subdivision 1.

Definitions.

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

(b) "Total public and private health care spending" means:

(1) spending on all medical care, including but not limited to dental, vision and hearing, mental health, substance use disorder treatment, prescription drugs, medical equipment and supplies, long-term care, and home care, whether paid through premiums, co-payments and deductibles, other out-of-pocket payments, or funding from the government, employers, or other sources; and

(2) the costs of administering, delivering, and paying for medical care, including but not limited to all expenses incurred by insurers, providers, employers, individuals, and the government to select, negotiate, purchase, administer, and provide coverage for health care, dental care, long-term care, prescription drugs, the 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.

(c) "All necessary care" means the full range of services listed in the proposed Minnesota Health Plan legislation for a universal health care financing system specified in subdivision 5, including medical, dental, vision and hearing, mental health, substance use disorder treatment, reproductive and sexual health, prescription drugs, medical equipment and supplies, long-term care, home care, and the coordination of care.

Subd. 2.

Initial assumptions.

(a) When calculating administrative savings under the universal health care financing proposal, the analysts shall recognize that simple, direct payment of medical services avoids the need for provider networks, eliminates prior authorization requirements, and eliminates administrative complexity of other payment schemes, along with the need for creating risk adjustment mechanisms and measuring, tracking, and paying entities according to risk-adjusted or nonrisk-adjusted payment schemes.

(b) The analysts shall assume that, while gross provider payments may be reduced to reflect reduced administrative costs, net provider income would remain similar to the current system. The analysts shall not assume that payment rate negotiations will track current Medicaid, Medicare, or market payment rates or a combination of those rates, because provider compensation, after adjusting for reduced administrative costs, would not be universally raised or lowered but would be negotiated based on market needs, so provider compensation might be raised in an underserved area such as mental health but lowered in other areas.

Subd. 3.

Contract for analysis of proposal.

(a) The commissioner of health shall contract with one or more independent entities to conduct an analysis of the benefits and costs of a legislative proposal for a universal health care financing system and a similar analysis of the current health care financing system to assist the state in comparing the proposal to the current system. The contract must be designed to produce estimates for all elements in subdivision 6.

(b) The commissioner shall issue a request for information. Based on responses to the request for information, the commissioner shall issue a request for proposals that specifies requirements for the design, analysis, and deliverables, and shall select one or more contractors based on responses to the request for proposals. The commissioner shall consult with the chief authors of this section in implementing this paragraph.

(c) The commissioner is exempt from the requirements of Minnesota Statutes, chapters 16A and 16C, when entering into a new contract or amending an existing contract to complete the necessary analysis required under this section.

Subd. 4.

Access to information.

(a) The commissioner may request that a state agency provide the commissioner and contractor with data as defined in Minnesota Statutes, sections 62J.04 and 295.52, in a usable format as requested by the commissioner at no cost to the commissioner.

(b) The commissioner may request from a state agency unique or custom data sets. The agency may charge the commissioner for providing these data sets at the same rate the agency would charge any other public or private entity.

(c) Any data submitted to the commissioner shall retain their original classification under the Minnesota Data Practices Act in Minnesota Statutes, chapter 13.

(d) The commissioner, under the authority of Minnesota Statutes, chapter 62J, may collect data necessary for the performance of assigned duties and shall collect this data in a form and manner that ensures the collection of high-quality, transparent data.

(e) The commissioner of human services shall make available to the vendor selected under subdivision 3 any relevant findings from:

(1) any actuarial and economic analysis for a MinnesotaCare public option implementation plan and waiver; and

(2) any analysis of a direct payment system.

Subd. 5.

Proposal.

The commissioner of health, in consultation with the commissioners of human services and commerce, shall submit to the contractor for analysis the legislative proposal known as the Minnesota Health Plan, proposed in the 93rd Minnesota Legislature as Senate File No. 2740/House File No. 2798, that would establish a universal health care financing system designed to:

(1) ensure all Minnesotans have health care coverage;

(2) cover all necessary care; and

(3) allow patients to choose their doctors, hospitals, and other providers.

Subd. 6.

Proposal analysis.

(a) The analysis must measure the performance of both the proposed Minnesota Health Plan and the current public and private health care financing system over a ten-year period to contrast the impact of these approaches on:

(1) coverage: the number of people who are uninsured versus the number of people who are insured;

(2) benefit completeness: adequacy of coverage measured by the completeness of the coverage and the number of people lacking coverage for key necessary care elements such as dental services, long-term care, medical equipment or supplies, vision and hearing, and other health services. The analysis must take into account the variety of benefit designs in the commercial market and report the extent of coverage in each market segment;

(3) underinsurance: whether people with coverage can afford the care they need or whether cost prevents them from accessing care. This includes affordability in terms of premiums, deductibles, and out-of-pocket expenses;

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

(5) health care spending: total public and private health care spending in Minnesota under the current system versus under the Minnesota Health Plan legislative proposal, including all spending by individuals, businesses, and government. Where relevant, the analysis must be broken out by key necessary care areas, such as medical, dental, and mental health. The analysis of total health care spending must examine whether there are savings or additional costs under the universal health care financing system established by the legislative proposal compared to the existing system due to:

(i) changes in the cost of insurance, billing, underwriting, marketing, evaluation, and other administrative functions for all entities involved in the health care system, including savings from global budgeting for hospitals and institutional care, instead of billing for individual services provided;

(ii) changes in prices for medical services and products, including pharmaceuticals, due to price negotiations under the proposal;

(iii) the impact on utilization, health outcomes, and workplace absenteeism due to prevention, early intervention, and health-promoting activities;

(iv) shortages or excess capacity of medical facilities, equipment, and personnel, including

caregivers and staff, under either the current system or the proposal, including the rate of inappropriate emergency room usage. The analysis must break down capacity by geographic differences such as rural versus metropolitan, and disparate access by population group;

(v) the impact on state, local, and federal government non-health-care expenditures. This may include factors such as reduced crime and out-of-home placement costs due to the availability of mental health or substance use disorder coverage and other factors identified by additional analyses;

(vi) job losses or gains within the health care system, related to any changes in health care delivery, health billing, and insurance administration;

(vii) job losses or gains elsewhere in the economy under the proposal due to any reduction in insurance and administrative burdens on businesses;

(viii) impact on disparities in health care access and outcomes; and

(ix) care coordination and case management, including care management conducted by health plan companies, to assess the costs of coordinating and navigating care for enrollees.

(b) The commissioner may provide interim reports and status updates, and shall issue a final report by January 15, 2026, to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy. The findings and recommendations of the report must address the feasibility and affordability of the proposal and the projected impact of the proposal on the variables listed in paragraph (a). The report must also include:

(1) clear documentation of the technical assumptions made to conduct the analysis;

(2) a comprehensive description of the methodological approach used;

(3) the sensitivity of results to variations in the assumptions; and

(4) the data sources and the robustness of the information used.

EFFECTIVE DATE.

This section is effective the day following final enactment.

Sec. 20. **ACTUARIAL AND ECONOMIC ANALYSES FOR PUBLIC OPTION IMPLEMENTATION PLAN AND WAIVER.**

Subdivision 1.

Contracting requirement; consultation.

(a) The commissioner of human services must contract with one or more independent third-party actuarial firms, which may include the actuarial firm that develops and certifies current MinnesotaCare rates, to perform and certify actuarial and economic analyses of different public option models that meet the requirements of this section.

(b) The commissioner of human services, in implementing this section, shall consult with the commissioners of commerce and health and the Board of Directors of MNsure.

Subd. 2.

Content of analyses; state-specific impacts.

The actuarial and economic analyses of public option models must include conclusions, data, and assumptions related to:

(1) estimated 1332 waiver pass-through funding Minnesota will receive each year for the first five years after the implementation of the public option;

(2) changes to existing federal funding and federal financing options from all sources other than a 1332 waiver pass-through;

(3) impact on the state budget, including but not limited to any state subsidy of the public option;

(4) impacts on enrollment, stratification of enrollee risk across plans, premiums, cost-sharing, other enrollee costs, variety and volume of enrollee plan options, provider network adequacy, provider reimbursement rates, and other material considerations in medical assistance and MinnesotaCare, on an aggregated and disaggregated basis for populations, including but not limited to populations defined by race, ethnicity, and geography, as requested by the commissioner of human services;

(5) projected impacts on the individual health insurance market, including impacts on enrollment, stratification of enrollee risk across plans, premiums, cost-sharing, other insured costs, variety and volume of insured plan options, provider network adequacy, provider reimbursement rates, and other material considerations, on an aggregated and disaggregated basis for populations, including populations defined by race, ethnicity, and geography, as requested by the commissioner of human services; and

(6) projected impact of changes to the risk rating of the current MinnesotaCare population, the expected public option population, and the current individual health insurance market.

Subd. 3.

Content of analyses; health and affordability.

The actuarial and economic analyses must include:

(1) the estimated affordability of premiums and cost-sharing for consumers and the extent to which the model meets the affordability threshold in United States Code, title 26, section 36B(b)(3)(A)(i), as indexed according to item (ii) of that section. For purposes of this clause, "affordability" for consumers means:

(i) using a household budget approach that considers the total costs paid by consumers for health care coverage, including the enrollee share of premiums and enrollee out-of-pocket costs, including deductibles, co-payments, coinsurance, and other forms of cost-sharing;

(ii) minimizing premium affordability cliffs; and

(iii) considering affordability by age and geographic location; and

(2) the estimated impact on racial and ethnic disparities in rates of insurance and access to health care services.

Subd. 4.

Content of analyses; MinnesotaCare public option.

The actuarial and economic analyses must include conclusions, data, and assumptions sufficient for the commissioners of commerce, human services, and health; the Board of Directors of MNsure; and the legislature to evaluate different public option models, including a MinnesotaCare public option under which MinnesotaCare continues to be administered as a basic health program in accordance with Minnesota Statutes, section 256L.02, subdivision 5. The actuarial and economic analyses must meet the requirements of this section.

Subd. 5.

Content of analyses; 1332 waiver requirements.

The actuarial and economic analyses must include data and analyses sufficient for the commissioners of commerce, human services, and health; the Board of Directors of MNsure; and the legislature to design and evaluate different public option models, including but not limited to a MinnesotaCare public option, that would receive approval under a 1332 waiver from the United States Department of Health and Human Services and United States Department of Treasury, including but not limited to data necessary for the actuarial firm or another independent third-party firm to complete:

(1) actuarial analyses and actuarial certifications required to support an estimate by the state that a proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement as described in Code of Federal Regulations, title 45, section 155.1308; and

(2) economic analyses required to support an estimate by the state that a proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement, and the federal deficit requirement as described in Code of Federal Regulations, title 45, section 155.1308.

Subd. 6.

Content of analyses; commissioner discretion.

