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(SENATE AUTHORS: KLEIN)

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A bill for an act

relating to health insurance; establishing a standardized health plan to be offered in the individual and small group insurance markets; requiring a report; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 62E.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[62E.60] CITATION.**

Sections 62E.60 to 62E.70 may be cited as the "Minnesota Standardized Health Plan Act."

Sec. 2. **[62E.61] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of sections 62E.60 to 62E.70, the terms defined in this section have the meanings given.

Subd. 2. **Advisory board.** "Advisory board" means the board established under section 62E.65.

Subd. 3. **Affordable Care Act.** "Affordable Care Act" has the meaning given in section 62K.03, subdivision 2.

Subd. 4. **Critical access hospital.** "Critical access hospital" means a hospital that is federally certified or is undergoing federal certification as a critical access hospital pursuant to Code of Federal Regulations, title 42, section 485, subpart F.

Subd. 5. **Equivalent rate.** "Equivalent rate" means:

(1) for a hospital that is a pediatric specialty hospital with a level one trauma center, the payment rate determined by the medical assistance fee schedule for the hospital from the most recent year for which a complete set of hospital financial data is publicly available on July 1, 2023, multiplied by a conversion factor equal to the ratio of the statewide payment-to-cost ratio for Medicare to the hospital's specific payment-to-cost ratio for the most recent set of hospital financial data publicly available on July 1, 2023. In any given year, the rate must be adjusted annually for cumulative inflation by a factor equal to the average percent increase in the Medicare inpatient and outpatient prospective payment systems over the previous three years; and

(2) for any health care service that does not have an existing Medicare reimbursement rate and for services that have low volume statewide relative to other Medicare services, including pediatric and obstetric services, a rate set by the commissioner after consultation with hospitals, physicians, other health care providers, and the commissioners of health and human services. The equivalent rate must utilize the ratio of medical assistance payment rates to existing Medicare payment rates whenever possible.

Subd. 6. **Essential access hospital.** "Essential access hospital" means a critical access hospital or an acute care hospital located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, with no more than 25 licensed hospital beds.

Subd. 7. **Essential community provider.** "Essential community provider" means a provider that is designated as an essential community provider by the commissioner of health in accordance with section 62Q.19.

Subd. 8. **Health care cooperative.** "Health care cooperative" has the meaning given in section 62R.04.

Subd. 9. **Health care provider.** "Health care provider" means a health professional licensed, certified, or registered under chapters 147, 147A, 147C, 148, 148E, 148F, 150A, 151, or 153.

Subd. 10. **Health carrier.** "Health carrier" has the meaning given in section 62A.011, subdivision 2.

Subd. 11. **Health plan.** "Health plan" means a policy, contract, certificate, or agreement, as defined in section 62A.011, subdivision 3.

Subd. 12. **Health system.** "Health system" means a corporation or other organization that owns, contains, or operates three or more hospitals.

Subd. 13. **Individual health plan.** "Individual health plan" has the meaning given in section 62A.011, subdivision 4.

Subd. 14. **Individual market.** "Individual market" means the market for health insurance coverage offered to individuals either through MNsure or outside of MNsure.

Subd. 15. **Insurance producer.** "Insurance producer" has the meaning given in section 60K.31, subdivision 6.

Subd. 16. **Medical inflation.** "Medical inflation" means the annual percentage change in the medical care index component of the United States Department of Labor's Bureau of Labor Statistics' consumer price index for medical care services and medical care commodities, or the applicable predecessor or successor index, based on the average change in the medical care index over the previous ten years.

Subd. 17. **Medicare reimbursement rate.** (a) "Medicare reimbursement rate" means the facility-specific reimbursement rate for a particular health care service provided under title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

(b) For a critical access hospital that is reimbursed through the Medicare prospective payments systems rate, Medicare reimbursement rate means the rate based on allowable costs as reported in Medicare cost reports and the hospital cost-to-charge ratios for the specific hospital.

Subd. 18. **MNsure.** "MNsure" has the meaning given in section 62V.02, subdivision 8.

Subd. 19. **Small group health plan.** "Small group health plan" has the meaning given in section 62K.03, subdivision 12.

Subd. 20. **Small group market.** "Small group market" has the meaning given in section 62V.02, subdivision 12.

