A bill for an act

relating to health care; establishing a statewide health improvement program; monitoring child obesity; establishing a health improvement fund; establishing a public health improvement assessment; establishing health care homes; increasing continuity of care; modifying outreach efforts; establishing primary care education initiatives; increasing affordability and continuity of care with public health care programs; creating a health insurance exchange; establishing Section 125 Plans; providing for registration of health insurance access brokers; providing for fund transfers; providing for health care payment restructuring system; creating a Health Care Transformation Commission; restructuring the health care payment system; creating a savings reinvestment fund; establishing a savings recapture assessment; establishing cost containment goals; specifying an affordability standard; providing subsidies for employer-subsidized coverage; requiring providers to list prices; establishing an electronic prescription drug program; providing for fees; requiring mandated reports; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2006, sections 13.3806, by adding a subdivision; 62A.65, subdivision 3; 62E.141; 62L.12, subdivision 4; 62Q.735, subdivision 1; 144.1501, subdivision 2, by adding a subdivision; 256.01, by adding a subdivision; 256B.69, by adding a subdivision; 256L.05, by adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivision 3; 256L.15, by adding a subdivision; Minnesota Statutes 2007 Supplement, sections 62J.496, by adding a subdivision; 62J.81, subdivision 1; 62J.82, subdivision 1; 256.962, subdivisions 5, 6; 256B.056, subdivision 10; 256L.03, subdivisions 3, 5; 256L.04, subdivisions 1, 7; 256L.05, subdivision 3a; 256L.07, subdivision 1; 256L.15, subdivisions 1, 2; Laws 2007, chapter 147, article 5, section 19; proposing coding for new law in Minnesota Statutes, chapters 16A; 62J; 145; 256B; proposing coding for new law as Minnesota Statutes, chapter 62U; repealing Minnesota Statutes 2006, sections 62A.63; 62A.64; 62Q.49; 62Q.65; 62Q.736; 256L.15, subdivision 3.

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

ARTICLE 1

PUBLIC HEALTH

Section 1. **[16A.726] HEALTH IMPROVEMENT FUND.**

Subdivision 1. **Health improvement fund.** There is created in the state treasury a public health improvement fund to which must be credited revenue from the health improvement assessment under section 145.9865. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the health improvement fund not currently needed must be credited to the public health improvement fund.

Subd. 2. **Fund reimbursements.** Money in the health improvement fund must be appropriated for the statewide health improvement program under section 145.986.

Sec. 2. **[145.986] STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

Subdivision 1. **Goals.** It is the goal of the state to substantially reduce the percentage of Minnesotans who are obese or overweight, use tobacco, or misuse alcohol.

Subd. 2. **Grants to local communities.** (a) Beginning January 1, 2009, the commissioner of health shall award grants to community health boards established pursuant to section 145A.09, and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight, use tobacco, use illegal drugs, or misuse alcohol.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, worksite, and health care settings; and

(5) be focused on policy, systems, and environmental changes that support healthy behaviors.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. The funding phases for grants shall consist of:

(1) an initiation phase, during which the grant recipient must complete a community needs assessment, establish a community leadership team, identify community consortium members, and complete a staffing plan;

(2) a planning phase, during which the grant recipient must complete a community action plan and an evaluation plan, and will identify strengths and weaknesses, technical assistance needs, partners, and additional funding resources; and

(3) an implementation phase, during which the grant recipient must implement the community action plan, evaluate the effectiveness of the interventions, and modify or discontinue interventions found to be ineffective.

Grant recipients shall not receive funding at the planning phase level until all the activities of the initiation phase have been completed and approved by the commissioner. Grant recipients shall not receive funding at the implementation phase level until all activities at the planning phase have been completed and approved by the commissioner.

(d) Grant recipients in the initiation and planning phases shall receive funding at a standard base amount to be established by the commissioner. Grant recipients in the implementation phase shall receive the standard base amount and a standard per capita amount to be established by the commissioner. By January 15, 2011, the commissioner of health shall recommend whether any funding should be distributed to community health boards and tribal governments based on health disparities demonstrated in the populations served.

(e) Grant recipients in all phases shall report their activities and their progress towards the outcomes established under subdivision 3 to the commissioner in a format and at a time specified by the commissioner.

(f) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 3. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

Subd. 3. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet the goals specified in subdivision 1, and annually review the progress of grant recipients in meeting the outcomes.

(b) The commissioner shall measure current public health status, using existing measures and data collection systems when available, to determine baseline data against which progress shall be monitored.

Subd. 4. **Technical assistance and oversight.** The commissioner shall provide content expertise, technical expertise, and training to grant recipients. The commissioner shall ensure that the statewide health improvement program meets the outcomes established under subdivision 3 by conducting a comprehensive statewide evaluation and assisting grant recipients to modify or discontinue interventions found to be ineffective.

Subd. 5. **Evaluation.** Using the outcome measures established in subdivision 3, the commissioner shall conduct a biennial evaluation of the statewide health improvement program funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation.

Subd. 6. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. These reports

must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010.

Subd. 7. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs that work to reduce the percentage of Minnesotans who are obese or overweight, use tobacco, or misuse alcohol, or replace discontinued state or federal funds previously used to reduce the percentage of Minnesotans who are obese or overweight, use tobacco, use illegal drugs, or misuse alcohol. Funds must not be used to supplant current state or local funding to community health boards or tribal governments used to reduce the percentage of Minnesotans who are obese or overweight, use tobacco, use illegal drugs, or misuse alcohol.

Sec. 3. **[145.9865] PUBLIC HEALTH IMPROVEMENT ASSESSMENT.**

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

(b) "Commissioner" means the commissioner of commerce for nonprofit health plan companies subject to the jurisdiction of the commissioner of commerce, and the commissioner of health for nonprofit health plan companies subject to the jurisdiction of the commissioner of health.

(c) "Hospital" means a hospital that is required to report to the commissioner of health under section 144.698, except facilities of the federal Indian Health Service, Veterans Administration, and state-operated facilities.

(d) "Net patient revenue" means net patient revenue, as reported by the hospital to the health care cost information system under section 144.698 for the fiscal year ending in the calendar year two years before the current calendar year, excluding net Medicare and Medicaid revenue.

(e) "Nonprofit health plan company" includes a health maintenance organization operating under chapter 62D and a nonprofit health service plan corporation operating under chapter 62C.

(f) "Total premium revenue" means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time that is normally one month, excluding premiums paid to a nonprofit health plan company

from the Federal Employees Health Benefit Program and revenues received from the Department of Human Services for state health care programs; and

(2) premiums from Medicare wraparound subscribers for health benefits that supplement Medicare coverage.

Subd. 2. **Hospital assessment.** (a) By June 1, 2009, each hospital shall pay to the commissioner of health a public health improvement assessment equal to 0.15 percent of net patient revenue. The commissioner shall credit the assessment to the health improvement fund established under section 16A.726.

(b) By June 1, 2010, and each June 1 thereafter, each hospital shall pay to the commissioner of health a public health improvement assessment determined by the commissioner under subdivision 4. The commissioner shall credit the assessment to the health improvement fund.

(c) The commissioner shall notify each hospital by May 1 of each year of the assessment due by June 1. If, for any year, data needed to determine actual net patient revenue for the previous calendar year is not available in time to determine the assessment due, the commissioner may estimate net patient revenue for the purposes of this section until actual data is available, and must make any necessary adjustments.

(d) Assessments under this section may be applied toward a hospital's community benefit as reported under section 144.699. Nothing in this section requires a hospital to increase its total level of community benefit beyond its current level.

Subd. 3. **Health plan company assessment.** (a) By June 1, 2009, each nonprofit health plan company shall pay to the commissioner of health a public health improvement assessment equal to 0.15 percent of the total premium revenues of the nonprofit health plan company for calendar year 2008 as reported to the commissioner.

(b) By June 1, 2010, and each June 1 thereafter, each nonprofit health plan company shall pay to the commissioner of health a public health improvement assessment determined by the commissioner under subdivision 4. The commissioner shall credit the assessment to the health improvement fund.

(c) The commissioner of health shall notify each nonprofit health plan company by May 1 of each year of the assessment due by June 1. If, for any year, data needed to determine actual total premium revenue for the previous calendar year is not available in time to determine the assessment due, the commissioner of health may estimate total premium revenue for the purposes of this section until actual data is available, and must make any necessary adjustments.

(d) Assessments under this section may be applied toward a nonprofit health plan company's community benefit requirements. Nothing in this section requires a nonprofit

health plan company to increase its total level of community benefit beyond its current level.

Subd. 4. **Assessment percentage, 2010 and thereafter.** The amount assessed in year 2010 and thereafter is $40,000,000 each year, divided among hospitals under subdivision 2 in proportion to their net patient revenue and among nonprofit health plan companies under subdivision 3 in proportion to their total premium revenue. The commissioner of health shall determine the share to be assessed against hospitals and the share to be assessed against nonprofit health plan companies and shall set the assessment as the same percentage of net patient revenue for each hospital and the same percentage of total premium revenue for each nonprofit health plan company, provided that the percentage assessed must not be more than 0.3 percent of net patient revenue for hospitals or 0.3 percent of total premium revenue for nonprofit health plan companies.

Subd. 5. **Expiration.** This section expires July 1, 2013.

Sec. 4. **[145.987] BMI MONITORING IN CHILDREN AND YOUTH.**

By July 1, 2009, the commissioner of health shall establish and implement a program to monitor the trends of children who are overweight and obese in the state by collecting and analyzing Body Mass Index data. The commissioner must not collect or use data on individuals as defined in section 13.02, subdivision 5. To the extent possible, in establishing this Body Mass Index monitoring program, the commissioner shall use existing child and youth monitoring systems or surveys. The Body Mass Index data collected shall be used to measure progress in reducing the percentage of overweight and obese children in the state, and shall be used to accurately target intervention and prevention services throughout the state. To the extent necessary for implementation and analysis, the Department of Health may share data collected under this program with the Department of Education, consistent with the requirements in Minnesota Statutes, chapter 13. Analysis of the data collected and trends of children who are overweight and obese shall be reported annually to the legislature by the commissioner of health, beginning January 15, 2011.

ARTICLE 2
HEALTH CARE HOMES

Section 1. **[256B.0431] ENROLLEE REQUIREMENTS RELATED TO HEALTH CARE HOMES.**

Subdivision 1. **Selection of primary care clinic.** The commissioner, beginning January 1, 2009, shall encourage state health care program enrollees eligible for services

under the fee-for-service system to select a primary care clinic or medical group, within two months of enrollment. The commissioner, beginning July 1, 2009, shall encourage enrollees who have a complex or chronic condition to select a primary care clinic or medical group at which clinicians have been certified as health care homes under section 256B.0751, subdivision 3. The commissioner and county social service agencies shall provide enrollees with lists of primary care clinics, medical groups, and clinicians certified as health care homes, and shall establish a toll-free number to provide enrollees with assistance in choosing a clinic, medical group, or health care home.

Subd. 2. **Initial health assessment.** The commissioner shall encourage state health care program enrollees eligible for services under the fee-for-service system to complete an initial health assessment at their selected primary care clinic or medical group, within one month of selection, in order to identify individuals with, or who are at risk of developing, complex or chronic health conditions, and to identify preventive health care needs.

