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State of Minnesota
HOUSE OF REPRESENTATIVES

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HOUSE FILE No. **155**

January 16, 2007

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The bill was read for the first time and referred to the Committee on Health and Human Services

A bill for an act

relating to human services; creating a children's health security account; establishing the children's health security program; specifying eligibility criteria, covered services, and administrative procedures; establishing the Legislative Task Force on Children's Health Care Coverage; requiring reports; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 16A; proposing coding for new law as Minnesota Statutes, chapter 256N.

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

Section 1. [16A.726] CHILDREN'S HEALTH SECURITY ACCOUNT.

A children's health security account is created in a special revenue fund in the state treasury. The commissioner shall deposit to the credit of the account money made available to the account. Notwithstanding section 11A.20, any investment income attributable to the investment of the children's health security account not currently needed shall be credited to the children's health security account.

Sec. 2. [256N.01] CITATION.

This chapter may be cited as the Children's Health Security Act.

Sec. 3. [256N.02] DEFINITIONS.

Subdivision 1. **Applicability.** The terms used in this chapter have the following meanings unless otherwise provided for by text.

Subd. 2. **Child.** "Child" means (1) an individual under age 19; or (2) an unmarried child who is a full-time student under the age of 25 years who is financially dependent upon a parent, grandparent, foster parent, relative caretaker, or legal guardian.

2.1 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human
 2.2 services.

2.3 Sec. 4. **[256N.03] ESTABLISHMENT.**

2.4 The commissioner shall establish the children's health security program. The
 2.5 commissioner shall begin implementation of the program on July 1, 2008, or upon federal
 2.6 approval, whichever is later.

2.7 Sec. 5. **[256N.05] ELIGIBILITY.**

2.8 Subdivision 1. **General requirements.** Children meeting the eligibility
 2.9 requirements of this section are eligible for the children's health security program.

2.10 Subd. 2. **Income limit.** (a) Children in families with household incomes equal to
 2.11 or less than 300 percent of the federal poverty guidelines are eligible for the children's
 2.12 health security program. Children are eligible to enroll effective July 1, 2008, or upon
 2.13 federal approval, whichever is later.

2.14 (b) Effective July 1, 2010, eligibility is expanded to include all children in families
 2.15 with household incomes in excess of 300 percent of the federal poverty guidelines.

2.16 Subd. 3. **Residency.** (a) To be eligible for health coverage under the children's
 2.17 health security program, children must be permanent residents of Minnesota. For purposes
 2.18 of this requirement, a permanent Minnesota resident is a person who has demonstrated,
 2.19 through persuasive and objective evidence, that the person is domiciled in the state and
 2.20 intends to live in the state permanently.

2.21 (b) To be eligible as a permanent resident, an applicant, or the applicant's parent
 2.22 or guardian as applicable, must demonstrate the requisite intent to live in the state
 2.23 permanently by:

2.24 (1) showing that the applicant, or the applicant's parent or guardian as applicable,
 2.25 maintains a residence at a verified address, through the use of evidence of residence
 2.26 described in paragraph (c); and

2.27 (2) signing an affidavit declaring that the applicant currently resides in the state and
 2.28 intends to reside in the state permanently, and the applicant did not come to the state for
 2.29 the primary purpose of obtaining medical coverage or treatment.

2.30 (c) An applicant, or a parent or guardian of an applicant, may verify a residence
 2.31 address by presenting a valid state driver's license, a state identification card, a voter
 2.32 registration card, a rent receipt, a statement by the landlord, apartment or emergency
 2.33 shelter manager, or homeowner verifying that the individual is residing at the address, or
 2.34 other form of verification approved by the commissioner.

3.1 (d) A child who is temporarily absent from the state does not lose eligibility for the
 3.2 children's health security program. "Temporarily absent from the state" means the person
 3.3 is out of the state for a temporary purpose and intends to return when the purpose of the
 3.4 absence has been accomplished. A person is not temporarily absent from the state if
 3.5 another state has determined that the person is a resident for any purpose. If temporarily
 3.6 absent from the state, the person must follow the requirements of the health plan in which
 3.7 the person is enrolled to receive services.