Subd. 21. **Standardized health plan.** "Standardized health plan" means the health plan designed pursuant to section 62E.62.

Sec. 3. **[62E.62] STANDARDIZED HEALTH PLAN.**

Subdivision 1. **Establishment.** (a) By January 1, 2025, the commissioner must by rule establish a standardized health plan to be offered by health carriers licensed in Minnesota that offer health plans in the individual and small group markets. The standardized health plan must:

(1) offer health coverage at the bronze, silver, and gold levels of coverage as described under section 62K.06;

(2) include, at a minimum, essential health benefits in accordance with the requirements of the Affordable Care Act;

(3) be actuarially sound and allow the health carrier to continue to meet any statutory financial requirements;

(4) comply with the Affordable Care Act, including the risk-adjustment requirements under Code of Federal Regulations, title 45, section 153, and any state law that applies to individual or small group health plans; and

(5) have defined cost-sharing that is designed to improve access and affordability and decrease racial health disparities through a variety of means, including improving perinatal health care coverage and providing first dollar coverage for certain high value services, including primary and behavioral health care.

(c) When creating the standardized health plan, the commissioner, in coordination with the commissioners of health, human services, and management and budget, must establish a stakeholder engagement process that includes physicians; health care industry and consumer representatives; representatives of health care providers and individuals who work in health care; and individuals who work with or represent communities that are affected by higher rates of health disparities and inequities.

(d) The commissioner may update the standardized health plan annually through the stakeholder engagement process described under paragraph (c).

Subd. 2. **Network adequacy requirements.** (a) Each standardized health plan must have a network that meets the network adequacy requirements in section 62K.10.

(b) Each network must also:

(1) be culturally responsive and, to the extent possible, reflect the diversity of the standardized health plan's enrollees in terms of race, ethnicity, gender identity, and sexual orientation in the service area that the network covers;

(2) be no more narrow than the most restrictive network the health carrier is offering for nonstandardized health plans in the individual market for the medal tier for that rating area; and

(3) include the essential community providers located in the service area of the standardized health plan.

(c) If a health carrier is unable to achieve the network adequacy requirements specified in this subdivision, the health carrier must file an action plan with the commissioner that describes the health carrier's efforts to achieve the requirements of this subdivision.

(d) The commissioner must promulgate rules regarding network adequacy requirements and the required action plan described in paragraph (c).

Subd. 3. **Offerings.** (a) Beginning January 1, 2026, a health carrier that offers an individual health plan to Minnesota residents must offer the standardized health plan in the individual market in each county where the health carrier offers an individual health plan and must offer the standardized health plan throughout the entire county, unless the health carrier complies with section 62K.13.

(b) Beginning January 1, 2026, any health carrier that offers a small group health plan in Minnesota must offer the standardized health plan in the small group market in each county where the health carrier offers a small group health plan and must offer the standardized health plan throughout the entire county, unless the health carrier complies with section 62K.13.

(c) A health carrier offering individual health plans must offer the standardized health plan through MNsure during (1) the open enrollment period described in section 62K.15, and (2) any special or limited open enrollment periods as defined under the Affordable Care Act. The standardized health plans must be offered in a manner that allows consumers to easily compare the standardized health plans offered by each health carrier.

Sec. 4. **[62E.63] PREMIUM RATES.**

Subdivision 1. **Establishment.** (a) In the individual market for the plan year beginning January 1, 2026, and in the small group market beginning January 1, 2026, a health carrier must offer the standardized health plan at a premium rate that is at least five percent less than the premium rate for the health plans that the health carrier offered in the individual and small group markets in the 2024 calendar year, as adjusted for medical inflation. The commissioner must calculate the premium rate reduction based on the rates charged in the same county in which the health carrier offered health plans in the individual and small group markets in calendar year 2024.

(b) For a health carrier offering the standardized health plan in the 2026 plan year in a county in which the health carrier did not offer a health plan in the individual or small group market in the 2024 calendar year, the health carrier that offers the standardized health plan must offer the standardized health plan:

(1) in the individual market at a premium that is at least five percent less than the average premium rate for individual health plans offered in that county in 2024, calculated based on the average premium rate for individual health plans offered in that county, as adjusted for medical inflation; and

(2) in the small group market at a premium rate that is at least five percent less than the average premium rate for small group plans offered in that county in 2024, as adjusted for medical inflation.