The actuarial and economic analyses must include all other data, information, or analyses related to a public option or 1332 waiver requested by the commissioner of human services, including potential modifications to a MinnesotaCare public option or other public option models that may improve one or more outcomes listed in subdivision 2 or 3.

Subd. 7.

Contract exemption.

The commissioner of human services is exempt from the requirements of Minnesota Statutes, chapters 16A and 16C, when entering into a new contract or amending an existing contract to complete the actuarial and economic analyses required under this section.

Subd. 8.

Consultation with governmental entities.

The commissioners of human services and commerce may consult with any federal or state governmental entity as necessary to complete the actuarial and economic analyses under this section or provide a final recommendation and implementation plan to the legislature under section 21.

EFFECTIVE DATE.

This section is effective the day following final enactment.

Sec. 21. **REPORT TO LEGISLATURE ON IMPLEMENTATION PLAN AND WAIVER FOR PUBLIC OPTION.**

By February 1, 2024, the commissioner of commerce, in consultation with the commissioners of human services and health and the Board of Directors of MNsure, must report the following to the chairs and ranking minority members of the legislative committees with primary jurisdiction over health care finance and policy and health insurance:

(1) the results of the actuarial and economic analyses performed under section 20;

(2) the extent to which each public option model maximizes federal funding;

(3) additional information that the commissioner determines to be necessary to design a public option, receive approval for a 1332 waiver from the United States Department of Health and Human Services and United States Department of Treasury, and implement the plan upon approval of a 1332 waiver application;

(4) the commissioner of commerce's final recommendation for a public option. The recommendation must include a detailed description of:

(i) the health care benefit set to be provided to enrollees;

(ii) premiums and cost-sharing for enrollees across the income range, including any age or geographic rating, after state or federal subsidies;

(iii) potential modifications to the public option that might improve one or more of the outcomes listed in section 20, subdivision 2 or 3;

(iv) plan issuers, which may include a health plan company, governmental entity, or other entity;

(v) plan administrators;

(vi) health care provider reimbursement rates and the availability of providers and health care services;

(vii) adequacy of the expected provider network;

(viii) a determination of the public option's compliance with the requirements to receive a 1332 waiver, including detailed descriptions of compliance with the requirements described in Code of Federal Regulations, titles 45, section 155.1308, and 31, section 33.108; and

(ix) the information described in section 20, subdivision 2, as specifically determined by using assumptions and parameters based on implementation of the final recommendation as the public option health benefit plan; and

(5) the commissioner's final implementation plan. The implementation plan must include a detailed description of:

(i) additional actuarial and economic analyses necessary to receive a 1332 waiver;

(ii) the 1332 waiver process and requirements;

(iii) a detailed draft timeline for the state's implementation of the proposed waiver as described in Code of Federal Regulations, title 45, section 155.1308;

(iv) costs to the state to implement the plan, including a detailed ten-year budget plan that is deficit neutral to the federal government as described in Code of Federal Regulations, title 45, section 155.1308; and

(v) proposed legislation the commissioner anticipates will be necessary to implement the public option by January 1, 2027.

EFFECTIVE DATE.

This section is effective the day following final enactment.

ARTICLE 20
APPROPRIATIONS

Sec. 3. **COMMISSIONER OF HEALTH**

Subd. 2.
Health Improvement

(t) **Center for health care affordability.** $2,752,000 in fiscal year 2024 and $3,989,000 in fiscal year 2025 are from the general fund to establish a center for health care affordability and to implement Minnesota Statutes, section 62J.312. The general fund base for this appropriation is $3,988,000 in fiscal year 2026 and $3,988,000 in fiscal year 2027.

(ee) **Analysis of a universal health care financing system.** $1,815,000 in fiscal year 2024 and $580,000 in fiscal year 2025 are from the general fund to the commissioner to contract for an analysis of the benefits and costs of a legislative proposal for a universal health care financing system and a similar analysis of the current health care financing system. The base for this appropriation is $580,000 in fiscal year 2026 and $0 in fiscal year 2027. This appropriation is available until June 30, 2027.

(ff) **Charitable assets public interest review.** (1) The appropriations under this paragraph are contingent upon legislative enactment of 2023 House File 402 by the 93rd Legislature. (2) $1,584,000 in fiscal year 2024 and $769,000 in fiscal year 2025 are from the general fund to review certain health care entity transactions; to conduct analyses of the impacts of health care transactions on health care cost, quality, and competition; and to issue public reports on health care transactions in Minnesota and their impacts. The base for this appropriation is $710,000 in fiscal year 2026 and $710,000 in fiscal year 2027.

Sec. 14. **COMMISSIONER OF COMMERCE**	2024	2025
(a) **Defrayal of costs for mandated coverage of biomarker testing.** $17,000 in fiscal year 2025 is for administrative costs to implement mandated coverage of biomarker testing to diagnose, treat, manage, and monitor illness or disease. The base for this appropriation is $2,611,000 in fiscal year 2026 and $2,611,000 in fiscal year 2027. The base includes $2,594,000 in fiscal year 2026 and $2,594,000 in fiscal year 2027 for defrayal of costs for mandated coverage of biomarker testing to diagnose, treat, manage, and monitor illness or disease.	0	17,000

Omnibus Commerce Conference Committee Report
S.F. No. 2744 Sen. Klein / H.F. 2680 Rep. Stephenson

Sections of Interest to Healthcare

ARTICLE 1
COMMERCE FINANCE

Sec. 2. DEPARTMENT OF COMMERCE

Subd. 6.Insurance
(b) $318,000 each year is to conduct a feasibility study on a proposal to offer free primary care to Minnesotans. These are onetime appropriations.

ARTICLE 2
INSURANCE POLICY

Sec. 23. **[62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**
Subdivision 1.
Prohibition.
No manufacturer shall impose, or cause to be imposed, an excessive price increase, whether directly or through a wholesale distributor, pharmacy, or similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or delivered to any consumer in the state.
Subd. 2.
Excessive price increase.
A price increase is excessive for purposes of this section when:
(1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:
(i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar year; or
(ii) 40 percent of the wholesale acquisition cost over the immediately preceding three calendar years; and
(2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds $30 for:
(i) a 30-day supply of the drug; or
(ii) a course of treatment lasting less than 30 days.
Subd. 3.
Exemption.
It is not a violation of this section for a wholesale distributor or pharmacy to increase the price of a generic or off-patent drug if the price increase is directly attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy by the manufacturer of the drug.

Sec. 24.

[62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.

Any manufacturer that sells, distributes, delivers, or offers for sale any generic or off-patent drug in the state must maintain a registered agent and office within the state.

Sec. 25.

[62J.844] ENFORCEMENT.

Subdivision 1.

Notification.

(a) The commissioner of health shall notify the manufacturer of a generic or off-patent drug and the attorney general of any price increase that the commissioner believes may violate section 62J.842.

(b) The commissioner of management and budget and any other state agency that provides or purchases a pharmacy benefit except the Department of Human Services, and any entity under contract with a state agency to provide a pharmacy benefit other than an entity under contract with the Department of Human Services, may notify the manufacturer of a generic or off-patent drug and the attorney general of any price increase that the commissioner or entity believes may violate section 62J.842.

Subd. 2.

Submission of drug cost statement and other information by manufacturer; investigation by attorney general.

(a) Within 45 days of receiving a notice under subdivision 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to the attorney general. The statement must:

(1) itemize the cost components related to production of the drug;

(2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any increase during the preceding calendar year, or preceding three calendar years as applicable, in the price of the drug; and

(3) provide any other information that the manufacturer believes to be relevant to a determination of whether a violation of section 62J.842 has occurred.

(b) The attorney general may investigate whether a violation of section 62J.842 has occurred, in accordance with section 8.31, subdivision 2.

Subd. 3.

Petition to court.

(a) On petition of the attorney general, a court may issue an order:

(1) compelling the manufacturer of a generic or off-patent drug to:

(i) provide the drug cost statement required under subdivision 2, paragraph (a); and

(ii) answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general under subdivision 2, paragraph (b);

(2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing an order requiring that drug prices be restored to levels that comply with section 62J.842;

(3) requiring the manufacturer to provide an accounting to the attorney general of all revenues resulting from a violation of section 62J.842;

(4) requiring the manufacturer to repay to all Minnesota consumers, including any third-party payers, any money acquired as a result of a price increase that violates section 62J.842;

(5) notwithstanding section 16A.151, requiring that all revenues generated from a violation of section 62J.842 be remitted to the state and deposited into a special fund, to be used for initiatives to reduce the cost to consumers of acquiring prescription drugs, if a manufacturer is unable to determine the individual transactions necessary to provide the repayments described in clause (4);
(6) imposing a civil penalty of up to $10,000 per day for each violation of section 62J.842;
(7) providing for the attorney general's recovery of costs and disbursements incurred in bringing an action against a manufacturer found in violation of section 62J.842, including the costs of investigation and reasonable attorney's fees; and
(8) providing any other appropriate relief, including any other equitable relief as determined by the court.
(b) For purposes of paragraph (a), clause (6), every individual transaction in violation of section 62J.842 is considered a separate violation.
Subd. 4.
Private right of action.
Any action brought pursuant to section 8.31, subdivision 3a, by a person injured by a violation of section 62J.842 is for the benefit of the public.
Sec. 26.
[62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR OFF-PATENT DRUGS FOR SALE.
Subdivision 1.
Prohibition.
A manufacturer of a generic or off-patent drug is prohibited from withdrawing that drug from sale or distribution within this state for the purpose of avoiding the prohibition on excessive price increases under section 62J.842.
Subd. 2.
Notice to board and attorney general.
Any manufacturer that intends to withdraw a generic or off-patent drug from sale or distribution within the state shall provide a written notice of withdrawal to the attorney general at least 90 days prior to the withdrawal.
Subd. 3.
Financial penalty.
The attorney general shall assess a penalty of $500,000 on any manufacturer of a generic or off-patent drug that the attorney general determines has failed to comply with the requirements of this section.
Sec. 27.
[62J.846] SEVERABILITY.
If any provision of sections 62J.841 to 62J.845 or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of sections 62J.841 to 62J.845 that can be given effect without the invalid provision or application.
Sec. 28.
[62J.85] CITATION.
Sections 62J.85 to 62J.95 may be cited as the "Prescription Drug Affordability Act."
Sec. 29.
[62J.86] DEFINITIONS.