Subd. 3. **Education and outreach.** The commissioner, beginning January 1, 2009, shall provide patient education and outreach to state health care program enrollees and applicants related to the importance of choosing a primary care clinic or medical group and a health care home. Education and outreach must be targeted to underserved or special populations.

Subd. 4. **State health care program.** For purposes of this section, "state health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Sec. 2. **[256B.0751] HEALTH CARE HOMES; DEFINITIONS; ESTABLISHMENT.**

Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0754, the following definitions apply.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of human services and the commissioner of health acting jointly.

(d) "State health care program" means the medical assistance, MinnesotaCare, or general assistance medical care programs.

Subd. 2. **Establishment of health care homes.** The commissioners shall establish health care homes for state health care program enrollees, enrollees who have, or are at risk of developing, complex or chronic health conditions. In establishing health care homes, the commissioners shall consider, and when appropriate incorporate, features of

the medical home model developed for the primary care coordination (provider-directed care coordination) program authorized under section 256B.0625, subdivision 51.

Subd. 3. **Certification.** The commissioners shall begin certification of individual clinicians, who participate as providers in state health care programs and meet the requirements of section 256B.0752, as health care homes, by July 1, 2009. Clinicians may enter into collaborative agreements with other clinicians to develop the components of a health care home. Clinician certification as a health care home is voluntary. Clinicians certified as health care homes must renew their certification annually, in order to maintain their status as health care homes.

Sec. 3. **[256B.0752] HEALTH CARE HOME REQUIREMENTS.**

Subdivision 1. **Requirement.** In order to be certified as a health care home, a clinician must meet the criteria specified in this section or criteria established by a managed care plan if the criteria has been approved by the commissioner.

Subd. 2. **Patient-provider relationship; care teams.** Each patient of a health care home must have an ongoing, long-term relationship with a primary care provider trained as a personal clinician to provide first contact, continuous, and comprehensive care for all of a patient's health care needs. Appropriate specialists and other health care professionals who do not practice in a traditional primary care field, and advanced practice registered nurses, must be allowed to serve as personal clinicians, if they provide care according to this section.

Subd. 3. **Care coordination.** The personal clinician and the team are responsible for providing for all the patient's health care needs or for arranging appropriate care with other qualified professionals, as part of a whole-person orientation. Health care must be coordinated across all provider types, all care locations, and the greater community. This requirement applies to care for all stages of life, including preventive care, acute care, chronic care, and end-of-life care. Care coordination must include ongoing planning to prepare for patient transitions across different types of care and provider types. The care team must also coordinate with those providing for the social service needs of the individual, if this is necessary to ensure a successful health outcome.

Subd. 4. **Care delivery.** (a) A health care home must provide or arrange for access to care 24-hours a day, seven days a week.

(b) Health care homes must encourage the patient and when authorized and appropriate, the family to actively participate in decision making, as a full member of the care team. Health care homes must consider patients and families as partners in decision

making, and must provide access to a patient-directed, decision-making process, including appropriate decision aids, when available.

(c) Care delivery must be facilitated by the use of health information technology and through systematic patient follow-up using internal clinic patient registries.

(d) Care must be provided in a culturally and linguistically appropriate manner.

(e) Within the context of a system of continuous quality improvement, care delivery, whenever possible, must be based on evidence-based medicine and use clinical decision-support tools.

(f) A health care home must provide enhanced access to care, using methods such as open scheduling, expanded hours, and new communication methods, such as e-mail, phone consultations, and e-consults.

Subd. 5. **Quality of care.** Health care homes must meet process, outcome, and quality standards as developed and specified by the commissioners. Health care homes must measure and publicly report all data necessary for the commissioners to monitor compliance with these standards.

Subd. 6. **Comprehensive health assessment.** Health care homes must encourage enrollees to complete a comprehensive health assessment for each enrollee determined, by the initial health assessment under section 256B.0431, subdivision 2, to have, or be at risk of developing, a complex or chronic health condition. Health care homes must develop, maintain, and ensure implementation of a comprehensive care plan for each enrollee who has or who is at risk of developing a complex or chronic condition based upon the comprehensive health assessment, health history, tests, and other information. The comprehensive care plan must meet the criteria specified by the commissioners.

Subd. 7. **Care coordinators.** (a) Health care homes must directly manage or employ care coordinators to manage the care provided to patients with complex or chronic conditions specified by the commissioners.

(b) Care coordination includes:

(1) identifying patients with complex or chronic conditions eligible for care coordination;

(2) assisting primary care providers in care coordination and education;

(3) helping patients coordinate their care or access needed services, including preventive care;

(4) communicating the care needs and concerns of the patient to the health care home;

(5) collecting data on process and outcome measures; and

(6) overseeing the development, maintenance, and implementation of care plans.

(c) Care coordination must meet the criteria as specified by the commissioner.

Subd. 8. **Health care home collaborative.** Health care homes must participate in the health care home collaborative described in section 256B.0754, subdivision 4, and as required by the commissioner for certification.

Sec. 4. **[256B.0753] CARE COORDINATION FEE.**

Subdivision 1. **Care coordination fee.** (a) The commissioner shall pay each health care home a per-person per-month care coordination fee for providing care coordination services. The fee must be paid for each fee-for-service state health care program enrollee eligible for a health care home, who is served by a personal clinician certified as a health care home.

(b) Payment of the care coordination fee is contingent on the health care home meeting the criteria specified in this section. The care coordination fee is in addition to reimbursement received by a health care home under the medical assistance fee-for-service payment system for health care services.

Subd. 2. **Amount of fee.** The care coordination fee must be determined by the commissioner, and must vary by thresholds of care complexity that include the additional time and resources needed for patients with limited English language skills, cultural differences, or other barriers to health care, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination, such as those with very complex health care needs or several chronic conditions.

Subd. 3. **Cost neutrality.** The commissioner may reduce payment rates for nonprimary care services, if initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner.

EFFECTIVE DATE. Subdivisions 1 and 2 are effective July 1, 2009, or upon federal approval, whichever is later.

Sec. 5. **[256B.0754] DUTIES OF THE COMMISSIONERS.**

Subdivision 1. **Establishment of certification standards and other criteria.** (a) The commissioners, by January 1, 2009, shall establish certification standards for health care homes consistent with the criteria in section 256B.0752.

(b) The commissioners, by January 1, 2009, shall develop care complexity thresholds and payment amounts for the care coordination fee established under section 256B.0753.

(c) The commissioners, by January 1, 2009, shall identify criteria to determine enrollees eligible for and in need of care coordination, and who would benefit from having a comprehensive care plan for their condition.

(d) The commissioners, by January 1, 2009, shall establish criteria and data collection procedures for evaluating health care homes.

(e) The commissioners, by January 1, 2009, shall develop health care home requirements for managed care plan contracts, performance incentives, and withholds, and shall develop the methodology for identifying and recapturing managed care savings resulting from implementation of the health care home model.

Subd. 2. **Monitoring and evaluation.** The commissioners shall ensure the collection from health care homes of data necessary to monitor implementation of the health care home model, measure and evaluate quality of care and outcomes, measure and evaluate patient experience, and determine cost savings from implementation of the health care home model. The commissioners shall collect and evaluate this data directly, but may contract with an appropriate private sector entity for technical assistance. The commissioners shall provide health care homes with practice profiles measuring utilization, cost, and quality.

Subd. 3. **Care Coordination Advisory Committee.** (a) The commissioners, by July 1, 2008, shall establish a Care Coordination Advisory Committee to assist the Departments of Human Services and Health in administering the health care home model, developing the criteria and standards required under subdivision 1, collecting data, and measuring and evaluating health outcomes and cost savings. The commissioners may satisfy this requirement by designating the advisory committee established for the provider-directed care coordination (primary care coordination) program as the committee meeting the requirements of this subdivision. If the commissioners make this designation, they must notify the chairs of the legislative committees with jurisdiction over health care policy and finance within ten days following the determination.

(b) If the commissioners elect to establish a new committee, they must select representatives from: primary care and specialist physicians, advanced practice registered nurses, patients and their families, health plans, organizations with expertise in care coordination models , and other relevant entities.

(c) The commissioners, or their designee, must convene the first meeting of the Care Coordination Advisory Committee within 30 days after the completion of the appointments under paragraph (b) or designating the existing provider-directed Care Coordination Committee under paragraph (a).

(d) The members of the Care Coordination Advisory Committee may not receive compensation or expenses under section 15.059 for their service on the committee.

(e) The commissioners must provide the committee with necessary staff support and meeting space for the operation of the committee.

(f) Notwithstanding section 15.059, the committee expires June 30, 2013.

Subd. 4. **Health care home collaborative.** The commissioners, by July 1, 2009, shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 5. **Patient-directed, decision-making process.** By January 1, 2009, the commissioners, in consultation with the Care Coordination Advisory Committee and the Institute of Clinical Systems Improvement, shall develop a patient-directed, decision-making support model to be used by health care homes. The commissioners shall:

(1) establish protocols that include identifying the use of a patient-directed, decision-making process and incorporating effectively the use of patient-decision aids, when appropriate;

(2) ensure the quality of the patient-decision aids available to the patient;

(3) ensure accessibility of the patient-decision aids, including the use of translators, when necessary; and

(4) ensure that providers are trained to use patient-decision aids effectively.

Subd. 6. **Annual reports.** Beginning January 15, 2009, and each January 15 thereafter, the commissioners shall report to the chairs of the legislative committees with jurisdiction over health care policy and finance regarding the implementation and administration of the health care home model for state health care program enrollees in both the fee-for-service and managed care sectors. The report must include information on the number of state health care program enrollees in health care homes, the number and characteristics of enrollees with complex or chronic conditions, the number and geographic distribution of health care home providers, the performance and quality of care of health care homes, measures of preventive care, costs related to implementation and payment of care coordination fees, health care home payment arrangements for managed care plans, and estimates of savings from implementation of the health care home model for both the fee-for-service and managed care sectors relative to the health care spending baseline calculated under section 62U.13.

Sec. 6. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 29. **Health care home model.** (a) The commissioner shall require managed care plans, as a condition of contract, to adopt by July 1, 2009, a health care home model for providing care to state health care program enrollees who have or are at risk of developing a complex or chronic health condition. The health care home model must

meet the criteria specified in this section and section 256B.0752. The commissioner, in consultation with the commissioner of health, may waive or modify criteria for managed care plans, if the commissioners determine that performance and quality standards would still be met.

(b) The commissioners shall require managed care plans to: (1) collect from health care homes data necessary to monitor implementation of the health care home model, measure and evaluate quality of care and outcomes, measure and evaluate patient experience, and determine cost-savings from implementation of the health care home model; and (2) submit this data to the commissioners. The commissioners shall provide managed care plans and their health care homes with practice profiles measuring utilization, cost, and quality.

(c) Managed care plans must encourage state health care program enrollees to complete an initial health assessment within three months from the time of enrollment, in order to identify individuals with, or who are at risk of developing, complex or chronic health conditions, and to identify preventive health care needs.

(d) The commissioner shall encourage managed care plans, beginning July 1, 2009, to complete a comprehensive health assessment for each enrollee determined, by the initial health assessment under paragraph (c), to have, or be at risk of developing, a complex or chronic health condition. The commissioner shall pay managed care plans a one-time health assessment fee for each enrollee who completes a comprehensive health assessment. Comprehensive health assessments must meet the criteria established for health care homes under section 256B.0752, subdivision 6. Managed care plans shall require health care homes to develop, maintain, and ensure the implementation of a comprehensive care plan for each enrollee who has or who is at risk of developing a complex or chronic condition based on the comprehensive health assessment, health history, tests, and other relevant information.