(c) In the individual market, for the plan year beginning January 1, 2027, and in the small group market, beginning January 1, 2027, a health carrier must offer the standardized health plan at a premium rate that is at least ten percent less than the premium rate for health plans that the health carrier offered in the individual and small group markets in the 2024 calendar year, as adjusted for medical inflation. The commissioner must calculate the premium rate reduction based on the rates charged in the same county in which the health carrier offered health plans in the individual and small group markets in 2024.

(d) For a health carrier offering the standardized health plan in the 2027 plan year in a county in which the carrier did not offer a health plan in the individual or small group market in the 2024 calendar year, a health carrier that offers the standardized health plan must offer the standardized health plan:

(1) in the individual market at a premium that is at least ten percent less than the average premium rate for individual health plans offered in that county in 2024, calculated based on the average premium rate for individual health plans offered in that county, as adjusted for medical inflation; and

(2) in the small group market at a premium rate that is at least ten percent less than the average premium rate for small group plans offered in that county in 2024, as adjusted for medical inflation.

(e) In the individual market, for the plan year beginning January 1, 2028, and in the small group market, beginning January 1, 2028, a health carrier must offer the standardized health plan at a premium rate that is at least 15 percent less than the premium rate for health plans that the health carrier offered in the individual and small group markets in the 2024 calendar year, as adjusted for medical inflation. The commissioner must calculate the premium rate reduction based on the rates charged in the same county in which the carrier offered health plans in the individual and small group markets in 2024.

(f) For a health carrier offering the standardized health plan in the 2028 plan year in a county in which the carrier did not offer a health plan in the individual or small group market

in the 2024 calendar year, the health carrier that offers the standardized health plan must offer the standardized health plan:

(1) in the individual market at a premium that is at least 15 percent less than the average premium rate for individual health plans offered in that county in 2024, calculated based on the average premium rate for individual health plans offered in that county, as adjusted for medical inflation; and

(2) in the small group market at a premium rate that is at least 15 percent less than the average premium rate for small group plans offered in that county in 2024, as adjusted for medical inflation.

(g) For the plan year beginning on or after January 1, 2029, and each year thereafter, a health carrier must limit any annual percentage increase in the premium rate for the standardized health plan in both the individual and small group markets to a rate that is no more than medical inflation, relative to the previous year.

Subd. 2. **Commissions.** Any commission paid to insurance producers to sell the standardized health plan must be comparable to the average commission paid to sell other health plans offered in the individual and small group markets.

Sec. 5. **[62E.64] RATE FILINGS; FAILURE TO MEET PREMIUM REQUIREMENTS.**

Subdivision 1. **Filings.** Each health carrier must file the health carrier's rates for the standardized health plan at the premium rates required under section 62E.63, in accordance with the rate filing requirements in section 62A.02.

Subd. 2. **Failure to meet premium rates.** (a) If a health carrier is unable to offer the standardized health plan at the premium rate in any year as required under section 62E.63, the health carrier must notify the commissioner of the reasons why the health carrier is unable to meet the premium requirements within the following timeline:

(1) for premium rates applicable in 2026, by May 1, 2025; and

(2) for premium rates applicable in 2027 or any subsequent year, by March 1 of the year preceding the year in which the premium rates go into effect.

(b) If a health carrier notifies the commissioner that the health carrier is unable to offer the standardized health plan at the premium rate in accordance with paragraph (a), or the commissioner determines, with support from an independent actuary and based on a review of the rate and form filings, that a health carrier has not met the premium requirements

under section 62E.63 or the health carrier has not met the network adequacy requirements specified in section 62E.62, the commissioner must hold a public hearing prior to the approval of the health carrier's final rates. For purposes of holding a public hearing, the commissioner must consider that a health carrier has met the network adequacy requirements if the health carrier files the action plan as required in section 62E.62, subdivision 2, paragraph (c).

(c) If a public health hearing is held, the commissioner must provide public notice of the hearing and must provide the opportunity for all affected parties to offer public testimony at the public hearing, including health carriers, hospitals, health care providers, consumer advocacy organizations, and consumers. All affected parties must be given the opportunity to present evidence regarding the health carrier's ability to meet the premium rate requirements or meet the network adequacy requirements. The commissioner must limit the evidence presented at the hearing to information that is related to the reasons the health carrier failed to meet the premium rate requirements or meet the network adequacy requirements for the standardized health plan in any single county or service area.