Subdivision 1.
Definitions.
For the purposes of sections 62J.85 to 62J.95, the following terms have the meanings given.
Subd. 2.
Advisory council.
"Advisory council" means the Prescription Drug Affordability Advisory Council established under section 62J.88.
Subd. 3.
Biologic.
"Biologic" means a drug that is produced or distributed in accordance with a biologics license application approved under Code of Federal Regulations, title 42, section 447.502.
Subd. 4.
Biosimilar.
"Biosimilar" has the meaning provided in section 62J.84, subdivision 2, paragraph (b).
Subd. 5.
Board.
"Board" means the Prescription Drug Affordability Board established under section 62J.87.
Subd. 6.
Brand name drug.
"Brand name drug" means a drug that is produced or distributed pursuant to:
(1) a new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or
(2) a biologics license application approved under United States Code, title 45, section 262(a)(c).
Subd. 7.
Generic drug.
"Generic drug" has the meaning provided in section 62J.84, subdivision 2, paragraph (e).
Subd. 8.
Group purchaser.
"Group purchaser" has the meaning given in section 62J.03, subdivision 6, and includes pharmacy benefit managers, as defined in section 62W.02, subdivision 15.
Subd. 9.
Manufacturer.
"Manufacturer" means an entity that:
(1) engages in the manufacture of a prescription drug product or enters into a lease with another manufacturer to market and distribute a prescription drug product under the entity's own name; and

(2) sets or changes the wholesale acquisition cost of the prescription drug product it manufacturers or markets.

Subd. 10.

Prescription drug product.

"Prescription drug product" means a brand name drug, a generic drug, a biologic, or a biosimilar.

Subd. 11.

Wholesale acquisition cost or WAC.

"Wholesale acquisition cost" or "WAC" has the meaning given in United States Code, title 42, section 1395W-3a(c)(6)(B).

Sec. 30.

[62J.87] PRESCRIPTION DRUG AFFORDABILITY BOARD.

Subdivision 1.

Establishment.

The commissioner of commerce shall establish the Prescription Drug Affordability Board, which shall be governed as a board under section 15.012, paragraph (a), to protect consumers, state and local governments, health plan companies, providers, pharmacies, and other health care system stakeholders from unaffordable costs of certain prescription drugs.

Subd. 2.

Membership.

(a) The Prescription Drug Affordability Board consists of nine members appointed as follows:

(1) seven voting members appointed by the governor;

(2) one nonvoting member appointed by the majority leader of the senate; and

(3) one nonvoting member appointed by the speaker of the house.

(b) All members appointed must have knowledge and demonstrated expertise in pharmaceutical economics and finance or health care economics and finance. A member must not be an employee of, a board member of, or a consultant to a manufacturer or trade association for manufacturers, or a pharmacy benefit manager or trade association for pharmacy benefit managers.

(c) Initial appointments must be made by January 1, 2024.

Subd. 3.

Terms.

(a) Board appointees shall serve four-year terms, except that initial appointees shall serve staggered terms of two, three, or four years as determined by lot by the secretary of state. A board member shall serve no more than two consecutive terms.

(b) A board member may resign at any time by giving written notice to the board.

Subd. 4.

Chair; other officers.

(a) The governor shall designate an acting chair from the members appointed by the governor.

(b) The board shall elect a chair to replace the acting chair at the first meeting of the board by a majority of the members. The chair shall serve for one year.

(c) The board shall elect a vice-chair and other officers from its membership as it deems necessary.

Subd. 5.

Staff; technical assistance.

(a) The board shall hire an executive director and other staff, who shall serve in the unclassified service. The executive director must have knowledge and demonstrated expertise in pharmacoeconomics, pharmacology, health policy, health services research, medicine, or a related field or discipline.

(b) The commissioner of health shall provide technical assistance to the board. The board may also employ or contract for professional and technical assistance as the board deems necessary to perform the board's duties.

(c) The attorney general shall provide legal services to the board.

Subd. 6.

Compensation.

The board members shall not receive compensation but may receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

Subd. 7.

Meetings.

(a) Meetings of the board are subject to chapter 13D. The board shall meet publicly at least every three months to review prescription drug product information submitted to the board under section 62J.90. If there are no pending submissions, the chair of the board may cancel or postpone the required meeting. The board may meet in closed session when reviewing proprietary information, as determined under the standards developed in accordance with section 62J.91, subdivision 3.

(b) The board shall announce each public meeting at least three weeks prior to the scheduled date of the meeting. Any materials for the meeting shall be made public at least two weeks prior to the scheduled date of the meeting.

(c) At each public meeting, the board shall provide the opportunity for comments from the public, including the opportunity for written comments to be submitted to the board prior to a decision by the board.

Sec. 31.

[62J.88] PRESCRIPTION DRUG AFFORDABILITY ADVISORY COUNCIL.

Subdivision 1.

Establishment.

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

Subd. 2.

Membership.

The council's membership shall consist of the following:

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

(2) two members representing health care providers;

(3) one member representing health plan companies;

(4) two members representing employers, with one member representing large employers and one member representing small employers;
(5) one member representing government employee benefit plans;
(6) one member representing pharmaceutical manufacturers;
(7) one member who is a health services clinical researcher;
(8) one member who is a pharmacologist;
(9) one member representing the commissioner of health with expertise in health economics;
(10) one member representing pharmaceutical wholesalers;
(11) one member representing pharmacy benefit managers;
(12) one member from the Rare Disease Advisory Council;
(13) one member representing generic drug manufacturers;
(14) one member representing pharmaceutical distributors; and
(15) one member who is an oncologist who is not employed by, under contract with, or otherwise affiliated with a hospital.

Subd. 3.

Terms.

(a) The initial appointments to the advisory council must be made by January 1, 2024. The initial appointed advisory council members shall serve staggered terms of two, three, or four years, determined by lot by the secretary of state. Following the initial appointments, the advisory council members shall serve four-year terms.
(b) Removal and vacancies of advisory council members shall be governed by section 15.059.

Subd. 4.

Compensation.

Advisory council members may be compensated according to section 15.059, except that those advisory council members designated in subdivision 2, clauses (10) to (15), must not be compensated.

Subd. 5.

Meetings.

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

Subd. 6.

Exemption.

Notwithstanding section 15.059, the advisory council shall not expire.

Sec. 32.

[62J.89] CONFLICTS OF INTEREST.

Subdivision 1.

Definition.

For purposes of this section, "conflict of interest" means a financial or personal association that has the potential to bias or have the appearance of biasing a person's decisions in matters related to the board, the advisory council, or in the conduct of the board's or council's activities. A conflict of interest includes any instance in

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

Subd. 2.

General.

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

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

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

Subd. 3.

Prohibitions.

Board members, board staff, or third-party contractors are prohibited from accepting gifts, bequeaths, or donations of services or property that raise the specter of a conflict of interest or have the appearance of injecting bias into the activities of the board.

Sec. 33.

[62J.90] PRESCRIPTION DRUG PRICE INFORMATION; DECISION TO CONDUCT COST REVIEW.

Subdivision 1.

Drug price information from the commissioner of health and other sources.

(a) The commissioner of health shall provide to the board the information reported to the commissioner by drug manufacturers under section 62J.84, subdivisions 3, 4, and 5. The commissioner shall provide this information to the board within 30 days of the date the information is received from drug manufacturers.

(b) The board may subscribe to one or more prescription drug pricing files, such as Medispan or FirstDatabank, or as otherwise determined by the board.

Subd. 2.

Identification of certain prescription drug products.

(a) The board, in consultation with the advisory council, shall identify selected prescription drug products based on the following criteria:

(1) brand name drugs or biologics for which the WAC increases by more than 15 percent or by more than $3,000 during any 12-month period or course of treatment if less than 12 months, after adjusting for changes in the consumer price index (CPI);
(2) brand name drugs or biologics with a WAC of $60,000 or more per calendar year or per course of treatment;
(3) biosimilar drugs that have a WAC that is not at least 20 percent lower than the referenced brand name biologic at the time the biosimilar is introduced; and
(4) generic drugs for which the WAC:
(i) is $100 or more, after adjusting for changes in the CPI, for:
(A) a 30-day supply;
(B) a course of treatment lasting less than 30 days; or
(C) one unit of the drug, if the labeling approved by the Food and Drug Administration does not recommend a finite dosage; and
(ii) increased by 200 percent or more during the immediate preceding 12-month period, as determined by the difference between the resulting WAC and the average WAC reported over the preceding 12 months, after adjusting for changes in the CPI.
The board is not required to identify all prescription drug products that meet the criteria in this paragraph.
(b) The board, in consultation with the advisory council and the commissioner of health, may identify prescription drug products not described in paragraph (a) that may impose costs that create significant affordability challenges for the state health care system or for patients, including but not limited to drugs to address public health emergencies.
(c) The board shall make available to the public the names and related price information of the prescription drug products identified under this subdivision, with the exception of information determined by the board to be proprietary under the standards developed by the board under section 62J.91, subdivision 3, and information provided by the commissioner of health classified as not public data under section 13.02, subdivision 8a, or as trade secret information under section 13.37, subdivision 1, paragraph (b), or as trade secret information under the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended.
Subd. 3.
Determination to proceed with review.
(a) The board may initiate a cost review of a prescription drug product identified by the board under this section.
(b) The board shall consider requests by the public for the board to proceed with a cost review of any prescription drug product identified under this section.
(c) If there is no consensus among the members of the board on whether to initiate a cost review of a prescription drug product, any member of the board may request a vote to determine whether to review the cost of the prescription drug product.
Sec. 34.
[62J.91] PRESCRIPTION DRUG PRODUCT REVIEWS.
Subdivision 1.
General.
Once a decision by the board has been made to proceed with a cost review of a prescription drug product, the board shall conduct the review and make a determination as to whether appropriate utilization of the prescription drug under review,

based on utilization that is consistent with the United States Food and Drug Administration (FDA) label or standard medical practice, has led or will lead to affordability challenges for the state health care system or for patients.

Subd. 2.

Review considerations.

In reviewing the cost of a prescription drug product, the board may consider the following factors:

(1) the price at which the prescription drug product has been and will be sold in the state;

(2) manufacturer monetary price concessions, discounts, or rebates, and drug-specific patient assistance;

(3) the price of therapeutic alternatives;

(4) the cost to group purchasers based on patient access consistent with the FDA-labeled indications and standard medical practice;

(5) measures of patient access, including cost-sharing and other metrics;

(6) the extent to which the attorney general or a court has determined that a price increase for a generic or off-patent prescription drug product was excessive under sections 62J.842 and 62J.844;

(7) any information a manufacturer chooses to provide; and

(8) any other factors as determined by the board.

Subd. 3.

Public data; proprietary information.

(a) Any submission made to the board related to a drug cost review must be made available to the public with the exception of information determined by the board to be proprietary and information provided by the commissioner of health classified as not public data under section 13.02, subdivision 8a, or as trade secret information under section 13.37, subdivision 1, paragraph (b), or as trade secret information under the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended.

(b) The board shall establish the standards for the information to be considered proprietary under paragraph (a) and section 62J.90, subdivision 2, including standards for heightened consideration of proprietary information for submissions for a cost review of a drug that is not yet approved by the FDA.