(e) The commissioner, beginning July 1, 2009, shall implement financial arrangements for managed care plans to ensure that plans encourage each enrollee who has or who is at risk of developing a complex or chronic health condition to choose a certified primary care clinic or medical group to serve as a health care home.

Sec. 7. **[256B.766] PRIMARY CARE PHYSICIAN REIMBURSEMENT RATE INCREASE.**

(a) Effective for physician services rendered on or after January 1, 2009, the commissioner shall increase reimbursements to primary care physicians deemed by the commissioner to meet the requirements in paragraph (b). Reimbursement may be increased

by not more than 50 percent above the reimbursement rate that would otherwise be paid to the primary care provider. Payments to health plan companies shall be adjusted to reflect increased reimbursement to primary care physicians as approved by the commissioner.

(b) The commissioner, in collaboration with the Office of Rural Health, shall determine areas of the state in need of primary care physicians. By September 1 of each year, beginning September 1, 2008, the commissioner shall accept applications from primary care physicians who agree to practice in a designated area for a period of no less than five years. The commissioner shall determine participant eligibility based on their suitability for practice serving a designated geographic area.

(c) The commissioner may reconsider the designated areas, as necessary. A primary care physician who agrees to practice in a designated area shall receive the increased reimbursement rates for at least a period of five years, unless the physician discontinues practicing in the designated area during the five-year period.

(d) A health care clinic or medical group may submit applications under this section for primary care physicians who will be hired to fill vacancies, prior to filling the vacant position.

ARTICLE 3
INCREASING ACCESS; CONTINUITY OF CARE

Section 1. Minnesota Statutes 2006, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established.

(b) The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach for at least 20 hours per week in the nursing field in a postsecondary program;

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with developmental disability or to teach for at least 20 hours per week in the nursing field in a postsecondary program;

(4) for other health care technicians agreeing to teach for at least 20 hours per week in their designated field in a postsecondary program. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields

where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology; and

(5) for pharmacists who agree to practice in designated rural areas~~; and~~.

(c) The commissioner shall use money from the account allocated for dental loan forgiveness:

~~(6)~~ (1) for dentists ~~agreeing~~ who: (i) agree to deliver at least ~~25~~ 20 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303, or (ii) have been trained in a foreign country, received a dental license from the Board of Dentistry, and who agree to provide services for a nonprofit organization, community clinic, or federally qualified health clinic in Minnesota for a period of at least three years; and

(2) for the dental school scholarship program under subdivision 7.

~~(b)~~ (d) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 2. Minnesota Statutes 2006, section 144.1501, is amended by adding a subdivision to read:

Subd. 7. **Dental school student scholarship program.** The commissioner may award up to three scholarships each year to:

(1) foreign-trained dental students who enroll in the Program for Advanced Standing Students at the University of Minnesota School of Dentistry and who agree upon graduation from the program and upon licensure by the Board of Dentistry to provide dental services in Minnesota for a nonprofit organization, community clinic, or federally qualified community health center for a period of at least three years; or

(2) current dental school students who agree after graduation to provide dental services in Minnesota for a nonprofit organization, community clinic, or federally qualified community health center for a period of at least three years.

Scholarships awarded under the program must be at least $30,000 each year that the graduates provide care under the scholarship agreement.

Sec. 3. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 27. **Automation and coordination for state health care programs.** (a) For purposes of this subdivision, "state health care program" means the medical assistance, MinnesotaCare, or general assistance medical care programs.

(b) By July 1, 2009, the commissioner shall improve coordination between state health care programs and social service programs including, but not limited to WIC, free and reduced school lunch programs, and food stamps, and shall develop and use automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program. By January 15, 2009, the commissioner shall, as necessary, identify and recommend to the legislature statutory changes to state health care and social service programs necessary to improve coordination and automation of outreach and enrollment efforts.

(c) By January 15, 2009, the commissioner shall establish and implement an automated process to send out state health care program renewal forms in the most common foreign languages, to those state health care program enrollees who request renewal forms in those foreign languages. The commissioner, as part of the initial enrollment process, shall inform applicants of the availability of this option.

(d) Beginning July 1, 2008, the commissioner, county social service agencies, and health care providers shall update state health care program enrollee addresses and related contact information, at the time of each enrollee contact.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 4. Minnesota Statutes 2007 Supplement, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare, medical assistance, or general assistance medical care, the commissioner, within the available appropriation, shall pay the organization a ~~$20~~ $25 application assistance bonus. The organization may provide an applicant a gift certificate or other incentive upon enrollment.

Sec. 5. Minnesota Statutes 2007 Supplement, section 256.962, subdivision 6, is amended to read:

Subd. 6. **School districts.** (a) At the beginning of each school year, a school district shall provide information to each student on the availability of health care coverage through the Minnesota health care programs.

(b) For each child who is determined to be eligible for ~~a~~ the free ~~or~~ and reduced ~~priced~~ school lunch program, the district shall provide the child's family with ~~an application for the Minnesota health care programs and~~ information on how to obtain an application for the Minnesota health care programs and application assistance.

(c) A district shall also ensure that applications and information on application assistance are available at early childhood education sites and public schools located within the district's jurisdiction.

(d) Each district shall designate an enrollment specialist to provide application assistance and follow-up services with families ~~who are eligible for the reduced or free lunch program or~~ who have indicated an interest in receiving information or an application for the Minnesota health care program. A district is eligible for the application assistance bonus described in subdivision 5.

(e) Each school district shall provide on their Web site a link to information on how to obtain an application and application assistance.

Sec. 6. Minnesota Statutes 2007 Supplement, section 256B.056, subdivision 10, is amended to read:

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60-day postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall verify ~~assets and~~ income for all applicants, and for all recipients upon renewal. The commissioner shall verify liquid assets for applicants, and for recipients upon renewal, only if the applicant or recipient is within ten percent of the applicable asset limit. The commissioner may verify nonliquid assets, but is not required to do so.

(d) If there is no change in an enrollee's income or asset information, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. These designated sites shall forward the renewal forms to the commissioner.

EFFECTIVE DATE. The amendments to paragraphs (c) and (d) are effective January 1, 2009.

Sec. 7. Minnesota Statutes 2007 Supplement, section 256L.03, subdivision 3, is amended to read:

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant, is subject to an annual limit of ~~$10,000~~ $20,000.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

EFFECTIVE DATE. This section is effective January 1, 2009, for enrollees for whom federal funding is not available, and is effective January 1, 2009, or upon federal approval, whichever is later, for enrollees for whom federal funding is available.

Sec. 8. Minnesota Statutes 2007 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or

established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and

(5) $6 for nonemergency visits to a hospital-based emergency room.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the ~~$10,000~~ $20,000 inpatient hospital benefit limit.

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the ~~$10,000~~ $20,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

EFFECTIVE DATE. This section is effective January 1, 2009, for enrollees for whom federal funding is not available, and is effective January 1, 2009, or upon federal approval, whichever is later, for enrollees for whom federal funding is available.

Sec. 9. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than ~~275~~ 300 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) ~~Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $50,000.~~

~~(c)~~ Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.

EFFECTIVE DATE. The effective date of this section is contingent on meeting the cost containment goals described in section 62U.14 and having sufficient funding for the expansion.

Sec. 10. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 200 percent of the federal poverty guidelines. Effective ~~July~~ January 1, 2009, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than ~~215~~ 300 percent of the federal poverty guidelines.

EFFECTIVE DATE. The effective date of this section is contingent on meeting the cost containment goals described in section 62U.14 and having sufficient funding for the expansion.

Sec. 11. Minnesota Statutes 2007 Supplement, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The

premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, the first period of eligibility begins the month the enrollee submitted the application or renewal for general assistance medical care.

(d) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period, before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 12. Minnesota Statutes 2006, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Delayed verification.** On the basis of information provided on the completed application, an applicant whose gross income is less than 90 percent of the applicable income standard and meets all other eligibility requirements, including compliance at the time of application with citizenship or nationality documentation requirements under section 256L.04, subdivision 10, shall be determined eligible beginning in the month of application. The applicant must provide all required verifications within 60 days' notice of the eligibility determination or eligibility shall be terminated. Applicants who are terminated for failure to provide all required verifications are not eligible to apply for coverage using the delayed verification procedures specified in this subdivision for 12 months.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 13. Minnesota Statutes 2006, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income

is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective ~~for~~ the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. ~~Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ The commissioner shall waive premiums for coverage provided under this paragraph to persons disenrolled for nonpayment who reapply under section 256L.05, subdivision 3b. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 14. Minnesota Statutes 2007 Supplement, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 ~~and the four-month requirement in subdivision 3~~, as

long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above ~~275~~ 300 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or ~~215~~ 300 percent of the federal poverty guidelines on or after ~~July~~ January 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

~~(c) Notwithstanding paragraphs (a) and (b), parents are not eligible for MinnesotaCare if gross household income exceeds $50,000 for the 12-month period of eligibility.~~

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later, except that the effective date for the amendment to paragraph (a) related to the expansion in eligibility to 300 percent of federal poverty guidelines is contingent on meeting the cost containment goals established in section 62U.14 and having sufficient funding for the expansion.

Sec. 15. Minnesota Statutes 2006, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled ~~or for at least four~~

~~months prior to application and renewal~~. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of $100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) ~~Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.~~

~~(c)~~ For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

~~(d)~~ (c) Applicants who were recipients of medical assistance or general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2.

~~(e) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.~~

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 16. Minnesota Statutes 2007 Supplement, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months. ~~This paragraph expires June 30, 2010.~~

Sec. 17. Minnesota Statutes 2007 Supplement, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. Until December 31, 2008, the sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to

the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) ~~Families~~ Children whose gross income is above ~~275~~ 300 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning January 1, 2009, MinnesotaCare enrollees shall pay premiums according to the affordability scale established in section 62U.15, subdivision 2, with the exception that children in families with income at or below 150 percent of the federal poverty guidelines and parents with income at or below 100 percent of federal poverty guidelines shall not pay a monthly premium.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later, except that the effective date to the amendment to paragraph (b) related to the expansion in eligibility to 300 percent of federal poverty guidelines is contingent on meeting the cost containment goals in section 62U.14 and having sufficient funding for the expansion.

Sec. 18. Minnesota Statutes 2006, section 256L.15, is amended by adding a subdivision to read:

Subd. 5. **First month premium exemption.** New enrollee households are exempt from premiums for the first month of MinnesotaCare enrollment. For purposes of this exemption, a "new enrollee household" is a household which has not been enrolled in MinnesotaCare for at least one year prior to application.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 19. Laws 2007, chapter 147, article 5, section 19, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, ~~2007, or upon federal approval, whichever is later~~ 2008.

Sec. 20. **REPEALER.**

Minnesota Statutes 2006, section 256L.15, subdivision 3, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval of the amendments to Minnesota Statutes, section 256L.15, subdivision 2, paragraph (c), whichever is later.

ARTICLE 4
HEALTH INSURANCE PURCHASING AND AFFORDABILITY REFORM

Section 1. Minnesota Statutes 2006, section 13.3806, is amended by adding a subdivision to read:

Subd. 1b. **Health Care Transformation Commission.** Use of data collected by the Health Care Transformation Commission is governed by section 62U.10, subdivision 2.