(d) The Office of the Insurance Ombudsman established in section 62E.66 must represent the interests of the consumers at any public hearing held in accordance with this subdivision.

(e) For the purpose of making a decision under this subdivision regarding rates, the commissioner must consider:

(1) any actuarial differences between the standardized health plan and the health plans the health carrier offered in the 2024 calendar year;

(2) any changes to the standardized health plan; and

(3) any state or federal health benefit coverage mandates implemented after the 2024 plan year.

(f) If a health carrier maintains that a hospital or health care provider is responsible for a health carrier's inability to meet premium rates or network adequacy requirements, the health carrier must provide the commissioner with reasonable information necessary to identify which hospitals or health care providers were the cause of the health carrier's failure to meet the premium rate requirements or meet network adequacy requirements.

(g) The commissioner must not use the failure of a health carrier to meet the premium rate requirements for the standardized health plan in a county as a reason to deny premium rate for a nonstandardized health plan offered by that health carrier in that county.

Subd. 3. **Setting reimbursement rates.** (a) The commissioner may, based on the evidence presented at a hearing held pursuant to subdivision 2 and other available data and actuarial analysis:

(1) establish health carrier reimbursement rates under the standardized health plan for hospital services, if necessary, to meet network adequacy requirements or premium rate requirements and require licensed hospitals to accept the reimbursement rates if established in accordance with this subdivision;

(2) establish health carrier reimbursement rates under the standardized health plan, if necessary, for health care providers for categories of services within the geographic service area for the standardized health plan and require health care providers to accept the reimbursement rates established pursuant to this section, if necessary, to ensure the standardized health plan meets the premium rate requirements or network adequacy requirements. The commissioner must not require a health care provider, other than a hospital that provides a majority of covered professional services through a single, contracted medical group for a health maintenance organization, to contract with any other health carrier; and

(3) require the health carrier to offer the standardized health plan in specific counties where no health carrier is offering the standardized health plan in that plan year in either the individual or small group market. In determining whether to require the health carrier to offer the standardized must plan in a specific county, the commissioner shall consider:

(i) the health carrier's structure, the number of covered lives the health carrier has in all lines of business in each county, and the health carrier's existing service area; and

(ii) alternative health care coverage available in each county, including health care cooperatives.

(b) The commissioner must only set reimbursement rates pursuant to this section for hospitals and health care providers that prevent the health carrier from meeting the premium rate requirements or network adequacy requirements for the standardized health plan being offered in a specific county or service area.

Subd. 4. **Setting reimbursement rates for hospitals.** (a) When establishing the reimbursement rates for hospitals under subdivision 3:

(1) the base reimbursement rate for hospital services must be not less than 155 percent of the hospital's Medicare reimbursement rate or equivalent rate;

(2) a hospital that is an essential access hospital or that is independent and not part of a health system must receive a 20 percentage point increase in the base reimbursement rate;

(3) a hospital that is an essential access hospital that is not part of a health system must receive a 40 percentage point increase in the base reimbursement rate;

(4) a hospital that is a pediatric specialty hospital with a level one pediatric trauma center must receive a 55 percentage point increase in the base reimbursement rate and is not eligible for additional factors under the subdivision;

(5) a hospital with a combined percentage of patients who are enrolled in the medical assistance program, MinnesotaCare, or Medicare that exceeds the statewide average must receive up to a 30 percentage point increase in the hospital's base reimbursement rate, with the actual increase to be determined based on the hospital's percentage share of such patients; and

(6) a hospital that is efficient in managing the underlying cost of care, as determined by the hospital's total margins, operating costs, and net patient revenue, must receive up to a 40 percentage point increase in its base reimbursement rate.

(b) Notwithstanding paragraph (a), clauses (1) to (6), when determining the reimbursement rates for hospitals, the commissioner may consult with employee membership organizations representing health care providers' employees and with hospital-based health care providers and consider the cost of adequate wages, benefits, staffing, and training for health care employees to provide continuous quality care.

Subd. 5. **Setting reimbursement rates for health care providers.** When establishing the reimbursement rates for health care providers under subdivision 3, the rates must not be less than 135 percent of the Medicare rates within the applicable geographic region for the same service.