3.8 (e) A child who moved to Minnesota primarily to obtain medical treatment or health
 3.9 coverage for a preexisting condition is not a permanent resident.

3.10 Subd. 4. **Enrollment voluntary.** Enrollment in the children's health security
 3.11 program is voluntary. Parents or guardians may retain private sector or Medicare coverage
 3.12 for a child as the sole source of coverage. Parents or guardians who have private sector or
 3.13 Medicare coverage for children may also enroll children in the children's health security
 3.14 program. If private sector or Medicare coverage is available, coverage under the children's
 3.15 health security program is secondary to the private sector or Medicare coverage.

3.16 **Sec. 6. [256N.07] COVERED SERVICES.**

3.17 Covered services under the children's health security program shall consist of all
 3.18 covered services under chapter 256B.

3.19 **Sec. 7. [256N.09] NO ENROLLEE PREMIUMS OR COST SHARING.**

3.20 In order to ensure broad access to coverage, the children's health security program
 3.21 has no enrollee premium or cost-sharing requirements.

3.22 **Sec. 8. [256N.11] APPLICATION PROCEDURES; ELIGIBILITY**
 3.23 **DETERMINATION.**

3.24 Subdivision 1. **Application procedure.** Applications for the program must be made
 3.25 available to provider offices, local human services agencies, school districts, schools,
 3.26 community health offices, and other sites willing to cooperate in program outreach. These
 3.27 sites may accept applications and forward applications to the commissioner. Applications
 3.28 may also be made directly to the commissioner.

3.29 Subd. 2. **Eligibility determination.** The commissioner shall determine an
 3.30 applicant's eligibility for the program within 30 days of the date the application is received
 3.31 by the Department of Human Services. The effective date of coverage is the day upon
 3.32 which eligibility is approved, except in cases of persons applying under presumptive
 3.33 eligibility.

4.1 Subd. 3. **Presumptive eligibility.** Coverage under the program is available during a
 4.2 presumptive eligibility period. The presumptive eligibility period begins on the date a
 4.3 health care provider or other entity designated by the commissioner determines, based
 4.4 on preliminary information, that the person meets the criteria in section 256N.05. The
 4.5 presumptive eligibility period ends on the day on which a determination is made as to
 4.6 the person's eligibility, except that if an application is not submitted by the last day of
 4.7 the month following the month during which the determination based on preliminary
 4.8 information is made, the presumptive eligibility period ends on the last day of the month.

4.9 Subd. 4. **Renewal of eligibility.** The commissioner shall require enrollees to renew
 4.10 eligibility every 12 months using a passive renewal process. The commissioner shall
 4.11 send a form to each enrollee that contains eligibility information for that individual. If
 4.12 the eligibility information on the form is correct, the enrollee can maintain eligibility for
 4.13 another 12 months without returning the form to the commissioner. If the eligibility
 4.14 information on the form is not correct, the enrollee must return the form with corrected
 4.15 information to the commissioner, and the commissioner shall redetermine eligibility for
 4.16 the enrollee on the basis of the corrected information.

4.17 **Sec. 9. [256N.13] SERVICE DELIVERY.**

4.18 Subdivision 1. **Contracts with health plan companies.** The commissioner may
 4.19 contract with health maintenance organizations licensed under chapter 62D, community
 4.20 integrated service networks licensed under chapter 62N, and accountable provider
 4.21 networks licensed under chapter 62T to provide covered health care services to program
 4.22 enrollees. Health plan companies under contract are responsible for coordinating covered
 4.23 health care services provided to eligible individuals. Health plan companies under
 4.24 contract:

4.25 (1) shall authorize and arrange for the provision of all needed covered health
 4.26 services under chapter 256B, with the exception of services available only under a medical
 4.27 assistance home and community-based waiver, in order to ensure appropriate health care
 4.28 is delivered to enrollees;

4.29 (2) shall accept the prospective, per capita payment from the commissioner in return
 4.30 for the provision of comprehensive and coordinated health care services for enrollees;

4.31 (3) may contract with health care and social service providers to provide covered
 4.32 services to enrollees; and

4.33 (4) shall institute enrollee grievance procedures according to the method established
 4.34 by the commissioner, utilizing applicable requirements of chapter 62D. Disputes not

5.1 resolved through this process may be appealed to the commissioner using the procedures
 5.2 in section 256.045.

