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HOUSE FILE No. 297

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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

1.1 relating to health care; establishing premium rate restrictions and expenditure
1.2 limits; requiring an interoperable electronic health records system; requiring a
1.3 plan to achieve universal health care; expanding the definition of dependent
1.4 coverage; eliminating the modification to the MinnesotaCare application form;
1.5 implementing an intensive care management program; increasing reimbursement
1.6 for critical access dental providers; extending medical assistance coverage to
1.7 Medicare Part D co-payments; creating grants for nonprofit dental providers with
1.8 a high proportion of uninsured patients; eliminating co-payments for medical
1.9 assistance and general assistance medical care; modifying the period of renewal
1.10 for MinnesotaCare; modifying the definition of employer-subsidized insurance;
1.11 providing for MinnesotaCare outreach; creating a prescription drug discount
1.12 program; expanding the benefit set for single adults; increasing the eligibility
1.13 income limit for single adults; increasing the cap for inpatient hospitalization
1.14 benefits for adults; modifying the definition of income for self-employed
1.15 farmers; removing insurance barriers for children in MinnesotaCare; eliminating
1.16 MinnesotaCare premiums for members of the military and their families;
1.17 reducing premiums for MinnesotaCare; restoring family planning grants;
1.18 creating a patient incentive health program; requiring uniform billing forms;
1.19 establishing a small employer option; proposing an amendment to the Minnesota
1.20 Constitution, article XIII, by adding a section; affirming that every resident
1.21 of Minnesota has the right to affordable health care; appropriating money;
1.22 amending Minnesota Statutes 2006, sections 62A.65, subdivision 3; 62E.02,
1.23 subdivision 7; 62J.04, subdivision 3, by adding a subdivision; 62J.041; 62J.301,
1.24 subdivision 3; 62J.38; 62J.495; 62L.02, subdivision 11; 62L.08, subdivision
1.25 8; 62Q.165, subdivisions 1, 2, by adding a subdivision; 256.01, subdivision
1.26 2b; 256B.056, subdivision 10; 256B.0625, by adding a subdivision; 256B.075,
1.27 subdivision 2; 256B.76; 256D.03, subdivisions 3, 4; 256L.01, subdivision 4;
1.28 256L.03, subdivisions 1, 3, 5; 256L.04, subdivisions 1a, 7, 10, by adding a
1.29 subdivision; 256L.05, subdivisions 1b, 2, 3a; 256L.07, subdivisions 1, 2, 3, 6;
1.30 256L.15, subdivisions 1, 2, 4; 256L.17, subdivision 7; Laws 2005, First Special
1.31 Session chapter 4, article 9, section 3, subdivision 2; proposing coding for new
1.32 law in Minnesota Statutes, chapters 256; 256L; repealing Minnesota Statutes
1.33 2006, sections 62A.301; 256B.0631; 256L.035.

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

1.36 Section 1. Minnesota Statutes 2006, section 62A.65, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

3.10 (h) Notwithstanding paragraphs (a) to (g), the rates must not be approved, unless the
3.11 commissioner has determined that the rates are reasonable. In determining reasonableness,
3.12 the commissioner shall consider the growth rates applied under section 62J.04, subdivision
3.13 1, paragraph (b) apply the premium growth limits established under section 62J.04,
3.14 subdivision 1b, to the calendar year or years that the proposed premium rate would be in
3.15 effect, and shall consider actuarially valid changes in risks associated with the enrollee
3.16 populations, and actuarially valid changes as a result of statutory changes in Laws 1992,
3.17 chapter 549.

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

3.30 Sec. 2. Minnesota Statutes 2006, section 62E.02, subdivision 7, is amended to read:

3.31 Subd. 7. **Dependent.** "Dependent" means a spouse or unmarried child ~~under the~~
3.32 ~~age of 19 years, a dependent child who is a student under the age of 25~~ regardless of
3.33 whether the dependent child is enrolled in an educational institution, or a dependent
3.34 child of any age who is disabled.

3.35 **EFFECTIVE DATE.** This section is effective January 1, 2008.

4.1 Sec. 3. Minnesota Statutes 2006, section 62J.04, is amended by adding a subdivision to
4.2 read:

4.3 Subd. 1b. **Premium growth limits.** (a) For calendar year 2008 and each year
4.4 thereafter, the commissioner shall set annual premium growth limits for health plan
4.5 companies. The premium limits set by the commissioner for calendar years 2008 to 2013
4.6 shall not exceed the regional Consumer Price Index for urban consumers for the preceding
4.7 calendar year plus two percentage points and an additional one percentage point to be used
4.8 to finance the implementation of the electronic medical record system described under
4.9 section 62J.495. The commissioner shall ensure that the additional percentage point is
4.10 being used to provide financial assistance to health care providers to implement electronic
4.11 medical record systems either directly or through an increase in reimbursement.

4.12 (b) For the calendar years beyond 2013, the rate of premium growth shall be
4.13 limited to the change in the Consumer Price Index for urban consumers for the previous
4.14 calendar year plus two percentage points. The commissioners of health and commerce
4.15 shall make a recommendation to the legislature by January 15, 2012, regarding the
4.16 continuation of the additional percentage point to the growth limit described in paragraph
4.17 (a). The recommendation shall be based on the progress made by health care providers
4.18 in instituting an electronic medical record system and in creating a statewide interactive
4.19 electronic health record system.

4.20 (c) The commissioner may add additional percentage points as needed to the
4.21 premium limit for a calendar year if a major disaster, bioterrorism, or a public health
4.22 emergency occurs that results in higher health care costs. Any additional percentage
4.23 points must reflect the additional cost to the health care system directly attributed to
4.24 the disaster or emergency.

4.25 (d) The commissioner shall publish the annual premium growth limits in the State
4.26 Register by January 31 of the year that the limits are to be in effect.

4.27 (e) For the purposes of this subdivision, premium growth is measured as the
4.28 percentage change in per member, per month premium revenue from the current year to
4.29 the previous year. Premium growth rates shall be calculated for the following lines of
4.30 business: individual, small group, and large group. Data used for premium growth rate
4.31 calculations shall be submitted as part of the cost containment filing under section 62J.38.

4.32 (f) For purposes of this subdivision, "health plan company" has the meaning given
4.33 in section 62J.041.

4.34 (g) A health plan company may reduce reimbursement to providers in order to meet
4.35 the premium growth limitations required by this section.

5.1 Sec. 4. Minnesota Statutes 2006, section 62J.04, subdivision 3, is amended to read:

5.2 Subd. 3. **Cost containment duties.** The commissioner shall:

5.3 (1) establish statewide and regional cost containment goals for total health care
5.4 spending under this section and collect data as described in sections 62J.38 to 62J.41 to
5.5 monitor statewide achievement of the cost containment goals and premium growth limits;

5.6 (2) divide the state into no fewer than four regions, with one of those regions being
5.7 the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti,
5.8 Wright, and Sherburne Counties, for purposes of fostering the development of regional
5.9 health planning and coordination of health care delivery among regional health care
5.10 systems and working to achieve the cost containment goals;

5.11 (3) monitor the quality of health care throughout the state and take action as
5.12 necessary to ensure an appropriate level of quality;

5.13 (4) issue recommendations regarding uniform billing forms, uniform electronic
5.14 billing procedures and data interchanges, patient identification cards, and other uniform
5.15 claims and administrative procedures for health care providers and private and public
5.16 sector payers. In developing the recommendations, the commissioner shall review the
5.17 work of the work group on electronic data interchange (WEDI) and the American National
5.18 Standards Institute (ANSI) at the national level, and the work being done at the state and
5.19 local level. The commissioner may adopt rules requiring the use of the Uniform Bill
5.20 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic
5.21 version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized
5.22 forms or procedures;

5.23 (5) undertake health planning responsibilities;

5.24 (6) authorize, fund, or promote research and experimentation on new technologies
5.25 and health care procedures;

5.26 (7) within the limits of appropriations for these purposes, administer or contract for
5.27 statewide consumer education and wellness programs that will improve the health of
5.28 Minnesotans and increase individual responsibility relating to personal health and the
5.29 delivery of health care services, undertake prevention programs including initiatives to
5.30 improve birth outcomes, expand childhood immunization efforts, and provide start-up
5.31 grants for worksite wellness programs;

5.32 (8) undertake other activities to monitor and oversee the delivery of health care
5.33 services in Minnesota with the goal of improving affordability, quality, and accessibility of
5.34 health care for all Minnesotans; and

5.35 (9) make the cost containment goal and premium growth limit data available to
5.36 the public in a consumer-oriented manner.

6.1 Sec. 5. Minnesota Statutes 2006, section 62J.041, is amended to read:

6.2 **62J.041 ~~INTERIM HEALTH PLAN COMPANY COST-CONTAINMENT~~**
 6.3 **GOALS HEALTH CARE EXPENDITURE LIMITS.**

6.4 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
 6.5 apply.

6.6 (b) "Health plan company" has the definition provided in section 62Q.01. This
 6.7 definition does not include the state employee health plan offered under chapter 43A.