Sec. 2. **[16A.727] HEALTH SAVINGS REINVESTMENT FUND.**

Subdivision 1. **Created.** A health savings reinvestment fund is created in the state treasury. The fund is a direct appropriated special revenue fund. The commissioner shall deposit to the credit of the fund all revenue from the health savings reinvestment assessment under section 62U.13.

Subd. 2. **Transfer; appropriation.** (a) On July 1 of each year, beginning in year 2010, the commissioner of finance shall transfer from the health savings reinvestment fund to the general fund an amount equal to the loss of income tax revenue for the immediately preceding calendar year attributable to the use of Section 125 Plans under section 62U.03 as determined by the commissioner of revenue. The amount necessary to make the transfer is appropriated from the health savings reinvestment fund to the commissioner of finance.

(b) Any balance in the fund remaining after the transfer under paragraph (a) is available for direct appropriation by law.

Sec. 3. Minnesota Statutes 2006, section 62A.65, subdivision 3, is amended to read:

Subd. 3. **Premium rate restrictions.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Except for policies issued under section 62U.03, subdivision 5, paragraph (b), premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) A health carrier may request approval by the commissioner to establish separate geographic regions determined by the health carrier and to establish separate index rates for each such region. The commissioner shall grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) each geographic region must be composed of no fewer than seven counties that create a contiguous region; and

(3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

(i) An insurer may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this paragraph. The rating practices guarantee must be in writing and must guarantee that the policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. An insurer that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (c), (f), and (h).

Sec. 4. Minnesota Statutes 2006, section 62E.141, is amended to read:

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

No employee of an employer that offers a group health plan as defined in section 62A.10, under which the employee is eligible for coverage, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under the employer's health plan. This section does not apply to persons enrolled in the Comprehensive Health Association as of June 30, 1993. With respect to persons eligible to enroll in the health plan of an employer that has more than 29 current employees,

as defined in section 62L.02, this section does not apply to persons enrolled in the Comprehensive Health Association as of December 31, 1994.

Sec. 5. Minnesota Statutes 2007 Supplement, section 62J.496, is amended by adding a subdivision to read:

Subd. 5. **Interoperable electronic health record requirements.** To meet the requirements of subdivision 1, hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(a) The electronic health record must be certified by the Certification Commission for Healthcare Information Technology, or its successor. This criterion only applies to hospitals and health care providers whose practice setting is a practice setting covered by Certification Commission for Healthcare Information Technology certifications. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(b) A health care provider who is a prescriber or dispenser of controlled substances must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 6. **[62J.497] ELECTRONIC PRESCRIPTION DRUG PROGRAM.**

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

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

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

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

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

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

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

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

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

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

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

(k) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005.

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

(m) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

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

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

Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish and maintain an electronic prescription drug program that complies with the applicable standards in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

(b) Nothing in this section requires providers, group purchasers, prescribers, or dispensers to conduct the transactions described in this section. If transactions described in this section are conducted, they must be done electronically using the standards described in this section. Nothing in this section requires providers, group purchasers, prescribers, or dispensers to electronically conduct transactions that are expressly prohibited by other sections or federal law.

(c) Providers, group purchasers, prescribers, and dispensers must use either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the recipient are part of the same legal entity. If an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard

or other applicable standards required by this section. Any pharmacy within an entity must be able to receive electronic prescription transmittals from outside the entity using the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health Insurance Portability and Accountability Act (HIPAA) requirement that may require the use of a HIPAA transaction standard within an organization.

(d) Entities transmitting prescriptions or prescription-related information where the prescriber is required by law to issue a prescription for a patient to a nonprescribing provider that in turn forwards the prescription to a dispenser are exempt from the requirement to use the NCPDP SCRIPT Standard when transmitting such prescriptions or prescription-related information.

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(1) get message transaction;

(2) status response transaction;

(3) error response transaction;

(4) new prescription transaction;

(5) prescription change request transaction;

(6) prescription change response transaction;

(7) refill prescription request transaction;

(8) refill prescription response transaction;

(9) verification transaction;

(10) password change transaction;

(11) cancel prescription request transaction; and/or

(12) cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions in accordance with the requirements of section 62J.536.

Sec. 7. Minnesota Statutes 2007 Supplement, section 62J.81, subdivision 1, is amended to read:

Subdivision 1. **Required disclosure of estimated ~~payment~~ out-of-pocket costs.** ~~(a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. Health plan companies must allow contracted providers, or their designee, to release this information. If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.~~

~~(b)~~ A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.

EFFECTIVE DATE. This section is effective January 1, 2010.

Sec. 8. Minnesota Statutes 2007 Supplement, section 62J.82, subdivision 1, is amended to read:

Subdivision 1. **Required information.** The Minnesota Hospital Association shall develop a Web-based system, available to the public free of charge, for reporting the following, for Minnesota residents:

(1) hospital-specific performance on the measures of care developed under section 256B.072 for acute myocardial infarction, heart failure, and pneumonia;

(2) by January 1, 2009, hospital-specific performance on the public reporting measures for hospital-acquired infections as published by the National Quality Forum and collected by the Minnesota Hospital Association and Stratis Health in collaboration with infection control practitioners; and

(3) ~~charge~~ price information, including, but not limited to, number of discharges, average length of stay, average ~~charge~~ price, average ~~charge~~ price per day, and median ~~charge~~ price, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association.

EFFECTIVE DATE. This section is effective January 1, 2010.

Sec. 9. Minnesota Statutes 2006, section 62L.12, subdivision 4, is amended to read:

Subd. 4. **Employer prohibition.** A small employer offering a health benefit plan shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another health carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.

Sec. 10. Minnesota Statutes 2006, section 62Q.735, subdivision 1, is amended to read:

Subdivision 1. **Contract disclosure.** (a) Before requiring a health care provider to sign a contract, a health plan company shall give to the provider a complete copy of the proposed contract, including:

(1) all attachments and exhibits;

(2) operating manuals;

(3) a general description of the health plan company's health service coding guidelines and requirement for procedures and diagnoses with modifiers, and multiple procedures; and

(4) all guidelines and treatment parameters incorporated or referenced in the contract.

(b) ~~The health plan company shall make available to the provider the fee schedule or a method or process that allows the provider to determine the fee schedule for each health care service to be provided under the contract.~~

~~(c) Notwithstanding paragraph (b),~~ A health plan company that is a dental plan organization, as defined in section 62Q.76, shall disclose information related to the individual contracted provider's expected reimbursement from the dental plan organization. Nothing in this section requires a dental plan organization to disclose the plan's aggregate maximum allowable fee table used to determine other providers' fees. The contracted provider must not release this information in any way that would violate any state or federal antitrust law.

Sec. 11. **[62U.01] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given, unless otherwise specified.

Subd. 2. **Baskets or baskets of care.** "Basket" or "baskets of care" means a collection of health care services that are paid separately under a fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient.

Subd. 3. **Clinically effective.** "Clinically effective" means that the use of a particular health technology improves patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology demonstrates a clinical advantage over alternative technologies. This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

Subd. 4. **Commission.** "Commission" means the Health Care Transformation Commission established under section 62U.04.

Subd. 5. **Cost effective.** "Cost effective" means that the economic costs of using a particular service, device, or health technology to achieve improvement in a patient's health outcome are justified given the comparison to both the economic costs and the improvement in patient health outcome resulting from the use of an alternative service, device, or technology, or from not providing the service, device, or technology.

Subd. 6. **Group purchaser.** "Group purchaser" has the meaning provided in section 62J.03.

Subd. 7. **Health plan.** "Health plan" means a health plan as defined in section 62A.011.

Subd. 8. **Health plan company.** "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

Subd. 9. **Health technology.** "Health technology" means medical and surgical devices and procedures, medical equipment, and diagnostic tests.

Subd. 10. **Participating provider.** "Participating provider" means a provider who has entered into a service agreement with a health plan company.

Subd. 11. **Provider or health care provider.** "Provider" or "health care provider" means a health care provider as defined in section 62J.03, subdivision 8.

Subd. 12. **Section 125 Plan.** "Section 125 Plan" means a cafeteria or premium-only plan under section 125 of the Internal Revenue Code that allows employees to pay for health insurance premiums with pretax dollars.

Subd. 13. **Service agreement.** "Service agreement" means an agreement, contract, or other arrangement between a health plan company and a provider under which the provider agrees that when health services are provided for an enrollee, the provider shall not make a direct charge against the enrollee for those services or parts of services which are covered by the enrollee's contract, but shall look to the service plan corporation for the payment for covered services, to the extent they are covered.

Subd. 14. **Third-party administrators.** "Third-party administrators" means a vendor of risk-management services or an entity administering a self-insurance or health insurance plan under section 60A.23.

Sec. 12. **[62U.02] HEALTH INSURANCE ACCESS BROKERS.**

Subdivision 1. **Establishment.** Any corporation authorized to do business in the state may apply to the commissioner of commerce for registration as a health insurance access broker to establish and operate a health insurance access broker under this section.

Subd. 2. **Registration criteria.** (a) In order to be registered as a health insurance access broker, a corporation must submit an application to the commissioner of commerce on a form prescribed by the commissioner and provide evidence to the satisfaction of the commissioner that the applicant meets the following requirements:

(1) is licensed under chapter 60K to sell health and life insurance;

(2) has sufficient knowledge of health insurance, the health insurance market, and of the federal and state laws that are relevant to health insurance;

(3) has the ability to assist clients in enrolling in private health coverage by offering a range of private health plan products from at least four health plan companies;

(4) agrees to provide applications and information on how to obtain application assistance for clients who may be eligible for state health care programs;

(5) has the capacity to transact the establishment and administration of Section 125 Plans on behalf of an employer;

(6) provides a range of services and transparent information on coverage options for current and potential clients, including, but not limited to, providing information by telephone, e-mail, and Web based;

(7) the ability to assist employees in understanding health plan coverage options and in enrolling in appropriate coverage; and

(8) has the financial and transactional ability to collect, hold, and disperse funds on behalf of clients, employers, or health plan companies.

(b) The commissioner of commerce may establish a fee to be paid by applicants and submitted with the application to cover the cost of registration and the cost of the online registry established under subdivision 4. The fee shall be deposited in the state government special revenue fund.

Subd. 3. **Duties by the commissioner of commerce.** The commissioner of commerce shall provide oversight of the health insurance access brokers registered under this section to ensure that the brokers continue to meet the requirements of this section and to provide consumer protection. The commissioner may require registered health insurance access brokers to submit periodic reports to the commissioner as specified by the commissioner.

Subd. 4. **Online registry.** The commissioner shall establish a Web-based registry of registered health insurance access brokers, and shall make the registry available to the public, upon request.

Sec. 13. **[62U.03] SECTION 125 PLANS.**

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

(a) "Employee" means an employee currently on an employer's payroll other than a retiree or disabled former employee.

(b) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on such employed person or persons.

Subd. 2. **Section 125 Plan requirement.** (a) Effective July 1, 2009, all employers with 11 or more current full-time equivalent employees shall establish a Section 125 Plan to allow their employees to purchase individual market or employer-based health

plan coverage with pretax dollars. Nothing in this section requires employers to offer or purchase group health insurance coverage for their employees.