(c) Prior to the board establishing the standards under paragraph (b), the public shall be provided notice and the opportunity to submit comments.

(d) The establishment of standards under this subdivision is exempt from the rulemaking requirements under chapter 14, and section 14.386 does not apply.

Sec. 35.

[62J.92] DETERMINATIONS; COMPLIANCE; REMEDIES.

Subdivision 1.

Upper payment limit.

(a) In the event the board finds that the spending on a prescription drug product reviewed under section 62J.91 creates an affordability challenge for the state health care system or for patients, the board shall establish an upper payment limit after considering:

(1) extraordinary supply costs, if applicable;

(2) the range of prices at which the drug is sold in the United States according to one or more pricing files accessed under section 62J.90, subdivision 1, and the range at which pharmacies are reimbursed in Canada; and
(3) any other relevant pricing and administrative cost information for the drug.
(b) An upper payment limit applies to all purchases of, and payer reimbursements for, a prescription drug that is dispensed or administered to individuals in the state in person, by mail, or by other means, and for which an upper payment limit has been established.
(c) In determining whether a drug creates an affordability challenge or determining an upper payment limit amount, the board may not use cost-effectiveness analyses that include the cost-per-quality adjusted life year or similar measure to identify subpopulations for which a treatment would be less cost-effective due to severity of illness, age, or pre-existing disability. For any treatment that extends life, if the board uses cost-effectiveness results, it must use results that weigh the value of all additional lifetime gained equally for all patients no matter their severity of illness, age, or pre-existing disability.
Subd. 2.
Implementation and administration of the upper payment limit.
(a) An
upper payment limit may take effect no sooner than 120 days following the date of its public release by the board.
(b) When setting an upper payment limit for a drug subject to the Medicare maximum fair price under United States Code, title 42, section 1191(c), the board shall set the upper payment limit at the Medicare maximum fair price.
(c) Health plan companies and pharmacy benefit managers shall report annually to the board, in the form and manner specified by the board, on how cost savings resulting from the establishment of an upper payment limit have been used by the health plan company or pharmacy benefit manager to benefit enrollees, including but not limited to reducing enrollee cost-sharing.
Subd. 3.
Noncompliance.
(a) The board shall, and other persons may, notify the Office
of the Attorney General of a potential failure by an entity subject to an upper payment limit to comply with that limit.
(b) If the Office of the Attorney General finds that an entity was noncompliant with the upper payment limit requirements, the attorney general may pursue remedies consistent with chapter 8 or appropriate criminal charges if there is evidence of intentional profiteering.
(c) An entity who obtains price concessions from a drug manufacturer that result in a lower net cost to the stakeholder than the upper payment limit established by the board is not considered noncompliant.
(d) The Office of the Attorney General may provide guidance to stakeholders concerning activities that could be considered noncompliant.
Subd. 4.
Appeals.
(a) Persons affected by a decision of the board may request an appeal
of the board's decision within 30 days of the date of the decision. The board shall hear the appeal and render a decision within 60 days of the hearing.
(b) All appeal decisions are subject to judicial review in accordance with chapter 14.

Sec. 36.

[62J.93] REPORTS.

Beginning March 1, 2024, and each March 1 thereafter, the board shall submit a report to the governor and legislature on general price trends for prescription drug products and the number of prescription drug products that were subject to the board's cost review and analysis, including the result of any analysis as well as the number and disposition of appeals and judicial reviews.

Sec. 37.

[62J.94] ERISA PLANS AND MEDICARE DRUG PLANS.

(a) Nothing in sections 62J.85 to 62J.95 shall be construed to require ERISA plans or Medicare Part D plans to comply with decisions of the board. ERISA plans or Medicare Part D plans are free to choose to exceed the upper payment limit established by the board under section 62J.92.

(b) Providers who dispense and administer drugs in the state must bill all payers no more than the upper payment limit without regard to whether an ERISA plan or Medicare Part D plan chooses to reimburse the provider in an amount greater than the upper payment limit established by the board.

(c) For purposes of this section, an ERISA plan or group health plan is an employee welfare benefit plan established by or maintained by an employer or an employee organization, or both, that provides employer sponsored health coverage to employees and the employee's dependents and is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Sec. 38.

[62J.95] SEVERABILITY.

If any provision of sections 62J.85 to 62J.94 or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of sections 62J.85 to 62J.94 that can be given effect without the invalid provision or application.

Sec. 39.

Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

Subd. 4.

Network adequacy.

(a) Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

(2) a sufficient number of primary care physicians have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters;

(3) specialty physician service is available through the network or contract arrangement;

(4) mental health and substance use disorder treatment providers, including but not limited to psychiatric residential treatment facilities, are available and accessible through the network or contract arrangement;

(5) to the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state law for a given provider, these services shall be available and accessible; and
(6) the network has available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees for covered health care services.
(b) The commissioner must determine network sufficiency in a manner that is consistent with the requirements of this section and may establish sufficiency by referencing any reasonable criteria, which may include but is not limited to:
(1) provider-covered person ratios by specialty;
(2) primary care professional-covered person ratios;
(3) geographic accessibility of providers;
(4) geographic variation and population dispersion;
(5) waiting times for an appointment with participating providers;
(6) hours of operation;
(7) the ability of the network to meet the needs of covered persons, which may include:
(i) low-income persons;
(ii) children and adults with serious, chronic, or complex health conditions, physical disabilities, or mental illness; or
(iii) persons with limited English proficiency and persons from underserved communities;
(8) other health care service delivery system options, including telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering care; and
(9) the volume of technological and specialty care services available to serve the needs of covered persons that need technologically advanced or specialty care services.
EFFECTIVE DATE.
The amendment to paragraph (a) is effective July 1, 2023.
Paragraph (b) is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 65. **EVALUATION OF EXISTING STATUTORY HEALTH BENEFIT MANDATES.**
Subdivision 1.
Evaluation process and content.
Beginning August 1, 2023, and annually
thereafter for the next five calendar years, the commissioner of commerce shall conduct an evaluation of the economic cost and health benefits of one state-required benefit included in Minnesota's EHB-benchmark plan, as defined in Code of Federal Regulations, title 45, section 156.20. The mandated benefit to be studied each year must be chosen from a list developed by the chairs of the house of representatives and senate commerce committees, in consultation with the ranking minority members of the house of representatives and senate commerce committees. The chairs and ranking minority members of the house of representatives and senate commerce committees must agree upon and inform the commissioner of at least one mandate to be reviewed for the period between August 1, 2023, and August 1, 2024. The commissioner shall consult with the commissioner of health and clinical and actuarial experts to assist in the evaluation and synthesis of available evidence.

The commissioner may obtain public input as part of the evaluation. At a minimum, the evaluation must consider the following:
(1) cost for services;
(2) the share of Minnesotans' health insurance premiums that are tied to each current mandated benefit;
(3) utilization of services;
(4) contribution to individual and public health;
(5) extent to which the mandate conforms with existing standards of care in terms of appropriateness or evidence-based medicine;
(6) the historical context in which the mandate was enacted, including how the mandate interacts with other required benefits; and
(7) other relevant criteria of effectiveness and efficacy as determined by the commissioner in consultation with the commissioner of health.
Subd. 2.
Report to legislature.
The commissioner must submit a written report on the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance policy and finance no later than 180 days after the commissioner receives notification from a chair, as required under Minnesota Statutes, section 62J.26, subdivision 3.
Sec. 66. **REPEALER.**
Minnesota Statutes 2022, section 62A.31, subdivisions 1b and 1i, are repealed.
EFFECTIVE DATE.
This section is effective August 1, 2025, and applies to policies offered, issued, or renewed on or after that date.

Omnibus Judiciary and Public Safety Committee Report

S.F. No. 2909 Sen. Latz / H.F. 2890 Rep. Moller

Sections of Interest to Healthcare

ARTICLE 19
CIVIL LAW

E. HEALTH CARE MEDIATION

Sec. 82.

[145.685] COMMUNICATION AND RESOLUTION AFTER A HEALTH CARE ADVERSE INCIDENT.

Subdivision 1.

Definitions.

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

(b) "Health care adverse incident" means an objective and definable outcome arising from or related to patient care that results in the death or physical injury of a patient.

(c) "Health care provider" means a person who is licensed, certified, or registered, or otherwise permitted by state law, to administer health care in the ordinary course of business or in the practice of a profession and practices at a health facility.

(d) "Health facility" means a hospital or outpatient surgical center licensed under sections 144.50 to 144.56; a medical, dental, or health care clinic; a diagnostic laboratory; or a birthing center licensed under section 144.615. The definition of health facility includes any corporation, professional corporation, partnership, limited liability company, limited liability partnership, or other entity comprised of health facilities or health care providers.

(e) "Open discussion" means all communications that are made during an open discussion process under this section and includes memoranda, work product, documents, and other materials that are prepared for or submitted in the course of or in connection with communications made under this section. Open discussion does not include any communication, memoranda, work product, or other materials that would otherwise be subject to discovery and were not prepared specifically for use in an open discussion pursuant to this section.

(f) "Patient" means a person who receives health care from a health care provider. If the patient is under 18 years of age and is not an emancipated minor, the definition of patient includes the patient's legal guardian or parent. If the patient is deceased or incapacitated, the definition of patient includes the patient's legal representative.

Subd. 2.

Engaging in an open discussion.

(a) If a health care adverse incident occurs, a health care provider involved in the health care adverse incident, the health facility involved in the health care adverse incident, or both jointly may provide the patient with written notice of their desire to enter into an open discussion with the patient to discuss potential

outcomes following a health care adverse incident in accordance with this section. A health facility may designate a person or class of persons who has the authority to provide the notice on behalf of the health facility. The patient involved in the health care adverse incident may provide oral notice to the health care provider, the health facility involved in the health care adverse incident, or both, of the patient's desire to enter into an open discussion with either the health care provider, or the health care provider and health facility jointly, to discuss potential outcomes following a health care adverse incident in accordance with this section.

(b) If a health care provider or health facility decides to enter into an open discussion as specified in this section, the written notice must be sent to the patient within 365 days from the date the health care provider or the health facility knew, or through the use of diligence should have known, of the health care adverse incident. The notice must include:

(1) the health care provider, health facility, or both jointly desire to pursue an open discussion in accordance with this section;

(2) the patient's right to receive a copy of the medical records related to the health care adverse incident and the patient's right to authorize the release of the patient's medical records related to the health care adverse incident to a third party;

(3) the patient's right to seek legal counsel and to have legal counsel present throughout the open discussion process;

(4) a copy of section 541.076 with notice that the time for a patient to bring a lawsuit is limited under section 541.076 and will not be extended by engaging in an open discussion under this section unless all parties agree in writing to an extension;

(5) that if the patient chooses to engage in an open discussion with the health care provider, health facility, or jointly with both, all communications made during the course of the open discussion process, including communications regarding the initiation of an open discussion are:

(i) privileged and confidential;

(ii) not subject to discovery, subpoena, or other means of legal compulsion for release; and

(iii) not admissible as evidence in a proceeding arising directly out of the health care adverse incident, including a judicial, administrative, or arbitration proceeding; and

(6) that any communications, memoranda, work product, documents, or other material that are otherwise subject to discovery and not prepared specifically for use in an open discussion under this section are not confidential.