6.8 (c) "~~Total~~ Health care expenditures" means incurred claims or expenditures on health
 6.9 care services, ~~administrative expenses, charitable contributions, and all other payments~~
 6.10 ~~made by health plan companies out of premium revenues.~~

6.11 (d) "~~Net expenditures~~" means ~~total expenditures minus exempted taxes and~~
 6.12 ~~assessments and payments or allocations made to establish or maintain reserves.~~

6.13 (e) "~~Exempted taxes and assessments~~" means ~~direct payments for taxes to~~
 6.14 ~~government agencies, contributions to the Minnesota Comprehensive Health Association,~~
 6.15 ~~the medical assistance provider's surcharge under section 256.9657, the Minnesota Care~~
 6.16 ~~provider tax under section 295.52, assessments by the Health Coverage Reinsurance~~
 6.17 ~~Association, assessments by the Minnesota Life and Health Insurance Guaranty~~
 6.18 ~~Association, assessments by the Minnesota Risk Adjustment Association, and any new~~
 6.19 ~~assessments imposed by federal or state law.~~

6.20 (f) (d) "Consumer cost-sharing or subscriber liability" means enrollee coinsurance,
 6.21 co-payment, deductible payments, and amounts in excess of benefit plan maximums.

6.22 Subd. 2. **Establishment.** The commissioner of health shall establish ~~cost~~
 6.23 ~~containment goals~~ health care expenditure limits for ~~the increase in net~~ calendar year
 6.24 2008, and each year thereafter, for health care expenditures by each health plan company
 6.25 for calendar years 1994, 1995, 1996, and 1997. The cost containment goals must be the
 6.26 same as the annual cost containment goals for health care spending established under
 6.27 section 62J.04, subdivision 1, paragraph (b). Health plan companies that are affiliates may
 6.28 elect to meet one combined ~~cost containment goal~~ health care expenditure limit. The
 6.29 limits set by the commissioner shall not exceed the premium limits established in section
 6.30 62J.04, subdivision 1b.

6.31 Subd. 3. **Determination of expenditures.** Health plan companies shall submit to
 6.32 the commissioner of health, by April 1, ~~1994, for calendar year 1993; April 1, 1995, for~~
 6.33 ~~calendar year 1994; April 1, 1996, for calendar year 1995; April 1, 1997, for calendar~~
 6.34 ~~year 1996; and April 1, 1998, for calendar year 1997~~ of each year beginning 2008, all
 6.35 information the commissioner determines to be necessary to implement this section.
 6.36 The information must be submitted in the form specified by the commissioner. The

7.1 information must include, but is not limited to, health care expenditures per member per
 7.2 month or cost per employee per month, and detailed information on revenues and reserves.
 7.3 The commissioner, to the extent possible, shall coordinate the submittal of the information
 7.4 required under this section with the submittal of the financial data required under chapter
 7.5 62J, to minimize the administrative burden on health plan companies. The commissioner
 7.6 may adjust final expenditure figures for demographic changes, risk selection, changes in
 7.7 basic benefits, and legislative initiatives that materially change health care costs, as long
 7.8 as these adjustments are consistent with the methodology submitted by the health plan
 7.9 company to the commissioner, and approved by the commissioner as actuarially justified.
 7.10 ~~The methodology to be used for adjustments and the election to meet one cost containment~~
 7.11 ~~goal for affiliated health plan companies must be submitted to the commissioner by~~
 7.12 ~~September 1, 1994. Community integrated service networks may submit the information~~
 7.13 ~~with their application for licensure. The commissioner shall also accept changes to~~
 7.14 ~~methodologies already submitted. The adjustment methodology submitted and approved~~
 7.15 ~~by the commissioner must apply to the data submitted for calendar years 1994 and 1995.~~
 7.16 ~~The commissioner may allow changes to accepted adjustment methodologies for data~~
 7.17 ~~submitted for calendar years 1996 and 1997. Changes to the adjustment methodology~~
 7.18 ~~must be received by September 1, 1996, and must be approved by the commissioner.~~

7.19 Subd. 4. **Monitoring of reserves.** (a) The commissioners of health and commerce
 7.20 shall monitor health plan company reserves and net worth as established under chapters
 7.21 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each
 7.22 commissioner respectively regulates to assess the degree to which savings resulting from
 7.23 the establishment of cost containment goals are passed on to consumers in the form of
 7.24 lower premium rates.

7.25 (b) Health plan companies shall fully reflect in the premium rates the savings
 7.26 generated by the cost containment goals. No premium rate, currently reviewed by the
 7.27 Department of Health or Commerce, may be approved for those health plan companies
 7.28 unless the health plan company establishes to the satisfaction of the commissioner of
 7.29 commerce or the commissioner of health, as appropriate, that the proposed new rate
 7.30 would comply with this paragraph.

7.31 (c) Health plan companies, except those licensed under chapter 60A to sell accident
 7.32 and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal
 7.33 quarter provide to the commissioner of health or commerce, as applicable, a projection of
 7.34 the level of reserves the company expects to attain during each quarter of the following
 7.35 fiscal year. These health plan companies shall submit with required quarterly financial
 7.36 statements a calculation of the actual reserve level attained by the company at the end

8.1 of each quarter including identification of the sources of any significant changes in the
 8.2 reserve level and an updated projection of the level of reserves the health plan company
 8.3 expects to attain by the end of the fiscal year. In cases where the health plan company has
 8.4 been given a certificate to operate a new health maintenance organization under chapter
 8.5 62D, or been licensed as a community integrated service network under chapter 62N, or
 8.6 formed an affiliation with one of these organizations, the health plan company shall also
 8.7 submit with its quarterly financial statement, total enrollment at the beginning and end of
 8.8 the quarter and enrollment changes within each service area of the new organization. The
 8.9 reserve calculations shall be maintained by the commissioners as trade secret information,
 8.10 except to the extent that such information is also required to be filed by another provision
 8.11 of state law and is not treated as trade secret information under such other provisions.

8.12 (d) Health plan companies in paragraph (c) whose reserves are less than the required
 8.13 minimum or more than the required maximum at the end of the fiscal year shall submit a
 8.14 plan of corrective action to the commissioner of health or commerce under subdivision 7.

8.15 (e) The commissioner of commerce, in consultation with the commissioner of health,
 8.16 shall report to the legislature no later than January 15, 1995, as to whether the concept of
 8.17 a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable
 8.18 for use with indemnity health insurers that do business in multiple states and that must
 8.19 comply with their domiciliary state's reserves requirements.

8.20 Subd. 5. **Notice.** The commissioner of health shall publish in the State Register
 8.21 and make available to the public by July 1, ~~1995~~ 2009, and each year thereafter, a list
 8.22 of all health plan companies that exceeded their ~~cost containment goal~~ health care
 8.23 expenditure limit for the ~~1994~~ previous calendar year. ~~The commissioner shall publish~~
 8.24 ~~in the State Register and make available to the public by July 1, 1996, a list of all health~~
 8.25 ~~plan companies that exceeded their combined cost containment goal for calendar years~~
 8.26 ~~1994 and 1995.~~ The commissioner shall notify each health plan company that the
 8.27 commissioner has determined that the health plan company exceeded its ~~cost containment~~
 8.28 ~~goal~~, health care expenditure limit at least 30 days before publishing the list, and shall
 8.29 provide each health plan company ~~with~~ ten days to provide an explanation for exceeding
 8.30 the ~~cost containment goal~~ health care expenditure limit. The commissioner shall review
 8.31 the explanation and may change a determination if the commissioner determines the
 8.32 explanation to be valid.

8.33 Subd. 6. **Assistance by the commissioner of commerce.** The commissioner of
 8.34 commerce shall provide assistance to the commissioner of health in monitoring health
 8.35 plan companies regulated by the commissioner of commerce.

9.1 Sec. 6. Minnesota Statutes 2006, section 62J.301, subdivision 3, is amended to read:

9.2 Subd. 3. **General duties.** The commissioner shall:

9.3 (1) collect and maintain data which enable population-based monitoring and trending
9.4 of the access, utilization, quality, and cost of health care services within Minnesota;

9.5 (2) collect and maintain data for the purpose of estimating total Minnesota health
9.6 care expenditures and trends;

9.7 (3) collect and maintain data for the purposes of setting cost containment goals and
9.8 premium growth limits under section 62J.04, and measuring cost containment goal and
9.9 premium growth limit compliance;

9.10 (4) conduct applied research using existing and new data and promote applications
9.11 based on existing research;

9.12 (5) develop and implement data collection procedures to ensure a high level of
9.13 cooperation from health care providers and health plan companies, as defined in section
9.14 62Q.01, subdivision 4;

9.15 (6) work closely with health plan companies and health care providers to promote
9.16 improvements in health care efficiency and effectiveness; and

9.17 (7) participate as a partner or sponsor of private sector initiatives that promote
9.18 publicly disseminated applied research on health care delivery, outcomes, costs, quality,
9.19 and management.