The following employers are exempt from the Section 125 Plan requirement:

(1) employers that offer a group health insurance plan as defined in section 62A.10;

(2) employers that are self-insured as defined in section 62E.02; or

(3) employers with no employees who are eligible to participate in a Section 125 Plan.

(b) Employers that offer a Section 125 Plan may enter into an agreement with the exchange to administer the employer's Section 125 Plan.

(c) Notwithstanding paragraph (a), an employer that has been certified by a licensed insurance broker as having received education and information on the benefits and advantages of offering Section 125 Plans is not required to establish a Section 125 Plan. This paragraph expires July 1, 2010.

Subd. 3. **Tracking compliance.** By July 1, 2010,the commissioner of commerce, in consultation with the commissioners of health, employment and economic development, and revenue, shall establish a method for tracking employer compliance with the Section 125 Plan requirement.

Subd. 4. **Employer requirements.** (a) Employers that do not offer a group health insurance plan as defined in section 62A.10 and are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase an individual market health plan for themselves and their dependents;

(2) allow employees to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an individual market health plan;

(3) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the health plan or the exchange; and

(4) provide notice to employees that individual market health plans purchased by employees through payroll deduction are not employer-sponsored or administered.

(b) Employers shall be held harmless from any and all liability claims related to the individual market health plans purchased by employees under a Section 125 Plan.

Subd. 5. **Health plan company requirements.** Individuals who purchase an individual market health plan through a Section 125 Plan may purchase coverage on a guaranteed issue basis during an annual open enrollment period that coincides with the open enrollment period for their employer's Section 125 Plan or upon experiencing a qualifying event as defined in United States Code, chapter 43, section 4980B. Nothing

in this section precludes a health plan company from issuing coverage with preexisting condition exclusions as authorized in law. Health plan companies may not charge higher or lower premiums based on health status for individuals who purchase coverage on a guaranteed issue basis under this section, except for variations in premium that are allowable based on health behaviors such as tobacco use.

Sec. 14. **[62U.04] HEALTH CARE TRANSFORMATION COMMISSION.**

Subdivision 1. **Creation.** The Health Care Transformation Commission is created for the purpose of coordinating the health care transformation activities within Minnesota.

Subd. 2. **Members.** (a) The Health Care Transformation Commission shall consist of ten members who are appointed as follows:

(1) three members appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate, including two public members and one senator;

(2) three members appointed by the speaker of the house of representatives, including two public members and one member of the house; and

(3) four members appointed by the governor, two of whom shall be state commissioners from the agencies listed in section 15.01.

(b) The appointing authorities must ensure that the appointed members who are not legislators or commissioners:

(1) have expertise in health care financing, health care delivery, health care quality improvement, health economics, actuarial science, or business operations;

(2) are not state employees or employees of a political subdivision; and

(3) do not have a direct financial interest in the outcome of the commission's business, other than as an individual consumer of health care services.

(c) Section 15.0575, subdivision 4, governs the removal of members.

(d) For the purposes of section 10A.09, members of the commission are public officials and must file a statement of economic interest as required under that section.

Subd. 3. **Operations of the commission.** (a) The commissioner of health shall convene the first meeting of the commission on or before July 1, 2008, following the initial appointment of the members.

(b) The commission shall elect a chair from its membership.

(c) Expenses shall be compensated in accordance with section 15.0575.

(d) The commission may appoint an executive director who, if appointed, shall:

(1) be a state employee;

(2) administer all of the activities and contracts of the commission; and

(3) hire and supervise staff for the commission.

Subd. 4. **Advisory committee established; responsibilities of the advisory committee and commission.** (a) There is established an advisory committee to the commission whose membership shall include, but not be limited to, the following members:

(1) two members appointed by the Minnesota Medical Association;

(2) two members appointed by the Minnesota Council on Health Plans;

(3) two members appointed by the Minnesota Hospital Association, at least one of which must be a rural hospital administrator;

(4) two members appointed by the Minnesota Medical Group Managers Association;

(5) one member appointed by the Minnesota Business Partnership; and

(6) one member appointed by the Minnesota Chamber of Commerce.

The appointing authorities under this paragraph must complete their appointments no later than July 30, 2008.

(b) The representatives from the Minnesota Hospital Association shall convene the first meeting of the advisory committee no later than 30 days following the completion of appointments under paragraph (a). The advisory group may accept staff support and use meeting facilities provided by the Minnesota Hospital Association. The committee shall select a chair at its first meeting. At any time, the committee may appoint additional members by majority vote of the entire committee.

(c) The advisory committee shall advise on a design and implementation plan for a health care payment restructuring system within the parameters described in this chapter. The plan must provide for the full implementation of the payment restructuring system by January 1, 2011. The design and plan must include:

(1) uniform definitions for the baskets of care and a comprehensive set of services as required under section 62U.10;

(2) a mechanism for soliciting and accepting payment bids from health care providers and health care systems as required under section 62U.10. The mechanism must ensure that the bids from different providers and care systems can be compared by consumers on both quality and cost;

(3) procedures to facilitate providers in participating in the payment system and, if needed, provide technical assistance to providers in assembling bids, contracting with other providers in order to assemble or submit bids, or otherwise participate in the payment system; and

(4) a method for monitoring, measuring, and evaluating the effectiveness of the payment restructuring system and for making adjustments, as necessary, to address any barriers or unintended consequences.

(d) In developing the payment restructuring system described in this chapter, the advisory committee shall consult and coordinate with the commissioners of health and human services, health care providers, health plan companies, organizations that work to improve health care quality in Minnesota, consumers, and employers.

(e) The advisory committee shall submit the design and implementation plan to the commission for review and adoption.

(f) By July 1, 2009, the commission shall make recommendations to the governor and the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health care policy and finance on how to incorporate Medicare into the payment restructuring system. In developing these recommendations, the commission shall negotiate with the Centers for Medicare and Medicaid Services and with the Minnesota congressional delegation and explore participation in a demonstration project or advocate for changes in federal law to enable a successful transformation of the health care system.

(g) The commission and the advisory committee may contract with other organizations and entities to carry out any of the duties described in this chapter, including evaluating the effectiveness of the payment restructuring system.

(h) The advisory committee expires July 1, 2012.

Subd. 5. **Standard benefit set and design.** (a) Based on the recommendations submitted by the Health Benefit Set and Design Advisory Committee, the commission shall establish a standard benefit set and design by July 1, 2009.

(b) The standard health benefit set and design must meet the requirements described in section 62U.06.

(c) Prior to establishing the standard benefit set and design, the commission shall convene public hearings throughout the state.

Subd. 6. **Reports.** The commission shall submit a report on January 15 of each year to the governor and legislature, beginning in 2010, on the following:

(1) the extent to which health care providers have reduced their costs and fees;

(2) the extent to which costs and cost growth are likely to be maintained or reduced in future years;

(3) the extent to which the quality of health care services has improved;

(4) the extent to which all Minnesotans have access to quality, affordable health care; and

(5) recommendations on additional actions that are needed in order to successfully achieve health care transformation in Minnesota.

Subd. 7. **Sunset.** The commission shall expire June 30, 2012. Upon expiration, the duties of the commission shall transfer to the Health Care Value Reporting Committee.

Sec. 15. **[62U.05] HEALTH CARE VALUE REPORTING COMMITTEE.**

Subdivision 1. **Creation.** The Health Care Value Reporting Committee is created for the purpose of collecting, analyzing, and disseminating data on health care quality.

Subd. 2. **Members.** (a) The Health Care Value Reporting Committee shall consist of seven members who shall be appointed by the Health Care Transformation Commission. The members must have expertise and knowledge in health care quality improvement and measurement.

(b) Upon the expiration of the Health Care Transformation Commission, the members shall be appointed as follows:

(1) three members appointed by the governor;

(2) two members appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate; and

(3) two members appointed by the speaker of the house of representatives.

(c) Membership terms shall be for four years.

Subd. 3. **Operation of the committee.** (a) The governor's designee shall convene the first meeting of the committee following the initial appointment of the members.

(b) The committee shall elect a chair among its members at the initial meeting.

(c) The committee shall be governed under section 15.0575 except that the members shall not be compensated and the committee shall not expire.

Subd. 4. **Duties.** (a) The Health Care Value Reporting Committee shall be responsible for collecting, analyzing, and disseminating data on health care quality.

(b) The Health Care Value Reporting Committee shall:

(1) establish the standards for measuring health care outcomes;

(2) establish a system for providers to report outcomes and processes associated with patient care. In establishing these standards and system, the Health Care Value Reporting Committee shall work with other organizations that are developing quality measurement and reporting systems to establish a single system for collection and reporting of data on provider quality;

(3) collect standardized electronic information outcomes and processes from health care providers;

(4) establish a system for risk adjusting the measures reported by providers January 1, 2010; and

(5) issue annual public reports on provider quality using the data submitted by providers, adjusted for patient complexity beginning July 1, 2010.

(c) The Health Care Value Reporting Committee may contract with organizations and collaborations of organizations such as the Minnesota Community Measurement or Stratis Health to carry out any of the duties described in this section.

Sec. 16. **[62U.06] STANDARD BENEFIT SET AND DESIGN; HEALTH BENEFIT AND DESIGN ADVISORY COMMITTEE.**

Subdivision 1. **Creation.** The Health Care Transformation Commission established in section 62U.04 shall convene a Health Benefit and Design Advisory Committee to make recommendations to the commission on a standard benefit set and design. The advisory committee shall consist of seven members. The members shall be appointed by the commission by August 15, 2008, and must have expertise in benefit design and development, actuarial analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits.

Subd. 2. **Operations of the committee.** (a) The chair of the Health Care Transformation Commission shall convene the first meeting of the advisory committee on or before September 1, 2008. The committee must meet at least once a year, and at other times as necessary.

(b) The commission shall provide office space, equipment and supplies, and technical support to the committee.

(c) The committee shall be governed by section 15.059, except the committee shall not expire. Upon the expiration of the Health Care Transformation Commission, the Health Benefit and Design Advisory Committee shall continue to exist under the oversight of the Health Care Value Reporting Committee.

Subd. 3. **Duties of the committee.** (a) By January 15, 2009, the committee shall develop and submit to the commission an initial cost-effective benefit set and design that provides individuals access to a broad range of health care services, including preventive health care, including dental care, comprehensive mental health services, chemical dependency treatment, vision care, language interpreter services, emergency transportation, and prescription drugs without incurring severe financial loss as a result of serious illness or injury. The benefit set must include necessary evidence-based health care services, procedures, and diagnostic tests that are scientifically proven to be both clinically effective and cost-effective. In establishing the initial benefit set, the committee may contract with the Institute for Clinical Systems Improvement (ICSI) to assemble existing scientifically based practice standards. The committee shall consider cultural, ethnic, and

religious values and beliefs to ensure that the health care needs of all Minnesota residents will be addressed in the benefit set.

(b) The benefit set must identify and include preventive services, chronic care coordination services, and early diagnostic tests, that, if included in the benefit set, with minimal or no cost-sharing requirements, would result in savings that are equal to or greater than the cost of providing the services.

(c) The benefit set must include ICSI-designated evidence-based outpatient care for asthma, heart disease, diabetes, and depression with no cost-sharing requirements, or with minimal cost-sharing requirements that would not impose an economic barrier to accessing the care.

(d) The benefit design must establish a maximum deductible for in-network benefits and for prescription drugs coverage and a maximum for out-of-pocket costs.