5.3 Subd. 2. **Contract administration.** The commissioner may contract with a
 5.4 private sector entity to administer and manage contracts with health plan companies
 5.5 under subdivision 1.

5.6 Subd. 3. **Contracts for waiver services.** The commissioner shall contract with
 5.7 health care and social service providers, on a fee-for-service basis, to provide program
 5.8 enrollees with covered services available only under a medical assistance home and
 5.9 community-based waiver. The commissioner shall determine eligibility for home and
 5.10 community-based waiver services using the criteria and procedures in chapter 256B.
 5.11 Disputes related to services provided on a fee-for-service basis may be appealed to the
 5.12 commissioner using the procedures in section 256.045.

5.13 **Sec. 10. ~~[256N.15]~~ PAYMENT RATES.**

5.14 The commissioner, in consultation with a health care actuary, shall establish the
 5.15 method and amount of payments for services. The commissioner shall annually contract
 5.16 with eligible entities to provide services to program enrollees. The commissioner, in
 5.17 consultation with the risk adjustment association established under section 62Q.03,
 5.18 subdivision 6, shall develop and implement a risk adjustment system for the program.

5.19 **Sec. 11. ~~[256N.17]~~ CONSUMER ASSISTANCE.**

5.20 Subdivision 1. **Assistance to applicants.** The commissioner shall assist applicants
 5.21 in choosing a health plan company by:

5.22 (1) establishing a Web site to provide information about health plan companies
 5.23 and to allow online enrollment;

5.24 (2) make information on health plan companies available at the sites specified in
 5.25 section 256N.11, subdivision 1;

5.26 (3) make applications and information on health plan companies available in
 5.27 Spanish, Hmong, Laotian, Russian, Somali, Vietnamese, and Cambodian, and provide
 5.28 language interpreter services as necessary to assist applicants in choosing a health plan
 5.29 company; and

5.30 (4) make benefit educators available to assist applicants in choosing a health plan
 5.31 company.

5.32 Subd. 2. **Ombudsperson.** The commissioner shall designate an ombudsperson
 5.33 to advocate for children enrolled in the children's health security program. The
 5.34 ombudsperson shall assist enrollees in understanding and making use of complaint and

6.1 appeal procedures and ensure that necessary medical services are provided to enrollees. At
 6.2 the time of enrollment, the commissioner shall inform enrollees about: the ombudsperson
 6.3 program; the right to a resolution of the enrollee's complaint by the health plan company
 6.4 if the enrollee experiences a problem with the health plan company or its providers; and
 6.5 appeal rights under section 256.045.

6.6 **Sec. 12. [256N.19] MONITORING AND EVALUATION OF QUALITY AND**
 6.7 **COSTS.**

6.8 The commissioner, as a condition of contract, shall require each participating health
 6.9 plan company and participating provider to submit, in the form and manner specified by
 6.10 the commissioner, data required for assessing enrollee satisfaction, quality of care, cost,
 6.11 and utilization of services. The commissioner shall evaluate this data, in order to:

6.12 (1) make summary information on the quality of care across health plan companies,
 6.13 medical clinics, and providers available to consumers;

6.14 (2) require health plan companies and providers, as a condition of contract, to
 6.15 implement quality improvement plans; and

6.16 (3) compare the cost and quality of services under the program to the cost and
 6.17 quality of services provided to private sector enrollees.