(c) If the patient agrees to engage in an open discussion with a health care provider, health facility, or jointly with both, the agreement must be in writing and must state that the patient has received the notice described in paragraph (b).

(d) Upon agreement to engage in an open discussion, the patient, health care provider, or health facility may include other persons in the open discussion process. All other persons included in the open discussion must be advised of the parameters of communications made during the open discussion process specified under paragraph (b), clauses (5) and (6).

(e) If a health care provider or health facility decides to engage in an open discussion, the health care provider or health facility may:

(1) investigate how the health care adverse incident occurred, including gathering information regarding the medical care or treatment and disclose the results of the investigation to the patient;
(2) openly communicate to the patient the steps the health care provider or health facility will take to prevent future occurrences of the health care adverse incident; and
(3) determine that no offer of compensation for the health care adverse incident is warranted or that an offer of compensation for the health care adverse incident is warranted.
(f) If a health care provider or health facility determines that no offer of compensation is warranted, the health care provider or health facility shall orally communicate that decision to the patient.
(g) If a health care provider or a health facility determines that an offer of compensation is warranted, the health care provider or health facility shall provide the patient with a written offer of compensation. If an offer of compensation is made under this paragraph, and the patient is not represented by legal counsel, the health care provider or health facility shall:
(1) advise the patient of the patient's right to seek legal counsel regarding the offer of compensation and encourage the patient to seek legal counsel; and
(2) provide notice to the patient that the patient may be legally required to repay medical and other expenses that were paid by a third party on the patient's behalf, including private health insurance, Medicaid, or Medicare, along with an itemized statement from the health provider showing all charges and third-party payments.
(h) Except for an offer of compensation made under paragraph (g), open discussions between the health care provider or health facility and the patient about compensation shall not be in writing.
Subd. 3.
Confidentiality of open discussions and offers of compensation.
(a) Open
discussion communications made under this section, including offers of compensation made under subdivision 2:
(1) do not constitute an admission of liability;
(2) are privileged and confidential and shall not be disclosed;
(3) are not admissible as evidence in any subsequent judicial, administrative, or arbitration proceeding arising directly out of the health care adverse incident, except as provided in paragraph (b);
(4) are not subject to discovery, subpoena, or other means of legal compulsion for release; and
(5) shall not be disclosed by any party in any subsequent judicial, administrative, or arbitration proceeding arising directly out of the health care adverse incident.
(b) A party may move the court or other decision maker in a subsequent proceeding to adjudicate the matter to admit as evidence a communication made during an open discussion that contradicts a statement made during the proceeding. The court or other decision maker shall allow a communication made during an open discussion that contradicts a statement made at a subsequent proceeding to adjudicate the matter into evidence only if the

communication made during an open discussion is material to the claims presented in the subsequent proceeding.

(c) Communications, memoranda, work product, documents, and other materials that are otherwise subject to discovery and that were not prepared specifically for use in an open discussion under this section are not confidential.

(d) The limitation on disclosure imposed by this subdivision includes disclosure during any discovery conducted as part of a subsequent adjudicatory proceeding, and a court or other adjudicatory body shall not compel any person who engages in an open discussion under this section to disclose confidential communications or agreements made under this section.

(e) This subdivision does not affect any other law, rule, or requirement with respect to confidentiality.

Subd. 4.

Payment and resolution.

(a) If a patient accepts an offer of compensation made pursuant to this section, and payment of compensation is made to a patient as a result, the payment to the patient is not payment resulting from:

(1) a written claim or demand for payment;

(2) a final judgment, settlement, or arbitration award against a health care institution for medical malpractice purposes; or

(3) a malpractice claim settled or in which judgment is rendered against a health care professional for purposes of reporting by malpractice insurance companies under sections 146A.03, 147.111, 147A.14, 148.102, 148.263, 148B.381, 148F.205, 150A.13, and 153.24.

(b) A health care provider or health facility may require, as a condition of an offer of compensation made pursuant to this section, a patient to execute all documents and obtain any necessary court approval to resolve a health care adverse incident. The parties shall negotiate the form of the documents to be executed and obtain court approval as necessary.

Subd. 5.

Sunset.

This section sunsets on June 30, 2031.

Subd. 6.

Applicability.

This section applies only to health care adverse incidents that occur on or after August 1, 2023.

Omnibus Jobs, Economic Development, Labor, and Industry Conference Committee Report

S.F. No. 3035 Sen. Champion / H.F. 3028 Rep. Hassan

Sections of Interest to Healthcare

ARTICLE 1
LABOR POLICY

Sec. 21.

[182.677] ERGONOMICS.

Subdivision 1.

Definitions.

(a) For purposes of this section, the definitions in this subdivision apply unless otherwise specified.

(b) "Health care facility" means a hospital with a North American Industrial Classification system code of 622110, 622210, or 622310; an outpatient surgical center with a North American Industrial Classification system code of 621493; and a nursing home with a North American Industrial Classification system code of 623110.

(c) "Warehouse distribution center" means an employer with 100 or more employees in Minnesota and a North American Industrial Classification system code of 493110, 423110 to 423990, 424110 to 424990, 454110, or 492110.

(d) "Meatpacking site" means a meatpacking or poultry processing site with 100 or more employees in Minnesota and a North American Industrial Classification system code of 311611 to 311615, except 311613.

(e) "Musculoskeletal disorder" or "MSD" means a disorder of the muscles, nerves, tendons, ligaments, joints, cartilage, blood vessels, or spinal discs.

Subd. 2.

Ergonomics program required.

(a) Every licensed health care facility, warehouse distribution center, or meatpacking site in the state shall create and implement an effective written ergonomics program establishing the employer's plan to minimize the risk of its employees developing or aggravating musculoskeletal disorders. The ergonomics program shall focus on eliminating the risk. To the extent risk exists, the ergonomics program must include feasible administrative or engineering controls to reduce the risk.

(b) The program shall include:

(1) an assessment to identify and reduce musculoskeletal disorder risk factors in the facility;

(2) an initial and ongoing training of employees on ergonomics and its benefits, including the importance of reporting early symptoms of musculoskeletal disorders;

(3) a procedure to ensure early reporting of musculoskeletal disorders to prevent or reduce the progression of symptoms, the development of serious injuries, and lost-time claims;

(4) a process for employees to provide possible solutions that may be implemented to reduce, control, or eliminate workplace musculoskeletal disorders;

(5) procedures to ensure that physical plant modifications and major construction projects are consistent with program goals; and
(6) annual evaluations of the ergonomics program and whenever a change to the work process occurs.
Subd. 3.
Annual evaluation of program required.
There must be an established procedure to annually assess the effectiveness of the ergonomics program, including evaluation of the process to mitigate work-related risk factors in response to reporting of symptoms of musculoskeletal disorders by employees. The annual assessment shall determine the success of the implemented ergonomic solutions and whether goals set by the ergonomics program have been met.
Subd. 4.
Employee training.
(a) An employer subject to this section must train all employees on the following:
(1) the name of each individual on the employer's safety committee;
(2) the facility's ergonomic program;
(3) the early signs and symptoms of musculoskeletal injuries and the procedures for reporting them;
(4) the procedures for reporting injuries and other hazards;
(5) any administrative or engineering controls related to ergonomic hazards that are in place or will be implemented for their positions; and
(6) the requirements of subdivision 9.
(b) New employees must be trained according to paragraph (a) prior to starting work. Current employees must receive initial training and ongoing annual training in accordance with the employer's ergonomics program. The employer must provide the training during working hours and compensate the employee for attending the training at the employee's standard rate of pay. All training must be in a language and with vocabulary that the employee can understand.
(c) Updates to the information conveyed in the training shall be communicated to employees as soon as practicable.
Subd. 5.
Involvement of employees.
Employers subject to this section must solicit feedback for its ergonomics program through its safety committee required by section 182.676, in addition to any other opportunities for employee participation the employer may provide. The safety committee must be directly involved in ergonomics worksite assessments and participate in the annual evaluation required by subdivision 3.
Subd. 6.
Workplace program or AWAIR.
An employer subject to this section must reference its ergonomics program in a written Workplace Accident and Injury Reduction (AWAIR) program required by section 182.653, subdivision 8.
Subd. 7.
Recordkeeping.

An employer subject to this section must maintain:
(1) a written certification dated and signed by each person who provides training and containing the name and job title of each employee who receives training pursuant to this section. The certifications must include the date training was conducted. The certification completed by the training providers must state that the employer has provided training consistent with the requirements of this section and include a brief summary or outline of the information that was included in the training session;
(2) a record of all worker visits to on-site medical or first aid personnel for the last five years, regardless of severity or type of illness or injury; and
(3) a record of all musculoskeletal disorders suffered by employees for the last five years.
Subd. 8.
Availability of records.
(a) The employer must ensure that the certification records required by subdivision 7, clause (1), are up to date and available to the commissioner, employees, and authorized employee representatives, if any, upon request.
(b) Upon the request of the commissioner, an employee who is a member of the facility's safety committee, or an authorized employee representative, the employer must provide the requestor a redacted version of the medical or first aid records and records of all musculoskeletal disorders. The name, contact information, and occupation of an employee, and any other information that would reveal the identity of an employee, must be removed in the redacted version. The redacted version must only include, to the extent it would not reveal the identity of an employee, the location where the employee worked, the date of the injury or visit, a description of the medical treatment or first aid provided, and a description of the injury suffered.
(c) The employer must also make available to the commissioner and the employee who is the subject of the records the unredacted medical or first aid records and unredacted records of musculoskeletal disorders required by subdivision 7, clause (2), upon request.
Subd. 9.
Reporting encouraged.
Any employer subject to this section must not institute or maintain any program, policy, or practice that discourages employees from reporting injuries, hazards, or safety and health standard violations, including ergonomic-related hazards and symptoms of musculoskeletal disorders.
Subd. 10.
Training materials.
The commissioner shall make training materials on implementation of this section available to all employers, upon request, at no cost as part of the duties of the commissioner under section 182.673.
Subd. 11.
Enforcement.
This section shall be enforced by the commissioner under sections 182.66 and 182.661. A violation of this section is subject to the penalties provided under section 182.666.
Subd. 12.
Grant program.