Subd. 4. **Continued review.** The committee shall review the benefit set and design on an ongoing periodic basis and shall adjust the benefit set and design, as necessary to ensure that the benefit set and design continues to be safe, effective, and scientifically based.

Sec. 17. **[62U.07] HEALTH TECHNOLOGY ASSESSMENT.**

Subdivision 1. **Technology Advisory Committee.** (a) The Health Care Transformation Commission shall appoint an advisory committee to make recommendations to the commission regarding the inclusion of new and existing health technologies to the standard benefit set and design.

(b) The advisory committee shall be made up of 11 members appointed by the commission, in consultation with the Institute for Clinical Systems Improvement, the Health Services Advisory Council, and the University of Minnesota. The membership shall include:

(1) six practicing physicians licensed under chapter 147; and

(2) five other practicing health care professionals who use health technology in their scope of practice.

The commission must complete the appointments required by this paragraph by September 1, 2008. The chair of the commission shall convene the first meeting of the Technology Advisory Committee within 30 days following the completion of the appointments to the committee.

(c) A member of the advisory committee may not:

(1) have a substantial financial interest in a health technology company; or

(2) be employed by or under contract with a health technology manufacturer during their term or for 18 months before their appointment.

(d) The advisory committee is subject to section 15.059, except that the committee shall not expire. Upon the expiration of the Health Care Transformation Commission, the Health Technology Assessment Committee shall continue to exist under the oversight of the Health Care Value Reporting Committee.

Subd. 2. **Technology selection process.** The commission, in consultation with the advisory committee, shall select existing and new health technologies to be reviewed by the committee. In making a selection, priority shall be given to any technology for which:

(1) there are concerns about its safety, efficacy, or cost-effectiveness;

(2) actual or expected expenditures are high due to demand for the technology, its cost or both; and

(3) there is adequate evidence available to conduct a complete review.

Subd. 3. **Technology review.** (a) Upon the selection of a health technology for review, the committee shall contract for a systematic evidence-based assessment of the technology's safety, efficacy, and cost-effectiveness. The contract shall be with an evidence-based practice center designated as such by the federal agency for health care research and quality, or another appropriate entity as designated by the committee.

(b) The committee shall provide notification to the public when a health technology has been selected for review. The notification must indicate when that review is to be initiated and how an interested party may submit evidence or provide public comment for consideration during the review.

Subd. 4. **Committee determination.** (a) Upon reviewing the completed assessment and any other evidence submitted regarding the safety, efficacy, and cost-effectiveness of the technology, the committee shall recommend to the commission:

(1) the conditions, if any, under which the health technology should be included as a covered benefit; and

(2) if covered, the criteria to be used to decide whether the technology is medically necessary, or proper and necessary treatment.

(b) The commissioners of human services, employee relations, and corrections may use the committee's recommendation in making coverage and reimbursement decisions unless the recommendation conflicts with an applicable federal statute or regulation.

(c) The committee's recommendation may not limit the use of a health technology necessary to preserve life on the basis of an individual's age or expected length of life or of an individual's present or predicted disability, degree of medical dependency, or quality of life.

Sec. 18. **[62U.08] PAYMENT RESTRUCTURING: INCENTIVE PAYMENTS BASED ON QUALITY OF CARE.**

Subdivision 1. **Development.** (a) By January 1, 2009, the Health Care Transformation Commission shall develop a system of quality incentive payments that link the level of payments to providers to the quality of care. The system must incorporate payments to primary care physicians, specialty care physicians, health care clinics, and hospitals eligible for these incentive payments.

(b) The requirements of section 62Q.101 do not apply under this incentive payment system.

Subd. 2. **Payment system criteria.** The quality incentive payment system shall meet the following criteria:

(1) providers meeting specified targets, or who demonstrate a significant amount of improvement over time, shall be eligible for quality incentive payments that are in addition to existing payment levels;

(2) priority shall be placed on measures of health care outcomes, rather than processes, wherever possible;

(3) quality measures for primary care providers shall include preventive services, coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, and depression;

(4) quality measures for specialty care shall be initially based on quality indicators measured and reported publicly by specialty societies;

(5) hospital measures shall be initially based on existing quality measures;

(6) to the greatest extent possible, quality measures must be adjusted for variation in patient population; and

(7) other indicators of care quality may be incorporated where appropriate. These indicators may include care infrastructure, collection and reporting of results, and measures of overall cost of care for individuals.

Subd. 3. **Implementation.** By July 1, 2009:

(1) the commissioner of human services shall implement this incentive payment system for all enrollees in the state's public health care programs;

(2) the commissioner of employee relations shall implement this incentive payment system for all participants in the state employee group insurance program; and

(3) all health plan companies shall implement this incentive payment system for all participating providers.

Sec. 19. **[62U.09] PAYMENT RESTRUCTURING: CARE COORDINATION PAYMENTS.**

Subdivision 1. **Development.** By July 1, 2009, the Health Care Transformation Commission shall develop a system that provides care coordination payments to health care providers. In order to be eligible for a care coordination payment, a health care provider must be certified as a health care home by the commissioner of health based on the certification standards for health care homes established under section 256B.0754.

Subd. 2. **Care coordination fee.** (a) Under the care coordination payments, health care homes shall receive a per-person per-month care coordination fee for providing care coordination services and directly managing onsite or employing care coordinators. For purpose of this section, the specifications of care coordination and care coordinators are described in section 256B.0752, subdivisions 3 and 7, respectively.

(b) The care coordination fee payment system may vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination, such as those with very complex health care needs or several chronic conditions.

(c) In developing the system of care coordination fees, the commission shall consider the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care.

(d) Care coordination fees may be phased-in, and must be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions.

Subd. 3. **Quality-based incentive payments.** The care coordination fees paid under this section are in addition to the quality incentive payments in section 62U.08.

Subd. 4. **Implementation.** (a) By July 1, 2009:

(1) the commissioner of human services shall implement the care coordination payments for enrollees in the state's public health care programs;

(2) the commissioner of employee relations shall implement the care coordination payments for participants in the state employee group insurance program; and

(3) all health plan companies shall implement this care coordination payments for enrollees.

(b) The commissioners of human services and employee relations and health plan companies may begin implementing this care coordination payments for enrollees and participants who have or are at risk of developing complex and chronic health conditions.

Sec. 20. **[62U.10] PAYMENT RESTRUCTURING; PROVIDER INNOVATION TO IMPROVE COSTS AND QUALITY.**

Subdivision 1. **Development.** (a) By January 15, 2009, the Health Care Transformation Commission shall report to the legislature recommendations for advancing an innovative payment system for the chronic conditions of coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, and depression.

(b) By January 15, 2010, the Health Care Transformation Commission shall report to the legislature additional changes necessary to accomplish comprehensive payment reform designed to support an innovative payment system to reduce costs and improve quality.

(c) By January 1, 2011, the Health Care Transformation Commission shall develop rules to implement a comprehensive payment system that encourages provider innovation to reduce costs and improve quality.

Subd. 2. **Encounter data.** (a) Beginning September 1, 2009, and every three months thereafter, all health plan companies and third-party administrators shall submit encounter data to the Health Care Transformation Commission. The data shall be submitted in a form and manner specified by the commission subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commission shall only use the data submitted under paragraph (a) for the purpose of carrying out its responsibilities in designing and implementing a payment restructuring system. If the commission contracts with other organizations or entities to carry out any of its duties or responsibilities described in this chapter, the contract must require that the organization or entity maintain the data that it receives according to the provisions of this section.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commission shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commission shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commission may publish analyses and reports that identify specific providers but only after the provider has been provided the opportunity by the commission to review

the data and submit comments. The provider shall have 21 days to review and comment, after which time the commission may release the data along with any comments submitted by the provider.

Subd. 3. **Utilization and health care costs.** (a) The commission shall develop a method of calculating the relative utilization and health care costs of providers. The method must exclude the costs of catastrophic cases and must include risk adjustments to reflect differences in the demographics, health, and special needs of the providers' patient population. The risk adjustment must be developed in accordance with generally accepted risk adjustment methodologies.

(b) Beginning April 1, 2010, the commission shall disseminate information to providers on their utilization and cost in comparison to an appropriate peer group.

(c) The commission shall develop a system to index providers based on their total risk-adjusted resource use and quality of care, and separately for the conditions of coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, and depression. In developing this system, the commission shall consult and coordinate with health care providers, health plan companies, and organizations that work to improve health care quality in Minnesota.

Subd. 4. **Chronic care package pricing and total care bids.** (a) The commission shall develop a standard method and format for providers to use for submitting package prices for the total cost of care or separately for the conditions of coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, or depression. This method shall be published in the State Register and must be made available to all providers.

(b) Beginning July 1, 2010, and annually thereafter, using the information developed in subdivision 3, providers may submit package prices to the commission for the cost of providing all necessary services to a patient or separately for the cost of providing services for patients with the chronic conditions of coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, or depression based on their disclosed prices under section 62U.11 combined with their actual risk-adjusted resource use for the most recent analytic period. The package prices submitted must reflect the providers' commitment to manage their risk-adjusted patient population within this cost.

(c) Until January 1, 2013, no provider shall submit a package price for the risk-adjusted cost of care that represents an increase of more than the increase in the previous calendar year's Consumer Price Index for all urban consumers plus two percentage points or a decrease of more than 15 percent below the provider's risk-adjusted cost of care calculated based on their average pricing levels for the previous calendar year.

(d) Beginning January 1, 2011, the commission shall annually publish the results of the process described in paragraph (b), and shall include only providers who choose to submit package prices. The results that are published must be on a risk-neutral basis. Effective January 1, 2012, the published results shall include all providers. For providers that have not submitted package prices, these results must be based on their weighted average contract prices for all health plan companies and third-party administrators, combined with their risk-adjusted historic resource use.

Subd. 5. **Provider assistance.** The commission shall provide education and technical assistance to providers on how to calculate and submit package prices for the risk-adjusted cost of care for the total cost of care and separately for the conditions of coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, and depression.

Subd. 6. **Payments.** The commission shall establish a method by which providers who have submitted a package price shall be paid for their total cost of care or separately for their cost of care in treating patients with the conditions of coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, and depression. The method must include periodic adjustments to payments to reflect providers' actual risk-adjusted cost relative to their package price.

Subd. 7. **Implementation.** By January 1, 2012:

(1) the commissioner of human services shall pay providers based on their package prices for all enrollees in the state's public health care programs;

(2) the commissioner of employee relations shall pay providers based on their package prices for participants in the state employee group program;

(3) all political subdivisions as defined in section 13.02, subdivision 11, that offer health benefits to their employees must pay providers based on their package prices or purchase a health plan that uses this payment system;

(4) all health plan companies shall use the information and methods developed under this section to develop products that encourage consumers to use high-quality, low-cost providers; and

(5) health plan companies that issue health plans in the individual market or the small employer market must offer at least one health plan that uses the information developed under subdivision 3 to establish financial incentives for consumers to choose high-quality, low-cost providers through enrollee cost sharing or selective provider networks.

Sec. 21. **[62U.11] PROVIDER PRICE AND QUALITY DISCLOSURE.**

(a) Beginning July 1, 2009, and annually thereafter, each physician clinic and hospital shall establish a list of prices for each health care procedure, service, package of services, or basket of care the provider provides and provide this information electronically to the Health Care Transformation Commission in the form and manner specified by the commission, and shall be provided to the public at no cost upon request. Providers may update this periodically to reflect new services, supply cost changes, and other factors.