6.18 **Sec. 13. [256N.21] FEDERAL APPROVAL.**

6.19 The commissioner shall seek all federal waivers and approvals necessary to
 6.20 implement this chapter including, but not limited to, waivers and approvals necessary to:

6.21 (1) merge medical assistance and MinnesotaCare coverage for children into the
 6.22 children's health security program;

6.23 (2) use federal medical assistance and MinnesotaCare dollars to pay for health care
 6.24 services under the children's health security program; and

6.25 (3) maximize receipt of the federal medical assistance match for covered children,
 6.26 by increasing income standards through the use of more liberal income methodologies as
 6.27 provided under United States Code, title 42, sections 1396a and 1396u-1.

6.28 **Sec. 14. [256N.23] RULEMAKING.**

6.29 The commissioner shall adopt rules to implement this chapter.

6.30 **Sec. 15. IMPLEMENTATION PLAN.**

6.31 The commissioner of human services shall develop an implementation plan for the
 6.32 children's health security coverage program and shall present this plan, any necessary draft

7.1 legislation, and a draft of proposed rules to the legislature by December 15, 2007. The
 7.2 commissioner shall evaluate the provision of services under the program to children with
 7.3 disabilities and shall present recommendations to the legislature by December 15, 2009,
 7.4 for any program changes necessary to ensure the quality and continuity of care.

7.5 **Sec. 16. LEGISLATIVE TASK FORCE ON CHILDREN'S HEALTH CARE**
 7.6 **COVERAGE.**

7.7 **Subdivision 1. Establishment; membership.** The Legislative Task Force on
 7.8 Children's Health Care Coverage is established. The task force consists of: five members
 7.9 of the house of representatives appointed under the rules of the house, of whom three
 7.10 members must be from the majority party and two members from the minority party;
 7.11 and five members of the senate appointed under the rules of the senate, of whom three
 7.12 members must be from the majority party and two members from the minority party. Task
 7.13 force members must be appointed by September 1, 2007.

7.14 **Subd. 2. Study; staff support.** (a) The task force shall study viable options to extend
 7.15 coverage to all children as provided in Minnesota Statutes, section 256N.05, subdivision
 7.16 2, paragraph (b), and provide recommendations to the legislature. The study must:

7.17 (1) evaluate methods to achieve universal coverage for children, including, but not
 7.18 limited to, changes to the employer-based coverage system and an expansion of eligibility
 7.19 for the children's health security program established under Minnesota Statutes, chapter
 7.20 256N;

7.21 (2) examine health care reform and cost containment methods that will contain costs
 7.22 and increase access and improve health outcomes;

7.23 (3) examine how to increase access to preventive care and health care services; and

7.24 (4) examine how to reduce health disparities among minority populations.

7.25 (b) The task force, through the Legislative Coordinating Commission, may hire staff
 7.26 or contract for staff support for the study.

7.27 **Subd. 3. Recommendations.** The task force shall report its recommendations
 7.28 to the legislature by January 15, 2009. Recommendations must be consistent with the
 7.29 following criteria:

7.30 (1) health care coverage must include preventive care and all other medically
 7.31 necessary services;

7.32 (2) health care coverage must be affordable for families, with the family share of
 7.33 premium costs and cost-sharing in total not exceeding five percent of family income;

7.34 (3) the system of coverage must give priority to ensuring access to and the quality
 7.35 and continuity of care; and

8.1 (4) enrollment must be simple and seamless for families.

8.2 Subd. 4. **Expiration.** This section expires January 16, 2009.

8.3 Sec. 17. **APPROPRIATION.**

8.4 (a) \$..... is appropriated from the general fund to the commissioner of human
8.5 services for the fiscal year ending June 30, 2008, to develop and implement the Children's
8.6 Health Security Act under Minnesota Statutes, chapter 256N.

8.7 (b) \$..... is appropriated from the general fund to the Legislative Coordinating
8.8 Commission for the fiscal year ending June 30, 2008, for staff support provided to the
8.9 Legislative Task Force on Children's Health Care Coverage.