9.20 Sec. 7. Minnesota Statutes 2006, section 62J.38, is amended to read:

9.21 **62J.38 COST CONTAINMENT DATA FROM GROUP PURCHASERS.**

9.22 (a) The commissioner shall require group purchasers to submit detailed data on total
9.23 health care spending for each calendar year. Group purchasers shall submit data for the
9.24 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the
9.25 preceding calendar year.

9.26 (b) The commissioner shall require each group purchaser to submit data on revenue,
9.27 expenses, and member months, as applicable. Revenue data must distinguish between
9.28 premium revenue and revenue from other sources and must also include information
9.29 on the amount of revenue in reserves and changes in reserves. Premium revenue data,
9.30 information on aggregate enrollment, and data on member months must be broken down
9.31 to distinguish between individual market, small group market, and large group market.
9.32 Filings under this section for calendar year 2008 must also include information broken
9.33 down by individual market, small group market, and large group market for calendar year
9.34 2007. Expenditure data must distinguish between costs incurred for patient care and
9.35 administrative costs. Patient care and administrative costs must include only expenses

10.1 incurred on behalf of health plan members and must not include the cost of providing
10.2 health care services for nonmembers at facilities owned by the group purchaser or affiliate.
10.3 Expenditure data must be provided separately for the following categories and for other
10.4 categories required by the commissioner: physician services, dental services, other
10.5 professional services, inpatient hospital services, outpatient hospital services, emergency,
10.6 pharmacy services and other nondurable medical goods, mental health, and chemical
10.7 dependency services, other expenditures, subscriber liability, and administrative costs.
10.8 Administrative costs must include costs for marketing; advertising; overhead; salaries
10.9 and benefits of central office staff who do not provide direct patient care; underwriting;
10.10 lobbying; claims processing; provider contracting and credentialing; detection and
10.11 prevention of payment for fraudulent or unjustified requests for reimbursement or
10.12 services; clinical quality assurance and other types of medical care quality improvement
10.13 efforts; concurrent or prospective utilization review as defined in section 62M.02; costs
10.14 incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital
10.15 costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred
10.16 pursuant to a partnership, joint venture, integration, or affiliation agreement with a
10.17 hospital, clinic, or other health care provider. Capital costs and costs incurred must be
10.18 recorded according to standard accounting principles. The reports of this data must also
10.19 separately identify expenses for local, state, and federal taxes, fees, and assessments. The
10.20 commissioner may require each group purchaser to submit any other data, including data
10.21 in unaggregated form, for the purposes of developing spending estimates, setting spending
10.22 limits, and monitoring actual spending and costs. In addition to reporting administrative
10.23 costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or
10.24 any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation
10.25 agreement with a hospital, clinic, or other health care provider; reports submitted under
10.26 this section also must include the payments made during the calendar year for these
10.27 purposes. The commissioner shall make public, by group purchaser data collected under
10.28 this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation
10.29 insurance plans and automobile insurance plans are exempt from complying with this
10.30 paragraph as it relates to the submission of administrative costs.

10.31 (c) The commissioner may collect information on:

10.32 (1) premiums, benefit levels, managed care procedures, and other features of health
10.33 plan companies;

10.34 (2) prices, provider experience, and other information for services less commonly
10.35 covered by insurance or for which patients commonly face significant out-of-pocket
10.36 expenses; and

11.1 (3) information on health care services not provided through health plan companies,
11.2 including information on prices, costs, expenditures, and utilization.

11.3 (d) All group purchasers shall provide the required data using a uniform format and
11.4 uniform definitions, as prescribed by the commissioner.

11.5 Sec. 8. Minnesota Statutes 2006, section 62J.495, is amended to read:

11.6 **62J.495 HEALTH INFORMATION TECHNOLOGY AND**
11.7 **INFRASTRUCTURE ~~ADVISORY COMMITTEE~~.**

11.8 Subdivision 1. **Implementation.** By January 1, 2015, all hospitals and health care
11.9 providers must have in place an interoperable electronic health records system within their
11.10 hospital system or clinical practice setting. The commissioner of health, in consultation
11.11 with the Health Information Technology and Infrastructure Advisory Committee, shall
11.12 develop a statewide plan to meet this goal, including uniform standards to be used for
11.13 the interoperable system for sharing and synchronizing patient data across systems.
11.14 The standards must be compatible with federal efforts. The uniform standards must be
11.15 developed by January 1, 2009, with a status report on the development of these standards
11.16 submitted to the legislature by January 15, 2008.

11.17 Subd. 2. ~~Establishment; members; duties~~ **Health Information Technology and**
11.18 **Infrastructure Advisory Committee.** (a) The commissioner shall establish a Health
11.19 Information Technology and Infrastructure Advisory Committee governed by section
11.20 15.059 to advise the commissioner on the following matters:

11.21 (1) assessment of the use of health information technology by the state, licensed
11.22 health care providers and facilities, and local public health agencies;

11.23 (2) recommendations for implementing a statewide interoperable health information
11.24 infrastructure, to include estimates of necessary resources, and for determining standards
11.25 for administrative data exchange, clinical support programs, patient privacy requirements,
11.26 and maintenance of the security and confidentiality of individual patient data; and

11.27 (3) other related issues as requested by the commissioner.

11.28 (b) The members of the Health Information Technology and Infrastructure Advisory
11.29 Committee shall include the commissioners, or commissioners' designees, of health,
11.30 human services, administration, and commerce and additional members to be appointed
11.31 by the commissioner to include persons representing Minnesota's local public health
11.32 agencies, licensed hospitals and other licensed facilities and providers, private purchasers,
11.33 the medical and nursing professions, health insurers and health plans, the state quality
11.34 improvement organization, academic and research institutions, consumer advisory
11.35 organizations with an interest and expertise in health information technology, and other

12.1 stakeholders as identified by the Health Information Technology and Infrastructure
12.2 Advisory Committee.

12.3 ~~Subd. 2. Annual report.~~ (c) The commissioner shall prepare and issue an annual
12.4 report not later than January 30 of each year outlining progress to date in implementing a
12.5 statewide health information infrastructure and recommending future projects.

12.6 ~~Subd. 3. Expiration.~~ (d) Notwithstanding section 15.059, this ~~section~~ subdivision
12.7 expires June 30, ~~2009~~ 2015.

12.8 Sec. 9. Minnesota Statutes 2006, section 62L.02, subdivision 11, is amended to read:

12.9 Subd. 11. **Dependent.** "Dependent" means an eligible employee's spouse,
12.10 unmarried child who is ~~under the age of 19 years, unmarried child~~ under the age of 25
12.11 years ~~who is a full-time student as defined in section 62A.301~~ regardless of whether
12.12 the dependent child is enrolled in an educational institution, dependent child of any age
12.13 who is disabled and who meets the eligibility criteria in section 62A.14, subdivision 2,
12.14 or any other person whom state or federal law requires to be treated as a dependent for
12.15 purposes of health plans. For the purpose of this definition, a child includes a child for
12.16 whom the employee or the employee's spouse has been appointed legal guardian and an
12.17 adoptive child as provided in section 62A.27.

12.18 **EFFECTIVE DATE.** This section is effective January 1, 2008.

12.19 Sec. 10. Minnesota Statutes 2006, section 62L.08, subdivision 8, is amended to read:

12.20 Subd. 8. **Filing requirement.** (a) A health carrier that offers, sells, issues, or renews
12.21 a health benefit plan for small employers shall file with the commissioner the index rates
12.22 and must demonstrate that all rates shall be within the rating restrictions defined in this
12.23 chapter. Such demonstration must include the allowable range of rates from the index rates
12.24 and a description of how the health carrier intends to use demographic factors including
12.25 case characteristics in calculating the premium rates.

12.26 (b) Notwithstanding paragraph (a), the rates shall not be approved; unless the
12.27 commissioner has determined that the rates are reasonable. In determining reasonableness,
12.28 the commissioner shall consider the growth rates applied under section 62J.04, subdivision
12.29 1, paragraph (b) apply the premium growth limits established under section 62J.04,
12.30 subdivision 1b, to the calendar year or years that the proposed premium rate would be
12.31 in effect, and shall consider actuarially valid changes in risk associated with the enrollee
12.32 population, and actuarially valid changes as a result of statutory changes in Laws 1992,
12.33 chapter 549.

13.1 Sec. 11. Minnesota Statutes 2006, section 62Q.165, subdivision 1, is amended to read:

13.2 Subdivision 1. **Definition.** It is the commitment of the state to achieve universal
13.3 health coverage for all Minnesotans by the year 2010. Universal coverage is achieved
13.4 when:

13.5 (1) every Minnesotan has access to a full range of quality health care services;

13.6 (2) every Minnesotan is able to obtain affordable health coverage which pays for the
13.7 full range of services, including preventive and primary care; and

13.8 (3) every Minnesotan pays into the health care system according to that person's
13.9 ability.