(b) The Health Care Transformation Commission shall develop a plan that requires all health care providers to comply with paragraph (a) beginning January 1, 2010.

(c) By January 1, 2009, each health care provider shall submit standardized electronic information on the outcomes and processes associated with patient care to the Health Care Value Reporting Committee.

Sec. 22. **[62U.12] PROVIDER PRICING.**

(a) Effective July 1, 2010, no health care provider shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser.

(b) This section does not apply to a variation based upon a payer being a governmental entity.

(c) This section does not apply to workers' compensation or no-fault automobile insurance payments.

(d) This section does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

Sec. 23. **[62U.13] HEALTH SAVINGS REINVESTMENT ASSESSMENT.**

Subdivision 1. **Projected spending baseline.** (a) The commissioner of health shall calculate the annual projected total health care spending for the state and establish a health care spending baseline beginning for the calendar year 2008 and for the next ten years based on the annual projected growth in spending.

(b) In establishing the health care spending baseline, the commissioner shall use the Center of Medicare and Medicaid Services forecast for total growth in national health care expenditures, and adjust this forecast to reflect the demographics, health status, and other factors deemed necessary by the commissioner. The commissioner shall contract with an actuarial consultant to make recommendations as to the adjustments needed to specifically reflect projected spending for Minnesota residents.

(c) The commissioner may adjust the projected baseline as necessary, to reflect any updated federal projections or account for unanticipated changes in federal policy.

(d) Medicare and long-term care spending must not be included in the calculations required under this section.

Subd. 2. **Actual spending.** (a) By June 1 of each year, beginning June 1, 2010, the commissioner shall determine the actual private and public health care expenditures for the calendar year preceding the current calendar year based on data collected under chapter 62J and shall determine the difference between the projected spending as determined under subdivision 1 and the actual spending for that year. The actual spending must be certified by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner shall determine an aggregate savings reinvestment amount, not to exceed 33 percent of the difference.

(b) Based on this calculation, the commissioner shall determine annually a savings reinvestment amount to be paid by health plan companies and third-party administrators. The aggregate savings reinvestment amount may not exceed 33 percent of the aggregate savings reflected in the difference between the actual spending and the projected spending.

Subd. 3. **Publication of spending.** The commissioner shall publish in the State Register by June 15 of each year, beginning June 15, 2010, the projected spending baseline, including any adjustments, and the actual spending for the preceding year.

Subd. 4. **Savings reinvestment assessments.** (a) Health plan companies and third-party administrators shall pay a health savings reinvestment assessment. The commissioner shall calculate the savings reinvestment assessments as follows:

(1) for health plan companies, the health savings reinvestment assessment must be based on a percentage of annual paid health care claims on policies that insure residents of this state; and

(2) for third-party administrators, the health savings reinvestment assessment must be a fee placed on the third-party administrator for each insured resident of the state in which the third-party administrator administered benefits for health care.

(b) A health plan company is not required to pay a health savings reinvestment assessment on policies or contracts insuring federal employees or Medicare beneficiaries, except private supplemental coverage.

(c) Health savings reinvestment assessments apply to claims paid or administration provided for plan years beginning on or after January 1, 2010.

(d) Health savings reinvestment assessments must be paid quarterly to the commissioner of revenue within 60 days after the close of each quarter, beginning no later than May 30, 2010.

Subd. 5. **Credit of assessments.** The commissioner of revenue shall credit the revenue derived from the assessments to the health savings reinvestment fund established under section 16A.727.

Sec. 24. **[62U.14] COST CONTAINMENT GOALS; CONTINGENT EXPANSION TO MINNESOTA CARE.**

Subdivision 1. **Cost containment goals.** Based on the projected spending baseline calculated under section 62U.13, subdivision 1, the following annual cost containment goals for public and private spending on health care services for Minnesota residents are established:

(1) for calendar year 2009, the cost containment goal is the baseline projected spending growth for 2009 established in section 62U.13 less one percentage point;

(2) for calendar year 2010, the cost containment goal is the baseline projected spending growth for 2010 less 1.5 percentage points;

(3) for calendar years 2011 and 2012, the cost containment goal is the baseline projected spending growth for 2011 and 2012 less two percentage points; and

(4) for calendar years after 2012, the cost containment goal is the projected baseline spending for 2013 less 2.5 percentage points.

Subd. 2. **Contingent expansion of MinnesotaCare.** (a) By June 1, 2010, the commissioner of health shall report to the commissioner of human services and the legislature on whether the cost containment goal for 2009 was met. If the goal was met, the commissioner of human services shall implement the eligibility expansion to the MinnesotaCare program for individuals and families with children up to 300 percent of federal poverty guidelines, to be effective July 1, 2010.

(b) If the cost containment goal has not been met, the legislature shall consider an eligibility expansion to the MinnesotaCare program based on available funding.

(c) The commissioner of health shall submit a plan to the legislature by January 15, 2013, if the cost containment goals established in this section have been met and the uninsured rate for Minnesota residents is greater than three percent. The plan must include efforts that will increase coverage to at least 97 percent insured.

Sec. 25. **[62U.15] AFFORDABILITY STANDARD.**

Subdivision 1. **Definition of affordability.** For purposes of this section, coverage is "affordable" if the sum of premiums, deductibles, and other out-of-pocket costs paid by an individual or family for health coverage does not exceed the applicable percentage of the individual or family's gross monthly income specified in subdivision 2. For individuals

and families with pretax income, the determination of "affordability" for purposes of this section shall compare the net cost of health coverage that includes pretax savings to the applicable percentage of the individual's or family's gross monthly income.

Subd. 2. **Incomes up to 300 percent of the federal poverty guidelines.** The following affordability standard is established for individuals and households with gross family incomes of 300 percent of the federal poverty guidelines or less:

AFFORDABILITY STANDARD

Federal Poverty Guideline Range	**Percent of Average Gross Monthly Income**
0-33%	minimum
33-54%	1.1%
55-81%	1.4%
82-109%	1.9%
110-136%	2.6%
137-164%	3.4%
165-191%	4.4%
192-219%	5.2%
220-248%	5.9%
248-274%	6.5%
275-300%	7.0%

Subd. 3. **Incomes greater than 300 percent but not exceeding 400 percent of the federal poverty guidelines.** For purposes of determining affordability, the affordability standard for individuals and households with gross family incomes greater than 300 percent but not exceeding 400 percent of the federal poverty guidelines shall be based on a continuation of the sliding scale specified in subdivision 2, with the percentage of average gross monthly income rising proportionately at each income range, to a maximum of 10.0 percent.

Sec. 26. **[62U.16] EMPLOYEE SUBSIDIES FOR EMPLOYER-SUBSIDIZED HEALTH COVERAGE PLAN.**

Subdivision 1. **Establishment of subsidy program.** The commissioner of human services shall develop a plan for a subsidy program for eligible employees with access to employer-subsidized health coverage. For purposes of this section, employer-subsidized health coverage has the meaning provided in section 256L.07, subdivision 2, paragraph (c).

Subd. 2. **Eligible employees.** In order to be eligible for a subsidy under this plan, an employee must:

(1) be covered by employer-subsidized health coverage that meets or is actuarially equivalent to the benefit set and design established by the Health Care Transformation Commission; and

(2) meet all eligibility criteria for the MinnesotaCare program established under chapter 256L, except for the requirements related to:

(i) no access to employer-subsidized coverage under section 256L.07, subdivision 2; and

(ii) no other health coverage under section 256L.07, subdivision 3.

Subd. 3. **Amount of subsidy.** The subsidy in the plan shall equal the amount the employee is required to pay for health coverage, including premiums, deductibles, and other cost sharing, minus an amount based on the affordability standard specified in section 62U.15. The maximum subsidy shall not exceed the amount of the subsidy that would have been provided under the MinnesotaCare program, if the employee and any dependents were eligible for that program.

Subd. 4. **Payment of subsidy.** As part of the plan, the commissioner shall pay the subsidy amount for an employee and any dependents to the employer, and this payment shall be credited towards the employee's share of premium.

Subd. 5. **Report.** The commissioner shall submit the plan creating the subsidy program to the legislature by January 15, 2009, for implementation by July 1, 2009.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 27. **REPEALER.**

Minnesota Statutes 2006, sections 62A.63; 62A.64; 62Q.49; 62Q.65; and 62Q.736, are repealed.

EFFECTIVE DATE. This section is effective January 1, 2010.

ARTICLE 5
APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

		2009		**Total**
General Fund	$	200,000	$	200,000
Health Care Access Fund		39,113,000		39,113,000

Health Improvement Fund		20,000,000		20,000,000
Total	**$**	**59,313,000**	**$**	**59,313,000**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2007, chapter 147, article 19, or other law to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal year indicated for each purpose. The figure "2009" used in this article means that the addition to or subtraction from the appropriation listed under it is available for the fiscal year ending June 30, 2009.

	APPROPRIATIONS Available for the Year Ending June 30
	2009

Sec. 3. **HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ 9,725,000**

Appropriations by Fund

	2009
General Fund	200,000
Health Care Access Fund	9,525,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Children and Economic Assistance Management**

Health Care Access	6,000

This is a onetime appropriation.

Subd. 3. **Basic Health Care Grants**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **MinnesotaCare Grants**

Health Care Access	4,435,000

Medical Assistance Basic Health Care Grants; Families and Children

General Fund	200,000

Primary Care Physician Rate Increases.

(a) Of the general fund appropriation, $200,000 is to the commissioner for the medical assistance reimbursement rate increase described in Minnesota Statutes, section 256B.766.

(b) Notwithstanding Minnesota Statutes, section 295.581, the commissioner of finance shall reimburse the medical assistance general fund account from the health care access fund the amount of general fund expenditures for this activity. The amount reimbursed under this paragraph is appropriated to the commissioner.

(c) **Other Health Care Grants**

Health Care Access	850,000

Mobile Dental Unit. (a) Of the health care access fund appropriation, $500,000 is to be awarded as a grant to a nonprofit organization to operate a mobile dental unit within the seven-county metropolitan area for treating the dental needs of underserved children and adults with a comprehensive approach of education, treatment, and follow-up routine visits. The organization must show viable partnerships with the dental community, community-based organizations, and local

school districts. The services provided by the organization must include:

(1) identifying and treating children with untreated dental conditions at locations with the community;

(2) educating children and their families about oral health diseases and the importance and benefits of a preventive oral health care program; and

(3) connecting local dental health care professionals and organizations with underserved children for follow-up and ongoing dental care services.

(b) The organization must report to the commissioner by January 15, 2010, the number of children served by the mobile unit, the services provided by the unit, the locations where children were served, and if follow-up services were provided.

This is a onetime appropriation.

Open Door Health Center. Of the health care access fund appropriation, $350,000 is to be awarded as a grant to the Open Door Health Center to act as a bridge funding to meet the demand for health care services in medically underserved areas. This is a onetime appropriation.

Subsidies for Employer-Subsidized Health Coverage. For the biennium beginning July 1, 2009, base level funding for the subsidy program described in Minnesota Statutes, section 62U.16, shall be $20,000,000 from the health care access fund for the first year

and $35,000,000 from the health care access fund for the second year.