(a) The commissioner shall establish an ergonomics grant program to provide matching funding for employers who are subject to this section to make ergonomic improvements recommended by an on-site safety survey. Minnesota Rules, chapter 5203, applies to the administration of the grant program.
(b) To be eligible for a grant under this section, an employer must:
(1) be a licensed health care facility, warehouse distribution center, or meatpacking site as defined by subdivision 1;
(2) have current workers' compensation insurance provided through the assigned risk plan, provided by an insurer subject to penalties under chapter 176, or as an approved self-insured employer; and
(3) have an on-site safety survey with results that recommend specific equipment or practices that will reduce the risk of injury or illness to employees and prevent musculoskeletal disorders. This survey must have been conducted by a Minnesota occupational safety and health compliance investigator or workplace safety consultant, an in-house safety and health committee, a workers' compensation insurance underwriter, a private consultant, or a person under contract with the assigned risk plan.
(c) Grant funds may be used for all or part of the cost of the following:
(1) purchasing and installing recommended equipment intended to prevent musculoskeletal disorders;
(2) operating or maintaining recommended equipment intended to prevent musculoskeletal disorders;
(3) property, if the property is necessary to meet the recommendations of the on-site safety survey that are related to prevention of musculoskeletal disorders;
(4) training required to operate recommended safety equipment to prevent musculoskeletal disorders; and
(5) tuition reimbursement for educational costs related to identifying ergonomic-related issues that are related to the recommendations of the on-site safety survey.
(d) The commissioner shall evaluate applications, submitted on forms developed by the commissioner, based on whether the proposed project:
(1) is technically and economically feasible;
(2) is consistent with the recommendations of the on-site safety survey and the objective of reducing risk of injury or illness to employees and preventing musculoskeletal disorders;
(3) was submitted by an applicant with sufficient experience, knowledge, and commitment for the project to be implemented in a timely manner;
(4) has the necessary financial commitments to cover all project costs;
(5) has the support of all public entities necessary for its completion; and
(6) complies with federal, state, and local regulations.
(e) Grants under this section shall provide a match of up to $10,000 for private funds committed by the employer to implement the recommended ergonomics-related equipment or practices.
(f) Grants will be awarded to all applicants that meet the eligibility and evaluation criteria under paragraphs (b), (c), and (d) until funding is depleted. If there are more eligible requests than funding, awards will be prorated.
(g) Grant recipients are not eligible to apply for another grant under chapter 176 until two years after the date of the award.
Subd. 13.

Standard development.
The commissioner may propose an ergonomics standard using the authority provided in section 182.655.
EFFECTIVE DATE.
This section is effective January 1, 2024, except subdivisions 9 and 12 are effective July 1, 2023.

ARTICLE 6
COVENANTS NOT TO COMPETE

Section 1.
[181.988] COVENANTS NOT TO COMPETE VOID IN EMPLOYMENT AGREEMENTS; SUBSTANTIVE PROTECTIONS OF MINNESOTA LAW APPLY.
Subdivision 1.
Definitions.
(a) "Covenant not to compete" means an agreement between an employee and employer that restricts the employee, after termination of the employment, from performing:
(1) work for another employer for a specified period of time;
(2) work in a specified geographical area; or
(3) work for another employer in a capacity that is similar to the employee's work for the employer that is party to the agreement.
A covenant not to compete does not include a nondisclosure agreement, or agreement designed to protect trade secrets or confidential information. A covenant not to compete does not include a nonsolicitation agreement, or agreement restricting the ability to use client or contact lists, or solicit customers of the employer.
(b) "Employer" means any individual, partnership, association, corporation, business, trust, or any person or group of persons acting directly or indirectly in the interest of an employer in relation to an employee.
(c) "Employee" as used in this section means any individual who performs services for an employer, including independent contractors.
(d) "Independent contractor" means any individual whose employment is governed by a contract and whose compensation is not reported to the Internal Revenue Service on a W-2 form. For purposes of this section, independent contractor also includes any corporation, limited liability corporation, partnership, or other corporate entity when an employer requires an individual to form such an organization for purposes of entering into a contract for services as a condition of receiving compensation under an independent contractor agreement.
Subd. 2.
Covenants not to compete void and unenforceable.
(a) Any covenant not to compete contained in a contract or agreement is void and unenforceable.
(b) Notwithstanding paragraph (a), a covenant not to compete is valid and enforceable if:
(1) the covenant not to compete is agreed upon during the sale of a business. The person selling the business and the partners, members, or shareholders, and the buyer of the business may agree on a temporary and geographically restricted covenant not to compete that will

prohibit the seller of the business from carrying on a similar business within a reasonable geographic area and for a reasonable length of time; or

(2) the covenant not to compete is agreed upon in anticipation of the dissolution of a business. The partners, members, or shareholders, upon or in anticipation of a dissolution of a partnership, limited liability company, or corporation may agree that all or any number of the parties will not carry on a similar business within a reasonable geographic area where the business has been transacted.

(c) Nothing in this subdivision shall be construed to render void or unenforceable any other provisions in a contract or agreement containing a void or unenforceable covenant not to compete.

(d) In addition to injunctive relief and any other remedies available, a court may award an employee who is enforcing rights under this section reasonable attorney fees.

Subd. 3.

Choice of law; venue.

(a) An employer must not require an employee who primarily resides and works in Minnesota, as a condition of employment, to agree to a provision in an agreement or contract that would do either of the following:

(1) require the employee to adjudicate outside of Minnesota a claim arising in Minnesota; or

(2) deprive the employee of the substantive protection of Minnesota law with respect to a controversy arising in Minnesota.

(b) Any provision of a contract or agreement that violates paragraph (a) is voidable at any time by the employee and if a provision is rendered void at the request of the employee, the matter shall be adjudicated in Minnesota and Minnesota law shall govern the dispute.

(c) In addition to injunctive relief and any other remedies available, a court may award an employee who is enforcing rights under this section reasonable attorney fees.

(d) For purposes of this section, adjudication includes litigation and arbitration.

(e) This subdivision applies only to claims arising under this section.

EFFECTIVE DATE.

This section is effective July 1, 2023, and applies to contracts and agreements entered into on or after that date.

ARTICLE 11
MISCELLANEOUS

Sec. 31.

Minnesota Statutes 2022, section 181.9413, is amended to read:

181.9413 SICK LEAVE BENEFITS; CARE OF RELATIVES.

(a) An employee may use personal sick leave benefits provided by the employer for absences due to an illness of or injury to the employee's child, as defined in section 181.940, subdivision 4, adult child, spouse, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent, or stepparent, for reasonable periods of time as the employee's attendance may be necessary, on the same terms upon which the employee is able to use sick leave benefits for the employee's own illness or injury. This section applies only to personal sick leave benefits payable to the employee from the employer's general assets.

(b) An employee may use sick leave as allowed under this section for safety leave, whether or not the employee's employer allows use of sick leave for that purpose for such reasonable periods of time as may be necessary. Safety leave may be used for assistance to the employee or assistance to the relatives described in paragraph (a). For the purpose of this section, "safety leave" is leave for the purpose of providing or receiving assistance because of sexual assault, domestic abuse, or harassment or stalking. For the purpose of this paragraph:
(1) "domestic abuse" has the meaning given in section 518B.01;
(2) "sexual assault" means an act that constitutes a violation under sections 609.342 to 609.3453 or 609.352; and
(3) "harass" and "stalking" have the meanings given in section 609.749.
(c) An employer may limit the use of safety leave as described in paragraph (b) or personal sick leave benefits provided by the employer for absences due to an illness of or injury to the employee's adult child, spouse, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent, or stepparent to no less than 160 hours in any 12-month period. This paragraph does not apply to absences due to the illness or injury of a child, as defined in section 181.940, subdivision 4.
(d) For purposes of this section, "personal sick leave benefits" means time accrued and available to an employee to be used as a result of absence from work due to personal illness or injury, but does not include short-term or long-term disability or other salary continuation benefits.
(e) For the purpose of this section, "child" includes a stepchild and a biological, adopted, and foster child.
(f) For the purpose of this section, "grandchild" includes a step-grandchild, and a biological, adopted, and foster grandchild.
(g) This section does not prevent an employer from providing greater sick leave benefits than are provided for under this section.
(h) An employer shall not discharge, discipline, penalize, interfere with, threaten, restrain, coerce, or otherwise retaliate or discriminate against an employee for requesting or obtaining a leave of absence under this section.

EFFECTIVE DATE.

This section is effective July 1, 2023.

ARTICLE 12
EARNED SICK AND SAFE TIME

Section 1.
Minnesota Statutes 2022, section 181.032, is amended to read:

181.032 REQUIRED STATEMENT OF EARNINGS BY EMPLOYER; NOTICE TO EMPLOYEE.

(a) At the end of each pay period, the employer shall provide each employee an earnings statement, either in writing or by electronic means, covering that pay period. An employer who chooses to provide an earnings statement by electronic means must provide employee access to an employer-owned computer during an employee's regular working hours to review and print earnings statements.

(b) The earnings statement may be in any form determined by the employer but must include:
(1) the name of the employee;
(2) the rate or rates of pay and basis thereof, including whether the employee is paid by hour, shift, day, week, salary, piece, commission, or other method;
(3) allowances, if any, claimed pursuant to permitted meals and lodging;
(4) the total number of hours worked by the employee unless exempt from chapter 177;
(5) the total number of earned sick and safe time hours accrued and available for use under section 181.9446;
(6) the total number of earned sick and safe time hours used during the pay period under section 181.9447;
(7) the total amount of gross pay earned by the employee during that period;
(6) (8) a list of deductions made from the employee's pay;
(7) (9) the net amount of pay after all deductions are made;
(8) (10) the date on which the pay period ends;
(9) (11) the legal name of the employer and the operating name of the employer if different from the legal name;
(10) (12) the physical address of the employer's main office or principal place of business, and a mailing address if different; and
(11) (13) the telephone number of the employer.
(c) An employer must provide earnings statements to an employee in writing, rather than by electronic means, if the employer has received at least 24 hours notice from an employee that the employee would like to receive earnings statements in written form. Once an employer has received notice from an employee that the employee would like to receive earnings statements in written form, the employer must comply with that request on an ongoing basis.
(d) At the start of employment, an employer shall provide each employee a written notice containing the following information:
(1) the rate or rates of pay and basis thereof, including whether the employee is paid by the hour, shift, day, week, salary, piece, commission, or other method, and the specific application of any additional rates;
(2) allowances, if any, claimed pursuant to permitted meals and lodging;
(3) paid vacation, sick time, or other paid time-off accruals and terms of use;
(4) the employee's employment status and whether the employee is exempt from minimum wage, overtime, and other provisions of chapter 177, and on what basis;
(5) a list of deductions that may be made from the employee's pay;
(6) the number of days in the pay period, the regularly scheduled pay day, and the pay day on which the employee will receive the first payment of wages earned;
(7) the legal name of the employer and the operating name of the employer if different from the legal name;
(8) the physical address of the employer's main office or principal place of business, and a mailing address if different; and
(9) the telephone number of the employer.
(e) The employer must keep a copy of the notice under paragraph (d) signed by each employee acknowledging receipt of the notice. The notice must be provided to each employee in English. The English version of the notice must include text provided by the commissioner