13.10 Sec. 12. Minnesota Statutes 2006, section 62Q.165, subdivision 2, is amended to read:

13.11 Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward
13.12 reducing the number of Minnesotans who do not have health coverage so that by January
13.13 1, ~~2000~~ 2010, ~~fewer than four percent of the state's population will be without health~~
13.14 ~~coverage~~ all Minnesota residents have access to affordable health care. The goal will be
13.15 achieved by improving access to private health coverage through insurance reforms and
13.16 market reforms, by making health coverage more affordable for low-income Minnesotans
13.17 through purchasing pools and state subsidies, and by reducing the cost of health coverage
13.18 through cost containment programs and methods of ensuring that all Minnesotans are
13.19 paying into the system according to their ability.

13.20 **EFFECTIVE DATE.** This section is effective July 1, 2007.

13.21 Sec. 13. Minnesota Statutes 2006, section 62Q.165, is amended by adding a
13.22 subdivision to read:

13.23 Subd. 4. **Legislative Commission on Health Care Access.** The Legislative
13.24 Commission on Health Care Access established under section 62J.07 shall make
13.25 recommendations on how to achieve the goal described in subdivision 2. The
13.26 recommendations shall include a timetable in which measurable progress must be
13.27 achieved toward this goal. The commission, with the assistance of the commissioners of
13.28 human services, health, and commerce, shall submit to the legislature by January 15,
13.29 2008, the recommendations and corresponding timetable.

13.30 **EFFECTIVE DATE.** This section is effective July 1, 2007.

13.31 Sec. 14. Minnesota Statutes 2006, section 256.01, subdivision 2b, is amended to read:

14.1 Subd. 2b. **Performance payments.** (a) The commissioner shall develop and
 14.2 implement a pay-for-performance system to provide performance payments to medical
 14.3 groups that demonstrate optimum care in serving individuals with chronic diseases who
 14.4 are enrolled in health care programs administered by the commissioner under chapters
 14.5 256B, 256D, and 256L.

14.6 (b) The commissioner shall also develop and implement a patient incentive health
 14.7 program to provide incentives and rewards to patients who are enrolled in health care
 14.8 programs administered by the commissioner under chapters 256B, 256D, and 256L and
 14.9 who have agreed to and met personal health goals established with their primary care
 14.10 provider to manage a chronic disease or condition, including, but not limited to, diabetes,
 14.11 high blood pressure, and coronary artery disease.

14.12 Sec. 15. **[256.9545] PRESCRIPTION DRUG DISCOUNT PROGRAM.**

14.13 Subdivision 1. **Establishment; administration.** The commissioner shall establish
 14.14 and administer the prescription drug discount program.

14.15 Subd. 2. **Commissioner's authority.** The commissioner shall administer a drug
 14.16 rebate program for drugs purchased according to the prescription drug discount program.
 14.17 The commissioner shall execute a rebate agreement from all manufacturers that choose to
 14.18 participate in the program for those drugs covered under the medical assistance program.
 14.19 For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes
 14.20 of the federal rebate program in United States Code, title 42, section 1396r-8. The
 14.21 rebate program shall utilize the terms and conditions used for the federal rebate program
 14.22 established according to section 1927 of title XIX of the federal Social Security Act.

14.23 Subd. 3. **Definitions.** For purposes of this section, the following terms have the
 14.24 meanings given them.

14.25 (a) "Commissioner" means the commissioner of human services.

14.26 (b) "Covered prescription drug" means a prescription drug as defined in section
 14.27 151.44, paragraph (d), that is covered under medical assistance as described in section
 14.28 256B.0625, subdivision 13, and that is provided by a participating manufacturer that has a
 14.29 fully executed rebate agreement with the commissioner under this section and complies
 14.30 with that agreement.

14.31 (c) "Enrolled individual" means a person who is eligible for the program under
 14.32 subdivision 4 and has enrolled in the program according to subdivision 5.

14.33 (d) "Health carrier" means an insurance company licensed under chapter 60A to
 14.34 offer, sell, or issue an individual or group policy of accident and sickness insurance as
 14.35 defined in section 62A.01; a nonprofit health service plan corporation operating under

15.1 chapter 62C; a health maintenance organization operating under chapter 62D; a joint
 15.2 self-insurance employee health plan operating under chapter 62H; a community integrated
 15.3 service network licensed under chapter 62N; a fraternal benefit society operating under
 15.4 chapter 64B; a city, county, school district, or other political subdivision providing
 15.5 self-insured health coverage under section 471.617 or sections 471.98 to 471.982; and a
 15.6 self-funded health plan under the Employee Retirement Income Security Act of 1974, as
 15.7 amended.

15.8 (e) "Participating manufacturer" means a manufacturer as defined in section 151.44,
 15.9 paragraph (c), that agrees to participate in the prescription drug discount program.

15.10 (f) "Participating pharmacy" means a pharmacy as defined in section 151.01,
 15.11 subdivision 2, that agrees to participate in the prescription drug discount program.

15.12 Subd. 4. **Eligibility.** (a) To be eligible for the program, an applicant must:

15.13 (1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision
 15.14 4;

15.15 (2) not be enrolled in medical assistance, general assistance medical care, or
 15.16 MinnesotaCare;

15.17 (3) not be enrolled in and have currently available prescription drug coverage under
 15.18 a health plan offered by a health carrier or employer or under a pharmacy benefit program
 15.19 offered by a pharmaceutical manufacturer; and

15.20 (4) not be enrolled in and have currently available prescription drug coverage
 15.21 under a Medicare supplement policy, as defined in sections 62A.31 to 62A.44, or
 15.22 policies, contracts, or certificates that supplement Medicare issued by health maintenance
 15.23 organizations or those policies, contracts, or certificates governed by section 1833 or 1876
 15.24 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as
 15.25 amended.

15.26 (b) Notwithstanding paragraph (a), clause (3), an individual who is enrolled in a
 15.27 Medicare Part D prescription drug plan or Medicare Advantage plan is eligible for the
 15.28 program but only for drugs that are not covered under the Medicare Part D plan or for
 15.29 drugs that are covered under the plan, but according to the conditions of the plan, the
 15.30 individual is responsible for 100 percent of the cost of the prescription drug.

15.31 Subd. 5. **Application procedure.** (a) Applications and information on the program
 15.32 must be made available at county social services agencies, health care provider offices, and
 15.33 agencies and organizations serving senior citizens. Individuals shall submit applications
 15.34 and any information specified by the commissioner as being necessary to verify eligibility
 15.35 directly to the commissioner. The commissioner shall determine an applicant's eligibility
 15.36 for the program within 30 days from the date the application is received. Upon notice of

16.1 approval, the applicant must submit to the commissioner the enrollment fee specified in
16.2 subdivision 10. Eligibility begins the month after the enrollment fee is received by the
16.3 commissioner.

16.4 (b) An enrollee's eligibility must be renewed every 12 months with the 12-month
16.5 period beginning in the month after the application is approved.

16.6 (c) The commissioner shall develop an application form that does not exceed one
16.7 page in length and requires information necessary to determine eligibility for the program.

16.8 Subd. 6. **Participating pharmacy.** (a) Upon implementation of the prescription
16.9 drug discount program, and until January 1, 2009, a participating pharmacy, with a
16.10 valid prescription, must sell a covered prescription drug to an enrolled individual at the
16.11 medical assistance rate.

16.12 (b) After January 1, 2009, a participating pharmacy, with a valid prescription, must
16.13 sell a covered prescription drug to an enrolled individual at the medical assistance rate,
16.14 minus an amount that is equal to the rebate amount described in subdivision 8, plus
16.15 the amount of any switch fee established by the commissioner under subdivision 10,
16.16 paragraph (b).

16.17 (c) Each participating pharmacy shall provide the commissioner with all information
16.18 necessary to administer the program, including, but not limited to, information on
16.19 prescription drug sales to enrolled individuals and usual and customary retail prices.

16.20 Subd. 7. **Notification of rebate amount.** The commissioner shall notify each
16.21 participating manufacturer, each calendar quarter or according to a schedule established
16.22 by the commissioner, of the amount of the rebate owed on the prescription drugs sold by
16.23 participating pharmacies to enrolled individuals.

16.24 Subd. 8. **Provision of rebate.** To the extent that a participating manufacturer's
16.25 prescription drugs are prescribed to a resident of this state, the manufacturer must provide
16.26 a rebate equal to the rebate provided under the medical assistance program for any
16.27 prescription drug distributed by the manufacturer that is purchased at a participating
16.28 pharmacy by an enrolled individual. The participating manufacturer must provide full
16.29 payment within 38 days of receipt of the state invoice for the rebate, or according to
16.30 a schedule to be established by the commissioner. The commissioner shall deposit all
16.31 rebates received into the Minnesota prescription drug dedicated fund established under
16.32 subdivision 11. The manufacturer must provide the commissioner with any information
16.33 necessary to verify the rebate determined per drug.

16.34 Subd. 9. **Payment to pharmacies.** Beginning January 1, 2009, the commissioner
16.35 shall distribute on a biweekly basis an amount that is equal to an amount collected under

17.1 subdivision 8 to each participating pharmacy based on the prescription drugs sold by that
 17.2 pharmacy to enrolled individuals on or after January 1, 2009.

17.3 Subd. 10. **Enrollment fee; switch fee.** (a) The commissioner shall establish an
 17.4 annual enrollment fee that covers the commissioner's expenses for enrollment, processing
 17.5 claims, and distributing rebates under this program.