Base Adjustment. The health care access fund base is increased by $19,150,000 in fiscal year 2010 and increased by $34,150,000 in fiscal year 2011.

Subd. 4. **Health Care Management**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **Health Care Policy Administration**

Health Care Access	182,000

Base Adjustment. The health care access fund is increased by $111,000 in fiscal year 2010 and decreased by $171,000 in fiscal year 2011.

Base Adjustment. The general fund base is increased by $2,121,000 in fiscal year 2010 and increased by $1,792,000 in fiscal year 2011.

(b) **Health Care Operations**

Health Care Access	3,248,000

Incentive Program and Outreach Grants. Of the appropriation for the Minnesota health care outreach program in Laws 2007, chapter 147, article 19, section 3, subdivision 7, paragraph (b):

(1) $400,000 in fiscal year 2009 from the general fund and $200,000 in fiscal year 2009 from the health care access fund are for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. For the biennium beginning July 1, 2009, base level funding for this activity shall be $360,000

from the general fund and $160,000 from the health care access fund; and

(2) $100,000 in fiscal year 2009 from the general fund and $50,000 in fiscal year 2009 from the health care access fund are for the outreach grants under Minnesota Statutes, section 256.962, subdivision 2. For the biennium beginning July 1, 2009, base level funding for this activity shall be $90,000 from the general fund and $40,000 from the health care access fund.

Outreach Funding. (a) Of the health care access fund appropriation, $100,000 is for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. This is in addition to the base level fund for the biennium beginning July 1, 2009. For the fiscal year beginning July 1, 2011, appropriations for this activity shall be from the health savings reinvestment fund.

(b) Notwithstanding Minnesota Statutes, section 295.581, the commissioner of finance shall reimburse the medical assistance general fund account from the health care access fund by $701,000 in fiscal year 2010 and $1,527,000 in fiscal year 2011 for the cost to the general fund for the increase in enrollment to the medical assistance program for families with children due to the outreach efforts.

Base Adjustment. The health care access fund base is decreased by $979,000 in fiscal year 2010 and increased by $556,000 in fiscal year 2011.

Subd. 5. **Continuing Care Management**

Health Care Access 804,000

Long-Term Care Worker Health Coverage Study. (a) Of the health care access fund appropriation, $804,000 is for the commissioner to study and report to the legislature by December 15, 2008, with recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market. The commissioner shall collect necessary actuarial data, employment data, current coverage data, and other needed information.

(b) The commissioner shall develop cost estimates for three levels of insurance coverage for long-term care workers:

(1) the coverage provided to state employees;

(2) the coverage provided to MinnesotaCare enrollees; and

(3) the benefits provided under an "average" private market insurance product, but with a deductible limited to $100 per person.

Premium cost sharing, waiting periods for eligibility, definitions of full- and part-time employment, and other parameters under the three options must be identical to those under the state employees' health plan.

(c) For purposes of this section, a long-term care worker is a person employed by a nursing facility, an intermediate care facility for persons with developmental disabilities, or a service provider that:

(1) is eligible under Laws 2007, chapter 147, article 7, section 71; and

(2) provides long-term care services.

The commissioner may recommend a different definition of long-term care worker if this definition presents insurmountable implementation issues.

(d) The recommendations must include measures to:

(1) ensure equitable treatment between employers that currently have different levels of expenditure for employee health insurance costs; and

(2) enforce the requirement that the rate increase be expended for the intended purpose.

This is a onetime appropriation.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 49,588,000**

Appropriations by Fund

	2009
Health Care Access	21,588,000
Health Improvement	20,000,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Community and Family Health Promotion**

Health Improvement	20,000,000

Statewide Health Improvement Program.

This appropriation is for the statewide health improvement program under Minnesota Statutes, section 145.986. Of this appropriation, $18,600,000 is for grants to local communities in accordance with Minnesota Statutes, section 145.986,

subdivision 2. The base level funding for the statewide health improvement program shall be $40,000,000 in fiscal year 2010.

Subd. 3. **Policy, Quality, and Compliance**

Health Care Access	29,588,000

Dental Loan Forgiveness and Scholarship Program. Of the health care access fund appropriation, $400,000 is for the dental loan forgiveness and scholarship program described in Minnesota Statutes, section 144.1501.

Federally Qualified Health Centers. Of the health care access fund appropriation, $4,000,000 is for subsidies to federally qualified health centers under Minnesota Statutes, section 145.9269. This amount shall be added to the base level funding.

Health Care Transformation Commission. Of the health care access fund appropriation, $12,000,000 is for the operation of the Health Care Transformation Commission. This is a onetime appropriation and is available until expended.

Electronic Health Records Grants. Of the health care access fund appropriation, $1,962,000 is for the electronic health records grant program in Minnesota Statutes, section 144.3345. Base level funding for this activity shall be $3,673,000 in fiscal year 2010 and $3,673,000 in fiscal year 2011. The appropriation for this activity expires after the fiscal year 2011 appropriation.

Electronic Health Records Revolving Account and Loan. Of the health care

access fund appropriation, $2,000,000 is for the electronic health record system revolving account and loan program in Minnesota Statutes, section 62J.496. Base level funding for this activity shall be $3,750,000 in fiscal year 2010 and $3,750,000 in fiscal year 2011. The appropriation for this activity expires after the fiscal year 2011 appropriation.

Sec. 5. **ADMINISTRATIVE ACTIVITIES FOR THE SAVINGS REINVESTMENT ASSESSMENT.**

$302,000 is appropriated from the health savings investment fund in fiscal year 2010 to the commissioner of health for administrative activities of the health reinvestment assessment under Minnesota Statutes, section 62U.13. This is a onetime appropriation.

Sec. 6. **TRANSFERS.**

(a) After the transfer to the general fund in accordance with Minnesota Statutes, section 16A.727, to the extent there are remaining funds in the health savings reinvestment fund, the commissioner of finance shall transfer to the general fund $2,121,000 in fiscal year 2010 to be appropriated to the commissioner of human services for the health care homes under Minnesota Statutes, sections 256B.0751 to 256B.0754.

(b) To the extent funds are remaining in the health savings reinvestment fund after the transfer described in paragraph (a), the commissioner of finance shall transfer to the general fund $1,250,000 in fiscal year 2010 to be appropriated in equal amounts to:

(1) to the Board of Regents of the Univerity of Minnesota to increase the number of primary care physicians who practice in underserved communities in the state and the number of primary care physician slots in residency programs in the state;

(2) to the Mayo Medical Foundation for medical school initiatives to increase the number of primary care physicians who practice in underserved communities in the state and the number of primary care physician slots in residency programs in the state;

(3) to the Office of Higher Education to increase the number of primary care physicians who practice in underserved communities in the state and the number of primary care physician slots in residency programs in the state;

(4) to the Duluth Graduate Medical Education Council, Inc. for medical school initiatives to increase the number of primary care physician slots in residency programs in the state;

(5) to the Office of Higher Education to provide grants to schools of nursing in Minnesota to increase the number of graduates of advanced practice registered nurse programs;

(6) to the Board of Regents of the University of Minnesota to address faculty shortages in primary care medicine;

(7) to the Mayo Medical Foundation to address faculty shortages in primary care medicine; and

(8) to the Office of Higher Education to provide grants to schools of nursing in Minnesota to address faculty shortages.

(c) To the extent funds are remaining in the health savings reinvestment fund after the transfers described in paragraphs (a) and (b), the commissioner of finance shall transfer to the health care access fund an amount sufficient to cover any structural deficit in the health care access fund, beginning in fiscal year 2011.

Sec. 7. **HEALTH INSURANCE ACCESS BROKER FEES.**

All fees received by the commissioner of commerce under Minnesota Statutes, section 62U.02, and deposited in the state government special revenue fund are appropriated to the commissioner of commerce for the purpose of implementing Minnesota Statutes, section 62U.02.

Sec. 8. **SUNSET OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2009, unless a different expiration date is specified.

Sec. 9. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2008, unless a different effective date is specified.

APPENDIX
Article locations in s3099-8

62A.63 DEFINITIONS.

Subdivision 1. **Application.** For purposes of section 62A.64, the terms defined in this section have the meanings given them.

Subd. 2. **Health care provider.** "Health care provider" means a person, hospital, or health care facility, organization, or corporation that is licensed, certified, or otherwise authorized by the laws of this state to provide health care.

Subd. 3. **Insurer.** "Insurer" means a health insurer regulated under this chapter, service plan corporation as defined under section 62C.02, subdivision 6, and health maintenance organization as defined under section 62D.02, subdivision 4.

62A.64 HEALTH INSURANCE; PROHIBITED AGREEMENTS.

An agreement between an insurer and a health care provider may not:

(1) prohibit, or grant the insurer an option to prohibit, the provider from contracting with other insurers or payors to provide services at a lower price than the payment specified in the contract;

(2) require, or grant the insurer an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other insurer or payor at a lower price; or

(3) require, or grant the insurer an option of, termination or renegotiation of the existing contract in the event the provider agrees to provide services to any other insurer or payor at a lower price.

62Q.49 ENROLLEE COST SHARING; NEGOTIATED PROVIDER PAYMENTS.

Subdivision 1. **Applicability.** This section applies to all health plans, as defined in section 62Q.01, subdivision 3, that provide coverage for health care to be provided entirely or partially:

(1) through contracts in which health care providers agree to accept discounted charges, negotiated charges, or other limits on health care provider charges;

(2) by employees of, or facilities or entities owned by, the issuer of the health plan; or

(3) through contracts with health care providers that provide for payment to the providers on a fully or partially capitated basis or on any other non-fee-for-service basis.

Subd. 2. **Disclosure required.** (a) All health plans included in subdivision 1 must clearly specify how the cost of health care used to calculate any co-payments, coinsurance, or lifetime benefits will be affected by the arrangements described in subdivision 1.

(b) Any summary or other marketing material used in connection with marketing of a health plan that is subject to this section must prominently disclose and clearly explain the provisions required under paragraph (a), if the summary or other marketing material refers to co-payments, coinsurance, or maximum lifetime benefits.

(c) A health plan that is subject to paragraph (a) must not be used in this state if the commissioner of commerce or health, as appropriate, has determined that it does not comply with this section.

62Q.65 ACCESS TO PROVIDER DISCOUNTS.

Subdivision 1. **Requirement.** A high deductible health plan must, when used in connection with a medical savings account or health savings account, provide the enrollee access to any discounted provider fees for services covered by the high deductible health plan, regardless of whether the enrollee has satisfied the deductible for the high deductible health plan.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given:

(1) "high deductible health plan" has the meaning given under the Internal Revenue Code of 1986, section 220(c)(2), with respect to a medical savings account; and the meaning given under Internal Revenue Code of 1986, section 223(c)(2), with respect to a health savings account;

(2) "medical savings account" has the meaning given under the Internal Revenue Code of 1986, section 220(d)(1);

(3) "discounted provider fees" means fees contained in a provider agreement entered into by the issuer of the high deductible health plan, or an affiliate of the issuer, for use in connection with the high deductible health plan; and

(4) "health savings account" has the meaning given under the Internal Revenue Code of 1986, section 223(d).

62Q.736 PAYMENT RATES.

A contract between a health plan company and a provider shall comply with section 62A.64.

256L.15 PREMIUMS.

Subd. 3. **Exceptions to sliding scale.** Children in families with income at or below 150 percent of the federal poverty guidelines pay a monthly premium of $4.