that informs employees that they may request, by indicating on the form, the notice be provided in a particular language. If requested, the employer shall provide the notice in the language requested by the employee. The commissioner shall make available to employers the text to be included in the English version of the notice required by this section and assist employers with translation of the notice in the languages requested by their employees.
(f) An employer must provide the employee any written changes to the information contained in the notice under paragraph (d) prior to the date the changes take effect.
Sec. 2.
Minnesota Statutes 2022, section 181.942, subdivision 1, is amended to read:
Subdivision 1.
Comparable position.
(a) An employee returning from a leave of absence under section 181.941 is entitled to return to employment in the employee's former position or in a position of comparable duties, number of hours, and pay. An employee returning from a leave of absence longer than one month must notify a supervisor at least two weeks prior to return from leave. An employee returning from a leave under section 181.9412 or 181.9413 sections 181.9445 to 181.9448 is entitled to return to employment in the employee's former position.
(b) If, during a leave under sections 181.940 to 181.944, the employer experiences a layoff and the employee would have lost a position had the employee not been on leave, pursuant to the good faith operation of a bona fide layoff and recall system, including a system under a collective bargaining agreement, the employee is not entitled to reinstatement in the former or comparable position. In such circumstances, the employee retains all rights under the layoff and recall system, including a system under a collective bargaining agreement, as if the employee had not taken the leave.
Sec. 3.
Minnesota Statutes 2022, section 181.9436, is amended to read:
181.9436 POSTING OF LAW.
The Division of Labor Standards and Apprenticeship shall develop, with the assistance of interested business and community organizations, an educational poster stating employees' rights under sections 181.940 to 181.9436 181.9448. The department shall make the poster available, upon request, to employers for posting on the employer's premises.
Sec. 4.
[181.9445] DEFINITIONS.
Subdivision 1.
Definitions.
For the purposes of section 177.50 and sections 181.9445 to 181.9448, the terms defined in this section have the meanings given them.
Subd. 2.
Commissioner.
"Commissioner" means the commissioner of labor and industry or authorized designee or representative.
Subd. 3.
Domestic abuse.
"Domestic abuse" has the meaning given in section 518B.01.
Subd. 4.

Earned sick and safe time.
"Earned sick and safe time" means leave, including
paid time off and other paid leave systems, that is paid at the same hourly rate as an employee earns from employment that may be used for the same purposes and under the same conditions as provided under section 181.9447, but in no case shall this hourly rate be less than that provided under section 177.24 or an applicable local minimum wage.
Subd. 5.
Employee.
"Employee" means any person who is employed by an employer,
including temporary and part-time employees, who performs work for at least 80 hours in a year for that employer in Minnesota. Employee does not include:
(1) an independent contractor; or
(2) an individual employed by an air carrier as a flight deck or cabin crew member who:
(i) is subject to United States Code, title 45, sections 181 to 188;
(ii) works less than a majority of their hours in Minnesota in a calendar year; and
(iii) is provided with paid leave equal to or exceeding the amounts in section 181.9446.
Subd. 6.
Employer.
"Employer" means a person who has one or more employees.
Employer includes an individual, a corporation, a partnership, an association, a business trust, a nonprofit organization, a group of persons, the state of Minnesota, a county, town, city, school district, or other governmental subdivision. In the case of an employee leasing company or professional employer organization, the taxpaying employer, as described in section 268.046, subdivision 1, remains the employer. In the case of an individual provider within the meaning of section 256B.0711, subdivision 1, paragraph (d), the employer includes any participant within the meaning of section 256B.0711, subdivision 1, paragraph (e), or participant's representative within the meaning of section 256B.0711, subdivision 1, paragraph (f). In the event that a temporary employee is supplied by a staffing agency, absent a contractual agreement stating otherwise, that individual shall be an employee of the staffing agency for all purposes of section 177.50 and sections 181.9445 to 181.9448.
Employer does not include the United States government.
Subd. 7.
Family member.
"Family member" means:
(1) an employee's:
(i) child, foster child, adult child, legal ward, child for whom the employee is legal guardian, or child to whom the employee stands or stood in loco parentis;
(ii) spouse or registered domestic partner;
(iii) sibling, stepsibling, or foster sibling;
(iv) biological, adoptive, or foster parent, stepparent, or a person who stood in loco parentis when the employee was a minor child;
(v) grandchild, foster grandchild, or stepgrandchild;
(vi) grandparent or stepgrandparent;
(vii) a child of a sibling of the employee;
(viii) a sibling of the parents of the employee; or
(ix) a child-in-law or sibling-in-law;

(2) any of the family members listed in clause (1) of a spouse or registered domestic partner;
(3) any other individual related by blood or whose close association with the employee is the equivalent of a family relationship; and
(4) up to one individual annually designated by the employee.
Subd. 8.
Health care professional.
"Health care professional" means any person licensed, certified, or otherwise authorized under federal or state law to provide medical or emergency services, including doctors, physician assistants, nurses, advanced practice registered nurses, mental health professionals, and emergency room personnel.
Subd. 9.
Sexual assault.
"Sexual assault" means an act that constitutes a violation under sections 609.342 to 609.3453 or 609.352.
Subd. 10.
Stalking.
"Stalking" has the meaning given in section 609.749.
Subd. 11.
Year.
"Year" means a regular and consecutive 12-month period, as determined by an employer and clearly communicated to each employee of that employer.
Sec. 5.
[181.9446] ACCRUAL OF EARNED SICK AND SAFE TIME.
(a) An employee accrues a minimum of one hour of earned sick and safe time for every 30 hours worked up to a maximum of 48 hours of earned sick and safe time in a year. Employees may not accrue more than 48 hours of earned sick and safe time in a year unless the employer agrees to a higher amount.
(b)(1) Except as provided in clause (2), employers must permit an employee to carry over accrued but unused sick and safe time into the following year. The total amount of accrued but unused earned sick and safe time for an employee must not exceed 80 hours at any time, unless an employer agrees to a higher amount.
(2) In lieu of permitting the carryover of accrued but unused sick and safe time into the following year as provided under clause (1), an employer may provide an employee with earned sick and safe time for the year that meets or exceeds the requirements of this section that is available for the employee's immediate use at the beginning of the subsequent year as follows: (i) 48 hours, if an employer pays an employee for accrued but unused sick and safe time at the end of a year at the same hourly rate as an employee earns from employment; or (ii) 80 hours, if an employer does not pay an employee for accrued but unused sick and safe time at the end of a year at the same or greater hourly rate as an employee earns from employment. In no case shall this hourly rate be less than that provided under section 177.24, or an applicable local minimum wage.
(c) Employees who are exempt from overtime requirements under United States Code, title 29, section 213(a)(1), as amended through the effective date of this section, are deemed to work 40 hours in each workweek for purposes of accruing earned sick and safe time,

except that an employee whose normal workweek is less than 40 hours will accrue earned sick and safe time based on the normal workweek.
(d) Earned sick and safe time under this section begins to accrue at the commencement of employment of the employee.
(e) Employees may use earned sick and safe time as it is accrued.
Sec. 6.
[181.9447] USE OF EARNED SICK AND SAFE TIME.
Subdivision 1.
Eligible use.
An employee may use accrued earned sick and safe time for:
(1) an employee's:
(i) mental or physical illness, injury, or other health condition;
(ii) need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition; or
(iii) need for preventive medical or health care;
(2) care of a family member:
(i) with a mental or physical illness, injury, or other health condition;
(ii) who needs medical diagnosis, care, or treatment of a mental or physical illness, injury, or other health condition; or
(iii) who needs preventive medical or health care;
(3) absence due to domestic abuse, sexual assault, or stalking of the employee or employee's family member, provided the absence is to:
(i) seek medical attention related to physical or psychological injury or disability caused by domestic abuse, sexual assault, or stalking;
(ii) obtain services from a victim services organization;
(iii) obtain psychological or other counseling;
(iv) seek relocation or take steps to secure an existing home due to domestic abuse, sexual assault, or stalking; or
(v) seek legal advice or take legal action, including preparing for or participating in any civil or criminal legal proceeding related to or resulting from domestic abuse, sexual assault, or stalking;
(4) closure of the employee's place of business due to weather or other public emergency or an employee's need to care for a family member whose school or place of care has been closed due to weather or other public emergency;
(5) the employee's inability to work or telework because the employee is: (i) prohibited from working by the employer due to health concerns related to the potential transmission of a communicable illness related to a public emergency; or (ii) seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, a communicable disease related to a public emergency and such employee has been exposed to a communicable disease or the employee's employer has requested a test or diagnosis; and
(6) when it has been determined by the health authorities having jurisdiction or by a health care professional that the presence of the employee or family member of the employee in the community would jeopardize the health of others because of the exposure of the employee or family member of the employee to a communicable disease, whether or not the employee or family member has actually contracted the communicable disease.

For the purposes of this subdivision, a public emergency shall include a declared emergency as defined in section 12.03 or a declared local emergency under section 12.29.

Subd. 2.

Notice.

An employer may require notice of the need for use of earned sick and safe time as provided in this paragraph. If the need for use is foreseeable, an employer may require advance notice of the intention to use earned sick and safe time but must not require more than seven days' advance notice. If the need is unforeseeable, an employer may require an employee to give notice of the need for earned sick and safe time as soon as practicable. An employer that requires notice of the need to use earned sick and safe time in accordance with this subdivision shall have a written policy containing reasonable procedures for employees to provide notice of the need to use earned sick and safe time, and shall provide a written copy of such policy to employees. If a copy of the written policy has not been provided to an employee, an employer shall not deny the use of earned sick and safe time to the employee on that basis.

Subd. 3.

Documentation.

(a) When an employee uses earned sick and safe time for more than three consecutive days, an employer may require reasonable documentation that the earned sick and safe time is covered by subdivision 1.

(b) For earned sick and safe time under subdivision 1, clauses (1), (2), (5), and (6), reasonable documentation may include a signed statement by a health care professional indicating the need for use of earned sick and safe time. However, if the employee or employee's family member did not receive services from a health care professional, or if documentation cannot be obtained from a health care professional in a reasonable time or without added expense, then reasonable documentation for the purposes of this paragraph may include a written statement from the employee indicating that the employee is using or used earned sick and safe time for a qualifying purpose covered by subdivision 1, clause (1), (2), (5), or (6).

(c) For earned sick and safe time under subdivision 1, clause (3), an employer must accept a court record or documentation signed by a volunteer or employee of a victims services organization, an attorney, a police officer, or an antiviolence counselor as reasonable documentation.