17.6 (b) The commissioner shall establish a reasonable switch fee that covers expenses
 17.7 incurred by participating pharmacies in formatting for electronic submission claims for
 17.8 prescription drugs sold to enrolled individuals.

17.9 Subd. 11. **Dedicated fund; creation; use of fund.** (a) The Minnesota prescription
 17.10 drug dedicated fund is established as an account in the state treasury. The commissioner
 17.11 of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any
 17.12 federal funds received for the program, all enrollment fees paid by the enrollees, and
 17.13 any appropriations or allocations designated for the fund. The commissioner of finance
 17.14 shall ensure that fund money is invested under section 11A.25. All money earned by the
 17.15 fund must be credited to the fund. The fund shall earn a proportionate share of the total
 17.16 state annual investment income.

17.17 (b) Money in the fund is appropriated to the commissioner to reimburse participating
 17.18 pharmacies for prescription drugs provided to enrolled individuals under subdivision 6,
 17.19 paragraph (b); to reimburse the commissioner for costs related to enrollment, processing
 17.20 claims, distributing rebates, and for other reasonable administrative costs related to
 17.21 administration of the prescription drug discount program; and to repay the appropriation
 17.22 provided by law for this section. The commissioner must administer the program so that
 17.23 the costs total no more than funds appropriated plus the drug rebate proceeds.

17.24 **EFFECTIVE DATE.** This section is effective July 1, 2007.

17.25 Sec. 16. Minnesota Statutes 2006, section 256B.056, subdivision 10, is amended to
 17.26 read:

17.27 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who
 17.28 are applying for the continuation of medical assistance coverage following the end of the
 17.29 60-day postpartum period to update their income and asset information and to submit
 17.30 any required income or asset verification.

17.31 (b) The commissioner shall determine the eligibility of private-sector health care
 17.32 coverage for infants less than one year of age eligible under section 256B.055, subdivision
 17.33 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage
 17.34 if this is determined to be cost-effective.

18.1 ~~(c) The commissioner shall modify the application for Minnesota health care~~
 18.2 ~~programs to require more detailed information related to verification of assets and income;~~
 18.3 ~~and shall verify assets and income for all applicants, and for all recipients upon renewal.~~

18.4 ~~(d) The commissioner shall require Minnesota health care program recipients to~~
 18.5 ~~report new or an increase in earned income within ten days of the change, and to verify new~~
 18.6 ~~or an increase in earned income that affects eligibility within ten days of notification by~~
 18.7 ~~the agency that the new or increased earned income affects eligibility. Recipients who fail~~
 18.8 ~~to verify new or an increase in earned income that affects eligibility shall be disenrolled.~~

18.9 Sec. 17. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
 18.10 subdivision to read:

18.11 Subd. 13i. **Medicare Part D co-payments.** For recipients who are enrolled in a
 18.12 Medicare Part D prescription drug plan or Medicare Advantage plan, medical assistance
 18.13 covers the co-payments which the recipient is responsible for under the Medicare Part D
 18.14 prescription drug plan or Medicare Advantage plan.

18.15 **EFFECTIVE DATE.** This section is effective July 1, 2007.

18.16 Sec. 18. Minnesota Statutes 2006, section 256B.075, subdivision 2, is amended to read:

18.17 **Subd. 2. Fee-for-service.** (a) The commissioner shall develop and implement
 18.18 a disease management program for medical assistance and general assistance medical
 18.19 care recipients who are not enrolled in the prepaid medical assistance or prepaid general
 18.20 assistance medical care programs and who are receiving services on a fee-for-service
 18.21 basis. The commissioner may contract with an outside organization to provide ~~these~~
 18.22 services under this subdivision.

18.23 (b) The commissioner shall seek any federal approval necessary to implement this
 18.24 section and to obtain federal matching funds.

18.25 (c) The commissioner shall develop and implement a pilot intensive care
 18.26 management program for medical assistance children with complex and chronic medical
 18.27 issues who are not able to participate in the metro-based U Special Kids program due
 18.28 to geographic distance.

18.29 (d) The commissioner shall develop and implement an intensive care management
 18.30 pilot program for children, adults, and families who have complex and chronic medical
 18.31 conditions, or who are at high risk of developing them, and who receive their primary
 18.32 care through a federally qualified health center or community clinic. For purposes of
 18.33 this paragraph, "federally qualified health center" means an entity that is receiving a
 18.34 grant under United States Code, title 42, section 254b, or, based on the recommendation

19.1 of the Health Resources and Services Administration within the Public Health Service,
19.2 is determined by the secretary to meet the requirements for receiving such a grant; and
19.3 "community clinic" means a clinic that is not a federally qualified health center, but is
19.4 certified by the Minnesota Department of Health as being eligible to receive a grant under
19.5 section 145.9268.

19.6 **EFFECTIVE DATE.** This section is effective July 1, 2007.

19.7 Sec. 19. Minnesota Statutes 2006, section 256B.76, is amended to read:

19.8 **256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.**

19.9 (a) Effective for services rendered on or after October 1, 1992, the commissioner
19.10 shall make payments for physician services as follows:

19.11 (1) payment for level one Centers for Medicare and Medicaid Services' common
19.12 procedural coding system codes titled "office and other outpatient services," "preventive
19.13 medicine new and established patient," "delivery, antepartum, and postpartum care,"
19.14 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
19.15 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
19.16 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
19.17 30, 1992. If the rate on any procedure code within these categories is different than the
19.18 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
19.19 then the larger rate shall be paid;

19.20 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
19.21 or (ii) 15.4 percent above the rate in effect on June 30, 1992;

19.22 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
19.23 percentile of 1989, less the percent in aggregate necessary to equal the above increases
19.24 except that payment rates for home health agency services shall be the rates in effect
19.25 on September 30, 1992;

19.26 (4) effective for services rendered on or after January 1, 2000, payment rates for
19.27 physician and professional services shall be increased by three percent over the rates in
19.28 effect on December 31, 1999, except for home health agency and family planning agency
19.29 services; and

19.30 (5) the increases in clause (4) shall be implemented January 1, 2000, for managed
19.31 care.

19.32 (b) Effective for services rendered on or after October 1, 1992, the commissioner
19.33 shall make payments for dental services as follows:

20.1 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25
20.2 percent above the rate in effect on June 30, 1992;

20.3 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
20.4 percentile of 1989, less the percent in aggregate necessary to equal the above increases;

20.5 (3) effective for services rendered on or after January 1, 2000, payment rates for
20.6 dental services shall be increased by three percent over the rates in effect on December
20.7 31, 1999;

20.8 (4) the commissioner shall award grants to community clinics or other nonprofit
20.9 community organizations, political subdivisions, professional associations, or other
20.10 organizations that demonstrate the ability to provide dental services effectively to public
20.11 program recipients. Grants may be used to fund the costs related to coordinating access for
20.12 recipients, developing and implementing patient care criteria, upgrading or establishing
20.13 new facilities, acquiring furnishings or equipment, recruiting new providers, or other
20.14 development costs that will improve access to dental care in a region. In awarding grants,
20.15 the commissioner shall give priority to applicants that plan to serve areas of the state in
20.16 which the number of dental providers is not currently sufficient to meet the needs of
20.17 recipients of public programs or uninsured individuals. The commissioner shall consider
20.18 the following in awarding the grants:

20.19 (i) potential to successfully increase access to an underserved population;

20.20 (ii) the ability to raise matching funds;

20.21 (iii) the long-term viability of the project to improve access beyond the period
20.22 of initial funding;

20.23 (iv) the efficiency in the use of the funding; and

20.24 (v) the experience of the proposers in providing services to the target population.

20.25 The commissioner shall monitor the grants and may terminate a grant if the grantee
20.26 does not increase dental access for public program recipients. The commissioner shall
20.27 consider grants for the following:

20.28 (i) implementation of new programs or continued expansion of current access
20.29 programs that have demonstrated success in providing dental services in underserved
20.30 areas;

20.31 (ii) a pilot program for utilizing hygienists outside of a traditional dental office to
20.32 provide dental hygiene services; and

20.33 (iii) a program that organizes a network of volunteer dentists, establishes a system to
20.34 refer eligible individuals to volunteer dentists, and through that network provides donated
20.35 dental care services to public program recipients or uninsured individuals;

21.1 (5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
21.2 shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

21.3 (6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000,
21.4 for managed care; and

21.5 (7) effective for services provided on or after January 1, 2002, payment for
21.6 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
21.7 lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

21.8 (c) Effective for dental services rendered on or after January 1, 2002, the
21.9 commissioner ~~may, within the limits of available appropriation,~~ shall increase
21.10 reimbursements to dentists and dental clinics deemed by the commissioner to be critical
21.11 access dental providers. Reimbursement to a critical access dental provider may be
21.12 increased by not more than 50 percent above the reimbursement rate that would
21.13 otherwise be paid to the provider. Payments to health plan companies shall be adjusted to
21.14 reflect increased reimbursements to critical access dental providers as approved by the
21.15 commissioner. In determining which dentists and dental clinics shall be deemed critical
21.16 access dental providers, the commissioner shall review:

21.17 (1) the utilization rate in the service area in which the dentist or dental clinic operates
21.18 for dental services to patients covered by medical assistance, general assistance medical
21.19 care, or MinnesotaCare as their primary source of coverage;

21.20 (2) the level of services provided by the dentist or dental clinic to patients covered
21.21 by medical assistance, general assistance medical care, or MinnesotaCare as their primary
21.22 source of coverage; and

21.23 (3) whether the level of services provided by the dentist or dental clinic is critical to
21.24 maintaining adequate levels of patient access within the service area.