Subd. 6. **Exceptions.** (a) Notwithstanding subdivision 4, the commissioner must not set reimbursement rates for:

(1) a hospital at less than 165 percent of the Medicare reimbursement rate or the equivalent rate; and

(2) any hospital for any plan year at an amount that is more than 20 percent lower than the rate negotiated between the health carrier and the hospital for the previous plan year.

(b) Notwithstanding subdivision 4, for a hospital with a negotiated reimbursement rate that is lower than ten percent of the statewide hospital median reimbursement rate measured as a percentage of Medicare for the 2024 plan year using data from the all-payer claims database described in section 62U.04, the commissioner must set the reimbursement rate for that hospital at no less than the greater of:

(1) the hospital's commercial reimbursement rate as a percentage of Medicare, minus one-third of the difference between the hospital's 2024 commercial reimbursement rate as a percentage of Medicare and the rate established by subdivision 4;

(2) 165 percent of the hospital's Medicare reimbursement rate or equivalent rate; or

(3) the rate established under subdivision 4.

Subd. 7. **Participation in the standard health plan.** (a) The commissioner may require a health care provider, after a hearing pursuant to subdivision 2, to participate in a standardized health plan network and to accept the reimbursement rate described in subdivision 5. A health care provider is prohibited from refusing to provide a covered health care service to a patient solely on the basis that the patient is enrolled in a standardized health plan.

(b) The commissioner may require a licensed hospital, after a hearing pursuant to subdivision 2, to participate in a standardized health plan. If a hospital is required to participate in the standardized health plan and refuses to participate, the commissioner must notify the commissioner of health. If the commissioner of health receives notification from the commissioner, the commissioner of health must issue a warning to the hospital. If the hospital refuses to participate in the standardized health plan after receiving the warning, the commissioner of health:

(1) must fine the hospital up to $10,000 per day for the first 30 days that the hospital refuses to participate and up to $40,000 per day for each day over 30 days that the hospital refuses to participate; and

(2) may suspend or impose conditions on the hospital's license.

(c) When determining the appropriate fine or action concerning a hospital's license pursuant to paragraph (b), the commissioner of health must consider (1) any recommendations from the commissioner; (2) the hospital's financial circumstances; and (3) other circumstances deemed relevant by the commissioner of health.

Subd. 8. **Appeal.** A health carrier, hospital, or health care provider may appeal a decision by the commissioner made pursuant to this section to the district court in the applicable jurisdiction. The commissioner's decision is the final agency subject to judicial review pursuant to chapter 14.

Subd. 9. **Balance billing.** A hospital or health care provider must not balance bill any standardized health plan enrollee for services covered by the standardized health plan and

must accept the reimbursement rates established by the commissioner pursuant to subdivision 3 or 4, if applicable for the service provided to the enrollee.

Subd. 10. **Rules.** The commissioner must adopt rules to ensure there is not an unfair competitive advantage for a health carrier that intends to offer the standardized health plan in the individual or small group market in a county where the health carrier has not previously offered health plans in that market or with a hospital with which the health carrier has not previously had a contract. The rules must align with the hospital reimbursement methodologies described in this section.

Sec. 6. **[62E.65] MINNESOTA STANDARDIZED HEALTH PLAN ADVISORY BOARD.**

Subdivision 1. **Membership.** (a) The governor must appoint up to 11 members to the Minnesota Standardized Health Plan Advisory Board. To the extent possible, the governor must appoint members who are diverse regarding race, ethnicity, immigration status, age, sexual orientation, gender identity, and geography. When considering the geographic diversity of the advisory board the governor must appoint members from both rural and urban areas of Minnesota.

(b) The advisory board membership must consist of at least one member who:

(1) has faced barriers to health access due to race, immigration status, or socioeconomic status;

(2) represents consumer advocacy organizations;

(3) has expertise in health equity;

(4) has expertise in purchasing health benefits for small businesses;

(5) represents health carriers or has actuarial experience in designing a health insurance plan and setting rates;

(6) represents hospitals or has experience with negotiating contracts between hospitals and health carriers;

(7) represents health care providers or has experience with negotiating contracts between health care providers and health carriers;

(8) represents an employee organization that represents employees in the health care industry; and

(9) is a licensed physician who is actively practicing in this state or is retired but practiced in this state.