(d) For earned sick and safe time to care for a family member under subdivision 1, clause (4), an employer must accept as reasonable documentation a written statement from the employee indicating that the employee is using or used earned sick and safe time for a qualifying purpose as reasonable documentation.

(e) An employer must not require disclosure of details relating to domestic abuse, sexual assault, or stalking or the details of an employee's or an employee's family member's medical condition as related to an employee's request to use earned sick and safe time under this section.

(f) Written statements by an employee may be written in the employee's first language and need not be notarized or in any particular format.

Subd. 4.

Replacement worker.

An employer may not require, as a condition of an employee using earned sick and safe time, that the employee seek or find a replacement worker to cover the hours the employee uses as earned sick and safe time.

Subd. 5.

Increment of time used.

Earned sick and safe time may be used in the smallest increment of time tracked by the employer's payroll system, provided such increment is not more than four hours.

Subd. 6.

Retaliation prohibited.

(a) An employer shall not discharge, discipline, penalize, interfere with, threaten, restrain, coerce, or otherwise retaliate or discriminate against a person because the person has exercised or attempted to exercise rights protected under this act, including but not limited to because the person requested earned sick and safe time, used earned sick and safe time, requested a statement of accrued sick and safe time, informed any person of his or her potential rights under sections 181.9445 to 181.9448, made a complaint or filed an action to enforce a right to earned sick and safe time under this section, or is or was participating in any manner in an investigation, proceeding, or hearing under this chapter.

(b) It shall be unlawful for an employer's absence control policy or attendance point system to count earned sick and safe time taken under this act as an absence that may lead to or result in retaliation or any other adverse action.

(c) It shall be unlawful for an employer or any other person to report or threaten to report the actual or suspected citizenship or immigration status of a person or their family member to a federal, state, or local agency for exercising or attempting to exercise any right protected under this act.

(d) A person need not explicitly refer to this act or the rights enumerated herein to be protected from retaliation.

Subd. 7.

Pay and benefits.

(a) During any use of earned sick and safe time, the employer must maintain coverage under any group insurance policy, group subscriber contract, or health care plan for the employee and any dependents, as if the employee was not using earned sick and safe time, provided, however, that the employee must continue to pay any employee share of the cost of such benefits.

(b) An employee returning from a leave under this section is entitled to return to employment at the same rate of pay the employee had been receiving when the leave commenced, plus any automatic adjustments in the employee's pay scale that occurred during the leave period. The employee returning from a leave is entitled to retain all accrued preleave benefits of employment and seniority as if there had been no interruption in service, provided that nothing under this section prevents the accrual of benefits or seniority during the leave pursuant to a collective bargaining or other agreement between the employer and employees.

Subd. 8.

Part-time return from leave.

An employee, by agreement with the employer,
may return to work part time during the leave period without forfeiting the right to return to employment at the end of the leave, as provided under this section.
Subd. 9.
Notice and posting by employer.
(a) Employers must give notice to all
employees that they are entitled to earned sick and safe time, including the amount of earned sick and safe time, the accrual year for the employee, the terms of its use under this section, and a copy of the written policy for providing notice as provided under subdivision 2; that retaliation against employees who request or use earned sick and safe time is prohibited; and that each employee has the right to file a complaint or bring a civil action if earned sick and safe time is denied by the employer or the employee is retaliated against for requesting or using earned sick and safe time.
(b) Employers must supply employees with a notice in English and the primary language of the employee, as identified by the employee, that contains the information required in paragraph (a) at commencement of employment or the effective date of this section, whichever is later.
(c) The means used by the employer must be at least as effective as the following options for providing notice:
(1) posting a copy of the notice at each location where employees perform work and where the notice must be readily observed and easily reviewed by all employees performing work;
(2) providing a paper or electronic copy of the notice to employees; or
(3) a conspicuous posting in a web-based or app-based platform through which an employee performs work.
The notice must contain all information required under paragraph (a).
(d) An employer that provides an employee handbook to its employees must include in the handbook notice of employee rights and remedies under this section.
(e) The Department of Labor and Industry shall prepare a uniform employee notice form for employers to use that provides the notice information required under this section. The commissioner shall prepare the uniform employee notice in the five most common languages spoken in Minnesota. Upon the written request of an employer who is subject to this section, the commissioner shall provide a copy of the uniform employee notice in any primary language spoken by an employee in the employer's place of business. If the commissioner does not provide the copy of the uniform employee notice in response to a request under this paragraph, the employer who makes the request is not subject to a penalty for failing to provide the required notice under this subdivision for violations that arise after the date of the request.
Subd. 10.
Employer records.
(a) Employers shall retain accurate records documenting
hours worked by employees and earned sick and safe time taken and comply with all requirements under section 177.30.
(b) An employer must allow an employee to inspect records required by this section and relating to that employee at a reasonable time and place.
Subd. 11.

Confidentiality and nondisclosure.
(a) If, in conjunction with this section,
an employer possesses:
(1) health or medical information regarding an employee or an employee's family member;
(2) information pertaining to domestic abuse, sexual assault, or stalking;
(3) information that the employee has requested or obtained leave under this section; or
(4) any written or oral statement, documentation, record, or corroborating evidence provided by the employee or an employee's family member, the employer must treat such information as confidential.
Information given by an employee may only be disclosed by an employer if the disclosure is requested or consented to by the employee, when ordered by a court or administrative agency, or when otherwise required by federal or state law.
(b) Records and documents relating to medical certifications, recertifications, or medical histories of employees or family members of employees created for purposes of section 177.50 or sections 181.9445 to 181.9448 must be maintained as confidential medical records separate from the usual personnel files. At the request of the employee, the employer must destroy or return the records required by sections 181.9445 to 181.9448 that are older than three years prior to the current calendar year.
(c) Employers may not discriminate against any employee based on records created for the purposes of section 177.50 or sections 181.9445 to 181.9448.
Sec. 7.
[181.9448] EFFECT ON OTHER LAW OR POLICY.
Subdivision 1.
No effect on more generous sick and safe time policies.
(a) Nothing
in sections 181.9445 to 181.9448 shall be construed to discourage employers from adopting or retaining earned sick and safe time policies that meet or exceed, and do not otherwise conflict with, the minimum standards and requirements provided in sections 181.9445 to 181.9448.
(b) Nothing in sections 181.9445 to 181.9448 shall be construed to limit the right of parties to a collective bargaining agreement to bargain and agree with respect to earned sick and safe time policies or to diminish the obligation of an employer to comply with any contract, collective bargaining agreement, or any employment benefit program or plan that meets or exceeds, and does not otherwise conflict with, the minimum standards and requirements provided in this section.
(c) Nothing in sections 181.9445 to 181.9448 shall be construed to preempt, limit, or otherwise affect the applicability of any other law, regulation, requirement, policy, or standard that provides for a greater amount, accrual, or use by employees of paid sick and safe time or that extends other protections to employees.
(d) Nothing in sections 181.9445 to 181.9448 shall be construed or applied so as to create any power or duty in conflict with federal law.
(e) Employers who provide earned sick and safe time to their employees under a paid time off policy or other paid leave policy that may be used for the same purposes and under the same conditions as earned sick and safe time, and that meets or exceeds, and does not

otherwise conflict with, the minimum standards and requirements provided in sections 181.9445 to 181.9448 are not required to provide additional earned sick and safe time.
(f) The provisions of sections 181.9445 to 181.9448 may be waived by a collective bargaining agreement with a bona fide building and construction trades labor organization that has established itself as the collective bargaining representative for the affected building and construction industry employees, provided that for such waiver to be valid, it shall explicitly reference sections 181.9445 to 181.9448 and clearly and unambiguously waive application of those sections to such employees.
(g) Sections 181.9445 to 181.9448 do not prohibit an employer from establishing a policy whereby employees may donate unused accrued sick and safe time to another employee.
(h) Sections 181.9445 to 181.9448 do not prohibit an employer from advancing sick and safe time to an employee before accrual by the employee.
Subd. 2.
Termination; separation; transfer.
Sections 181.9445 to 181.9448 do not require financial or other reimbursement to an employee from an employer upon the employee's termination, resignation, retirement, or other separation from employment for accrued earned sick and safe time that has not been used. If an employee is transferred to a separate division, entity, or location, but remains employed by the same employer, the employee is entitled to all earned sick and safe time accrued at the prior division, entity, or location and is entitled to use all earned sick and safe time as provided in sections 181.9445 to 181.9448. When there is a separation from employment and the employee is rehired within 180 days of separation by the same employer, previously accrued earned sick and safe time that had not been used must be reinstated. An employee is entitled to use accrued earned sick and safe time and accrue additional earned sick and safe time at the commencement of reemployment.
Subd. 3.
Employer succession.
(a) When a different employer succeeds or takes the place of an existing employer, all employees of the original employer who remain employed by the successor employer are entitled to all earned sick and safe time accrued but not used when employed by the original employer, and are entitled to use all earned sick and safe time previously accrued but not used.
(b) If, at the time of transfer of the business, employees are terminated by the original employer and hired within 30 days by the successor employer following the transfer, those employees are entitled to all earned sick and safe time accrued but not used when employed by the original employer, and are entitled to use all earned sick and safe time previously accrued but not used.
Sec. 8. **REPEALER.**
Minnesota Statutes 2022, section 181.9413, is repealed.
Sec. 9. **EFFECTIVE DATE.**

This article is effective January 1, 2024.

ARTICLE 14
EARNED SICK AND SAFE TIME APPROPRIATIONS

Section 1. **EARNED SICK AND SAFE TIME APPROPRIATIONS.**

(a) $1,445,000 in fiscal year 2024 and $2,209,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of labor and industry for enforcement and other duties regarding earned sick and safe time under Minnesota Statutes, sections 181.9445 to 181.9448, and chapter 177. The base for this appropriation is $1,899,000 for fiscal year 2026 and each year thereafter.

(b) $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of labor and industry for grants to community organizations under Minnesota Statutes, section 177.50, subdivision 4. This is a onetime appropriation.

Omnibus Higher Education Conference Committee Report
H.F. 2073 Rep. Pelowski / S.F. No. 2075 Sen. Fateh

Sections of Interest to Healthcare

ARTICLE 1
APPROPRIATIONS

	APPROPRIATIONS Available for the Year Ending June 30 2024	2025
Sec. 2. **MINNESOTA OFFICE OF HIGHER EDUCATION**		
Subd. 21. **Dual Training Competency Grants; Office of Higher Education** For transfer to the Dual Training Competency Grants account in the special revenue fund under Minnesota Statutes, section 136A.246, subdivision 10. The base for this transfer is $3,132,000 for fiscal year 2026 and thereafter. $132,000 each year is for transfer to the Department of Labor and Industry.	8,020,000	4,632,000