21.25 In the absence of a critical access dental provider in a service area, the commissioner may
21.26 designate a dentist or dental clinic as a critical access dental provider if the dentist or
21.27 dental clinic is willing to provide care to patients covered by medical assistance, general
21.28 assistance medical care, or MinnesotaCare at a level which significantly increases access
21.29 to dental care in the service area.

21.30 The commissioner shall annually establish a reimbursement schedule for critical
21.31 access dental providers and provider-specific limits on total reimbursement received
21.32 under the reimbursement schedule, and shall notify each critical access dental provider
21.33 of the schedule and limit.

21.34 (d) The commissioner shall award special hardship grants to nonprofit dental
21.35 providers with a high proportion of uninsured patients that equals or exceeds 15 percent
21.36 of the total number of patients served by that provider and the provider does not receive

22.1 a financial benefit comparable to other critical access dental providers under the critical
 22.2 access dental provider formula described in paragraph (c). The commissioner shall award
 22.3 a grant to these providers allocated in proportion to each critical access dental provider's
 22.4 ratio of uninsured patients to the total number of patients served by all providers who
 22.5 qualify for a grant under this paragraph.

22.6 (e) An entity that operates both a Medicare certified comprehensive outpatient
 22.7 rehabilitation facility and a facility which was certified prior to January 1, 1993, that is
 22.8 licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33
 22.9 percent of the clients receiving rehabilitation services in the most recent calendar year are
 22.10 medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation
 22.11 services at rates that are 38 percent greater than the maximum reimbursement rate
 22.12 allowed under paragraph (a), clause (2), when those services are (1) provided within the
 22.13 comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing
 22.14 facilities owned by the entity.

22.15 ~~(e)~~ (f) Effective for services rendered on or after January 1, 2007, the commissioner
 22.16 shall make payments for physician and professional services based on the Medicare
 22.17 relative value units (RVU's). This change shall be budget neutral and the cost of
 22.18 implementing RVU's will be incorporated in the established conversion factor.

22.19 Sec. 20. Minnesota Statutes 2006, section 256D.03, subdivision 3, is amended to read:

22.20 Subd. 3. **General assistance medical care; eligibility.** (a) General assistance
 22.21 medical care may be paid for any person who is not eligible for medical assistance under
 22.22 chapter 256B, including eligibility for medical assistance based on a spenddown of excess
 22.23 income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in
 22.24 paragraph (b), except as provided in paragraph (c), and:

22.25 (1) who is receiving assistance under section 256D.05, except for families with
 22.26 children who are eligible under Minnesota family investment program (MFIP), or who is
 22.27 having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

22.28 (2) who is a resident of Minnesota; and

22.29 (i) who has gross countable income not in excess of 75 percent of the federal poverty
 22.30 guidelines for the family size, using a six-month budget period and whose equity in assets
 22.31 is not in excess of \$1,000 per assistance unit. General assistance medical care is not
 22.32 available for applicants or enrollees who are otherwise eligible for medical assistance but
 22.33 fail to verify their assets. Enrollees who become eligible for medical assistance shall be
 22.34 terminated and transferred to medical assistance. Exempt assets, the reduction of excess
 22.35 assets, and the waiver of excess assets must conform to the medical assistance program in

23.1 section 256B.056, subdivision 3, with the following exception: the maximum amount of
23.2 undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by
23.3 the trustee, assuming the full exercise of the trustee's discretion under the terms of the
23.4 trust, must be applied toward the asset maximum;

23.5 (ii) who has gross countable income above 75 percent of the federal poverty
23.6 guidelines but not in excess of 175 percent of the federal poverty guidelines for the
23.7 family size, using a six-month budget period, whose equity in assets is not in excess
23.8 of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient
23.9 hospitalization; or

23.10 (iii) the commissioner shall adjust the income standards under this section each July
23.11 1 by the annual update of the federal poverty guidelines following publication by the
23.12 United States Department of Health and Human Services.

23.13 (b) Effective for applications and renewals processed on or after September 1, 2006,
23.14 general assistance medical care may not be paid for applicants or recipients who are adults
23.15 with dependent children under 21 whose gross family income is equal to or less than 275
23.16 percent of the federal poverty guidelines who are not described in paragraph (e).

23.17 (c) Effective for applications and renewals processed on or after September 1, 2006,
23.18 general assistance medical care may be paid for applicants and recipients who meet all
23.19 eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period
23.20 beginning the date of application. Immediately following approval of general assistance
23.21 medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04,
23.22 subdivision 7, with covered services as provided in section 256L.03 for the rest of the
23.23 ~~six-month~~ initial eligibility period, until their ~~six-month~~ annual renewal.

23.24 (d) To be eligible for general assistance medical care following enrollment in
23.25 MinnesotaCare as required by paragraph (c), an individual must complete a new
23.26 application.

23.27 (e) Applicants and recipients eligible under paragraph (a), clause (1); who have
23.28 applied for and are awaiting a determination of blindness or disability by the state medical
23.29 review team or a determination of eligibility for Supplemental Security Income or Social
23.30 Security Disability Insurance by the Social Security Administration; who fail to meet the
23.31 requirements of section 256L.09, subdivision 2; who are classified as end-stage renal
23.32 disease beneficiaries in the Medicare program; who are enrolled in private health care
23.33 coverage as defined in section 256B.02, subdivision 9; who are eligible under paragraph
23.34 (j); or who receive treatment funded pursuant to section 254B.02 are exempt from the
23.35 MinnesotaCare enrollment requirements of this subdivision.

24.1 (f) For applications received on or after October 1, 2003, eligibility may begin no
24.2 earlier than the date of application. For individuals eligible under paragraph (a), clause
24.3 (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are
24.4 eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but
24.5 may reapply if there is a subsequent period of inpatient hospitalization.

24.6 (g) Beginning September 1, 2006, Minnesota health care program applications and
24.7 renewals completed by recipients and applicants who are persons described in paragraph
24.8 (c) and submitted to the county agency shall be determined for MinnesotaCare eligibility
24.9 by the county agency. If all other eligibility requirements of this subdivision are met,
24.10 eligibility for general assistance medical care shall be available in any month during which
24.11 MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare,
24.12 notice of termination for eligibility for general assistance medical care shall be sent to
24.13 an applicant or recipient. If all other eligibility requirements of this subdivision are
24.14 met, eligibility for general assistance medical care shall be available until enrollment in
24.15 MinnesotaCare subject to the provisions of paragraphs (c), (e), and (f).

24.16 (h) The date of an initial Minnesota health care program application necessary to
24.17 begin a determination of eligibility shall be the date the applicant has provided a name,
24.18 address, and Social Security number, signed and dated, to the county agency or the
24.19 Department of Human Services. If the applicant is unable to provide a name, address,
24.20 Social Security number, and signature when health care is delivered due to a medical
24.21 condition or disability, a health care provider may act on an applicant's behalf to establish
24.22 the date of an initial Minnesota health care program application by providing the county
24.23 agency or Department of Human Services with provider identification and a temporary
24.24 unique identifier for the applicant. The applicant must complete the remainder of the
24.25 application and provide necessary verification before eligibility can be determined. The
24.26 county agency must assist the applicant in obtaining verification if necessary.

24.27 (i) County agencies are authorized to use all automated databases containing
24.28 information regarding recipients' or applicants' income in order to determine eligibility for
24.29 general assistance medical care or MinnesotaCare. Such use shall be considered sufficient
24.30 in order to determine eligibility and premium payments by the county agency.

24.31 (j) General assistance medical care is not available for a person in a correctional
24.32 facility unless the person is detained by law for less than one year in a county correctional
24.33 or detention facility as a person accused or convicted of a crime, or admitted as an
24.34 inpatient to a hospital on a criminal hold order, and the person is a recipient of general
24.35 assistance medical care at the time the person is detained by law or admitted on a criminal

25.1 hold order and as long as the person continues to meet other eligibility requirements
25.2 of this subdivision.

25.3 (k) General assistance medical care is not available for applicants or recipients who
25.4 do not cooperate with the county agency to meet the requirements of medical assistance.