(c) Initial appointments must be made by September 30, 2023.

Subd. 2. **Organization.** The advisory board must be organized and administered under section 15.0575.

Subd. 3. **Duties.** (a) The commissioner must consult with the advisory board in implementing sections 62E.60 to 62E.70.

(b) In addition to consulting with the commissioner, the advisory board may:

(1) consider recommendations to streamline prior authorization and utilization management processes for the standardized health plan;

(2) recommend ways to keep health care services in the communities where patients live; and

(3) consider whether alternative payment models may be appropriate for particular services, considering the impacts alternative payment models have on access to services and to health outcomes.

Subd. 4. **Technical support.** The Department of Commerce must provide technical and administrative support to the advisory board.

Sec. 7. **[62E.66] OFFICE OF INSURANCE OMBUDSMAN.**

(a) The Office of Insurance Ombudsman is created within the Department of Commerce to act as an advocate for consumer interests in matters related to access to and the affordability of the standardized health plan. The ombudsman must:

(1) interact with consumers regarding access, affordability, and coverage issues relating to the standardized health plan;

(2) evaluate data to assess the standardized health plan's network adequacy and affordability; and

(3) represent the interests of consumers in any public hearing held pursuant to section 62E.64.

(b) The ombudsman must act independently of the Department of Commerce. Any recommendations made or positions taken by the ombudsman do not reflect the recommendations of positions of the Department of Commerce or the commissioner.

Sec. 8. **[62E.67] RULES.**

The commissioner may adopt rules as necessary to develop, implement, and operate sections 62E.60 to 62E.70, using the expedited rulemaking process in section 14.389.

Sec. 9. **[62E.68] COST SHIFTING.**

(a) If the administrator of a self-funded health insurance plan voluntarily provides the commissioner with the plan's contracted rates and any other information deemed necessary and agreed upon by the plan's administrator and the commissioner, the commissioner may evaluate whether the rates of the self-funded health insurance plan reflect a cost shift between the self-funded plan and the standardized health plan offered by a health carrier pursuant to section 62E.62.

(b) If the commissioner, in consultation with the commissioner of health, determines that there is a cost shift, the commissioner must, to the extent practicable, provide to the administrator of the self-funded plan a description of which categories of services have experienced the greatest cost shift.

Sec. 10. **[62E.69] REPORTS.**

(a) The commissioner must contract with an independent third-party organization to submit three reports regarding the implementation of sections 62E.60 to 62E.70 as it relates to staffing, wages, benefits, training, and working conditions of hospital workers, to the extent information is available.

(b) When choosing an independent third-party organization, the commissioner must consider organizations with experience conducting in-person interviews with health care employers and employees in Minnesota.

(c) The independent third-party organization may make policy recommendations related to information in the report and may include data collected from employers, employees, and other third-party sources.

(d) The independent third party organization must submit the reports required under this section to the commissioner as follows:

(1) the first report by July 1, 2026;

(2) the second report by July 1, 2027; and

(3) the third report by July 1, 2028.

Sec. 11. **[62E.70] STANDARDIZED HEALTH PLAN SURVEY.**

(a) MNsure, in consultation with the advisory board, must develop and conduct a survey in collaboration with the commissioner that addresses the experience of consumers who purchase the standardized health plan. The survey must be completed by January 1, 2029.

(b) A summary of the results of the survey must be submitted by the commissioner to the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance by April 1, 2029.

Sec. 12. **MINNESOTA STANDARDIZED HEALTH PLAN FEDERAL WAIVER REQUEST.**

(a) The commissioner of commerce, in consultation with the commissioners of health and human services and the MNsure board, must apply to the secretary of the United States Department of Health and Human Services for a state innovation waiver, as authorized under section 1332 of the Affordable Care Act, to waive one or more requirements of the Affordable Care Act in order to capture all applicable savings to the federal government as a result of the implementation of the standardized health plan under Minnesota Statutes, sections 62E.60 to 62E.70.

(b) Upon approval of the section 1332 waiver application, the commissioner may use federal money received through the waiver to implement Minnesota Statutes, sections 62E.60 to 62E.70.

(c) The implementation and operation of Minnesota Statutes, section 62E.62, is contingent on the approval of the section 1332 waiver application and the receipt of federal funds.