25.5 (l) In determining the amount of assets of an individual eligible under paragraph
25.6 (a), clause (2), item (i), there shall be included any asset or interest in an asset, including
25.7 an asset excluded under paragraph (a), that was given away, sold, or disposed of for
25.8 less than fair market value within the 60 months preceding application for general
25.9 assistance medical care or during the period of eligibility. Any transfer described in this
25.10 paragraph shall be presumed to have been for the purpose of establishing eligibility for
25.11 general assistance medical care, unless the individual furnishes convincing evidence to
25.12 establish that the transaction was exclusively for another purpose. For purposes of this
25.13 paragraph, the value of the asset or interest shall be the fair market value at the time it
25.14 was given away, sold, or disposed of, less the amount of compensation received. For any
25.15 uncompensated transfer, the number of months of ineligibility, including partial months,
25.16 shall be calculated by dividing the uncompensated transfer amount by the average monthly
25.17 per person payment made by the medical assistance program to skilled nursing facilities
25.18 for the previous calendar year. The individual shall remain ineligible until this fixed period
25.19 has expired. The period of ineligibility may exceed 30 months, and a reapplication for
25.20 benefits after 30 months from the date of the transfer shall not result in eligibility unless
25.21 and until the period of ineligibility has expired. The period of ineligibility begins in the
25.22 month the transfer was reported to the county agency, or if the transfer was not reported,
25.23 the month in which the county agency discovered the transfer, whichever comes first. For
25.24 applicants, the period of ineligibility begins on the date of the first approved application.

25.25 (m) When determining eligibility for any state benefits under this subdivision,
25.26 the income and resources of all noncitizens shall be deemed to include their sponsor's
25.27 income and resources as defined in the Personal Responsibility and Work Opportunity
25.28 Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and
25.29 subsequently set out in federal rules.

25.30 (n) Undocumented noncitizens and nonimmigrants are ineligible for general
25.31 assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual
25.32 in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and
25.33 an undocumented noncitizen is an individual who resides in the United States without the
25.34 approval or acquiescence of the Immigration and Naturalization Service.

26.1 (o) Notwithstanding any other provision of law, a noncitizen who is ineligible for
26.2 medical assistance due to the deeming of a sponsor's income and resources, is ineligible
26.3 for general assistance medical care.

26.4 (p) Effective July 1, 2003, general assistance medical care emergency services end.

26.5 Sec. 21. Minnesota Statutes 2006, section 256D.03, subdivision 4, is amended to read:

26.6 Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is
26.7 eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical
26.8 care covers, except as provided in paragraph (c):

26.9 (1) inpatient hospital services;

26.10 (2) outpatient hospital services;

26.11 (3) services provided by Medicare certified rehabilitation agencies;

26.12 (4) prescription drugs and other products recommended through the process
26.13 established in section 256B.0625, subdivision 13;

26.14 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
26.15 for diabetics to monitor blood sugar level;

26.16 (6) eyeglasses and eye examinations provided by a physician or optometrist;

26.17 (7) hearing aids;

26.18 (8) prosthetic devices;

26.19 (9) laboratory and X-ray services;

26.20 (10) physician's services;

26.21 (11) medical transportation except special transportation;

26.22 (12) chiropractic services as covered under the medical assistance program;

26.23 (13) podiatric services;

26.24 (14) dental services as covered under the medical assistance program;

26.25 (15) outpatient services provided by a mental health center or clinic that is under
26.26 contract with the county board and is established under section 245.62;

26.27 (16) day treatment services for mental illness provided under contract with the
26.28 county board;

26.29 (17) prescribed medications for persons who have been diagnosed as mentally ill as
26.30 necessary to prevent more restrictive institutionalization;

26.31 (18) psychological services, medical supplies and equipment, and Medicare
26.32 premiums, coinsurance and deductible payments;

26.33 (19) medical equipment not specifically listed in this paragraph when the use of
26.34 the equipment will prevent the need for costlier services that are reimbursable under
26.35 this subdivision;

27.1 (20) services performed by a certified pediatric nurse practitioner, a certified family
27.2 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
27.3 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
27.4 practitioner in independent practice, if (1) the service is otherwise covered under this
27.5 chapter as a physician service, (2) the service provided on an inpatient basis is not included
27.6 as part of the cost for inpatient services included in the operating payment rate, and (3) the
27.7 service is within the scope of practice of the nurse practitioner's license as a registered
27.8 nurse, as defined in section 148.171;

27.9 (21) services of a certified public health nurse or a registered nurse practicing in
27.10 a public health nursing clinic that is a department of, or that operates under the direct
27.11 authority of, a unit of government, if the service is within the scope of practice of the
27.12 public health nurse's license as a registered nurse, as defined in section 148.171;

27.13 (22) telemedicine consultations, to the extent they are covered under section
27.14 256B.0625, subdivision 3b; and

27.15 (23) mental health telemedicine and psychiatric consultation as covered under
27.16 section 256B.0625, subdivisions 46 and 48.

27.17 (ii) Effective October 1, 2003, for a person who is eligible under subdivision 3,
27.18 paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited
27.19 to inpatient hospital services, including physician services provided during the inpatient
27.20 hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

27.21 (b) Effective August 1, 2005, sex reassignment surgery is not covered under this
27.22 subdivision.

27.23 (c) In order to contain costs, the commissioner of human services shall select
27.24 vendors of medical care who can provide the most economical care consistent with high
27.25 medical standards and shall where possible contract with organizations on a prepaid
27.26 capitation basis to provide these services. The commissioner shall consider proposals by
27.27 counties and vendors for prepaid health plans, competitive bidding programs, block grants,
27.28 or other vendor payment mechanisms designed to provide services in an economical
27.29 manner or to control utilization, with safeguards to ensure that necessary services are
27.30 provided. Before implementing prepaid programs in counties with a county operated or
27.31 affiliated public teaching hospital or a hospital or clinic operated by the University of
27.32 Minnesota, the commissioner shall consider the risks the prepaid program creates for the
27.33 hospital and allow the county or hospital the opportunity to participate in the program in a
27.34 manner that reflects the risk of adverse selection and the nature of the patients served by
27.35 the hospital, provided the terms of participation in the program are competitive with the
27.36 terms of other participants considering the nature of the population served. Payment for

28.1 services provided pursuant to this subdivision shall be as provided to medical assistance
 28.2 vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For
 28.3 payments made during fiscal year 1990 and later years, the commissioner shall consult
 28.4 with an independent actuary in establishing prepayment rates, but shall retain final control
 28.5 over the rate methodology.

28.6 ~~(d) Recipients eligible under subdivision 3, paragraph (a), shall pay the following~~
 28.7 ~~co-payments for services provided on or after October 1, 2003:~~

28.8 ~~(1) \$25 for eyeglasses;~~

28.9 ~~(2) \$25 for nonemergency visits to a hospital-based emergency room;~~

28.10 ~~(3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,~~
 28.11 ~~subject to a \$12 per month maximum for prescription drug co-payments. No co-payments~~
 28.12 ~~shall apply to antipsychotic drugs when used for the treatment of mental illness; and~~

28.13 ~~(4) 50 percent coinsurance on restorative dental services.~~

28.14 ~~(e) Co-payments shall be limited to one per day per provider for nonpreventive visits,~~
 28.15 ~~eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of~~
 28.16 ~~general assistance medical care are responsible for all co-payments in this subdivision.~~
 28.17 ~~The general assistance medical care reimbursement to the provider shall be reduced by~~
 28.18 ~~the amount of the co-payment, except that reimbursement for prescription drugs shall not~~
 28.19 ~~be reduced once a recipient has reached the \$12 per month maximum for prescription~~
 28.20 ~~drug co-payments. The provider collects the co-payment from the recipient. Providers~~
 28.21 ~~may not deny services to recipients who are unable to pay the co-payment, except as~~
 28.22 ~~provided in paragraph (f).~~

28.23 ~~(f) If it is the routine business practice of a provider to refuse service to an individual~~
 28.24 ~~with uncollected debt, the provider may include uncollected co-payments under this~~
 28.25 ~~section. A provider must give advance notice to a recipient with uncollected debt before~~
 28.26 ~~services can be denied.~~

28.27 ~~(g) (d)~~ Any county may, from its own resources, provide medical payments for
 28.28 which state payments are not made.

28.29 ~~(h) (e)~~ Chemical dependency services that are reimbursed under chapter 254B must
 28.30 not be reimbursed under general assistance medical care.

28.31 ~~(i) (f)~~ The maximum payment for new vendors enrolled in the general assistance
 28.32 medical care program after the base year shall be determined from the average usual and
 28.33 customary charge of the same vendor type enrolled in the base year.

28.34 ~~(j) (g)~~ The conditions of payment for services under this subdivision are the same
 28.35 as the conditions specified in rules adopted under chapter 256B governing the medical
 28.36 assistance program, unless otherwise provided by statute or rule.

29.1 ~~(k)~~ (h) Inpatient and outpatient payments shall be reduced by five percent, effective
 29.2 July 1, 2003. This reduction is in addition to the five percent reduction effective July 1,
 29.3 2003, and incorporated by reference in paragraph ~~(i)~~ (f).

29.4 ~~(l)~~ (i) Payments for all other health services except inpatient, outpatient, and
 29.5 pharmacy services shall be reduced by five percent, effective July 1, 2003.

29.6 ~~(m)~~ (j) Payments to managed care plans shall be reduced by five percent for services
 29.7 provided on or after October 1, 2003.

29.8 ~~(n)~~ (k) A hospital receiving a reduced payment as a result of this section may apply
 29.9 the unpaid balance toward satisfaction of the hospital's bad debts.

29.10 ~~(o) Fee-for-service payments for nonpreventive visits shall be reduced by \$3~~
 29.11 ~~for services provided on or after January 1, 2006. For purposes of this subdivision, a~~
 29.12 ~~visit means an episode of service which is required because of a recipient's symptoms,~~
 29.13 ~~diagnosis, or established illness, and which is delivered in an ambulatory setting by~~
 29.14 ~~a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse,~~
 29.15 ~~audiologist, optician, or optometrist.~~

29.16 ~~(p) Payments to managed care plans shall not be increased as a result of the removal~~
 29.17 ~~of the \$3 nonpreventive visit co-payment effective January 1, 2006.~~

29.18 **EFFECTIVE DATE.** This section is effective July 1, 2007.

29.19 Sec. 22. Minnesota Statutes 2006, section 256L.01, subdivision 4, is amended to read:

29.20 Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross
 29.21 family income" for nonfarm self-employed means income calculated for the ~~six-month~~
 29.22 12-month period of eligibility using the net profit or loss reported on the applicant's
 29.23 federal income tax form for the previous year and using the medical assistance families
 29.24 with children methodology for determining allowable and nonallowable self-employment
 29.25 expenses and countable income.

29.26 (b) "Gross individual or gross family income" for farm self-employed means income
 29.27 calculated for the ~~six-month~~ 12-month period of eligibility using as the baseline the
 29.28 adjusted gross income reported on the applicant's federal income tax form for the previous
 29.29 year ~~and adding back in reported depreciation amounts that apply to the business in which~~
 29.30 ~~the family is currently engaged.~~

29.31 (c) "Gross individual or gross family income" means the total income for all family
 29.32 members, calculated for the ~~six-month~~ 12-month period of eligibility.

29.33 **EFFECTIVE DATE.** This section is effective July 1, 2007.

30.1 Sec. 23. Minnesota Statutes 2006, section 256L.03, subdivision 1, is amended to read:

30.2 Subdivision 1. **Covered health services.** ~~For individuals under section 256L.04,~~
 30.3 ~~subdivision 7, with income no greater than 75 percent of the federal poverty guidelines~~
 30.4 ~~or for families with children under section 256L.04, subdivision 1, all subdivisions of~~
 30.5 ~~this section apply.~~ "Covered health services" means the health services reimbursed
 30.6 under chapter 256B, with the exception of inpatient hospital services, special education
 30.7 services, private duty nursing services, adult dental care services other than services
 30.8 covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency
 30.9 medical transportation services, personal care assistant and case management services,
 30.10 nursing home or intermediate care facilities services, inpatient mental health services,
 30.11 and chemical dependency services. Outpatient mental health services covered under the
 30.12 MinnesotaCare program are limited to diagnostic assessments, psychological testing,
 30.13 explanation of findings, mental health telemedicine, psychiatric consultation, medication
 30.14 management by a physician, day treatment, partial hospitalization, and individual, family,
 30.15 and group psychotherapy.

30.16 No public funds shall be used for coverage of abortion under MinnesotaCare
 30.17 except where the life of the female would be endangered or substantial and irreversible
 30.18 impairment of a major bodily function would result if the fetus were carried to term; or
 30.19 where the pregnancy is the result of rape or incest.

30.20 Covered health services shall be expanded as provided in this section.

30.21 Sec. 24. Minnesota Statutes 2006, section 256L.03, subdivision 3, is amended to read:

30.22 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include
 30.23 inpatient hospital services, including inpatient hospital mental health services and inpatient
 30.24 hospital and residential chemical dependency treatment, subject to those limitations
 30.25 necessary to coordinate the provision of these services with eligibility under the medical
 30.26 assistance spenddown. ~~Prior to July 1, 1997, the inpatient hospital benefit for adult~~
 30.27 ~~enrollees is subject to an annual benefit limit of \$10,000.~~ The inpatient hospital benefit for
 30.28 adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under
 30.29 section 256L.04, subdivisions 1 and 2, with family gross income that exceeds ~~175~~ 200
 30.30 percent of the federal poverty guidelines and who are not pregnant, is subject to an annual
 30.31 limit of ~~\$10,000~~ \$20,000.

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

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

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

31.7 Sec. 25. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:

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

31.11 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
31.12 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and
31.13 \$3,000 per family;

31.14 (2) \$3 per prescription for adult enrollees;

31.15 (3) \$25 for eyeglasses for adult enrollees;

31.16 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
31.17 episode of service which is required because of a recipient's symptoms, diagnosis, or
31.18 established illness, and which is delivered in an ambulatory setting by a physician or
31.19 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
31.20 audiologist, optician, or optometrist; and

31.21 (5) \$6 for nonemergency visits to a hospital-based emergency room.

31.22 (b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of
31.23 children under the age of 21 ~~in households with family income equal to or less than 175~~
31.24 ~~percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to~~
31.25 ~~parents and relative caretakers of children under the age of 21 in households with family~~
31.26 ~~income greater than 175 percent of the federal poverty guidelines for inpatient hospital~~
31.27 ~~admissions occurring on or after January 1, 2001.~~

31.28 (c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children
31.29 under the age of 21.

31.30 (d) Adult enrollees with family gross income that exceeds ~~175~~ 200 percent of the
31.31 federal poverty guidelines and who are not pregnant shall be financially responsible for
31.32 the coinsurance amount, if applicable, and amounts which exceed the ~~\$10,000~~ \$20,000
31.33 inpatient hospital benefit limit.

31.34 (e) When a MinnesotaCare enrollee becomes a member of a prepaid health
31.35 plan, or changes from one prepaid health plan to another during a calendar year, any

32.1 charges submitted towards the ~~\$10,000~~ \$20,000 annual inpatient benefit limit, and any
 32.2 out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted
 32.3 or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

32.4 Sec. 26. Minnesota Statutes 2006, section 256L.04, subdivision 1a, is amended to read:

32.5 Subd. 1a. **Social Security number required.** (a) Individuals and families applying
 32.6 for MinnesotaCare coverage must provide a Social Security number. This requirement
 32.7 does not apply to an undocumented noncitizen or nonimmigrant who is eligible for
 32.8 MinnesotaCare.

32.9 (b) The commissioner shall not deny eligibility to an otherwise eligible applicant
 32.10 who has applied for a Social Security number and is awaiting issuance of that Social
 32.11 Security number.

32.12 (c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the
 32.13 requirements of this subdivision.

32.14 (d) Individuals who refuse to provide a Social Security number because of
 32.15 well-established religious objections are exempt from the requirements of this subdivision.
 32.16 The term "well-established religious objections" has the meaning given in Code of Federal
 32.17 Regulations, title 42, section 435.910.

32.18 Sec. 27. Minnesota Statutes 2006, section 256L.04, subdivision 7, is amended to read:

32.19 Subd. 7. **Single adults and households with no children.** The definition of eligible
 32.20 persons includes all individuals and households with no children who have gross family
 32.21 incomes that are equal to or less than ~~175~~ 200 percent of the federal poverty guidelines.

32.22 Sec. 28. Minnesota Statutes 2006, section 256L.04, subdivision 10, is amended to read:

32.23 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited
 32.24 to citizens or nationals of the United States, qualified noncitizens, and other persons
 32.25 residing lawfully in the United States as described in section 256B.06, subdivision 4,
 32.26 paragraphs (a) to (e) and (j). Undocumented noncitizens and nonimmigrants are ineligible
 32.27 for MinnesotaCare.

32.28 (b) For purposes of this subdivision, a nonimmigrant is an individual in one or
 32.29 more of the classes listed in United States Code, title 8, section 1101(a)(15), and an
 32.30 undocumented noncitizen is an individual who resides in the United States without the
 32.31 approval or acquiescence of the Immigration and Naturalization Service. This paragraph
 32.32 does not apply to children.

33.1 (c) Families with children who are citizens or nationals of the United States must
 33.2 cooperate in obtaining satisfactory documentary evidence of citizenship or nationality
 33.3 according to the requirements of the federal Deficit Reduction Act of 2005, Public Law
 33.4 109-171. State and county workers must assist applicants in obtaining satisfactory
 33.5 documentary evidence of citizenship or nationality.

33.6 Sec. 29. Minnesota Statutes 2006, section 256L.04, is amended by adding a subdivision
 33.7 to read:

33.8 Subd. 14. **MinnesotaCare outreach.** (a) The commissioner shall award grants to
 33.9 public or private organizations to provide information on the importance of maintaining
 33.10 insurance coverage and on how to obtain coverage through the MinnesotaCare program in
 33.11 areas of the state with high uninsured populations.

33.12 (b) In awarding the grants, the commissioner shall consider the following:

33.13 (1) geographic areas and populations with high uninsured rates;

33.14 (2) the ability to raise matching funds; and

33.15 (3) the ability to contact or serve eligible populations.

33.16 The commissioner shall monitor the grants and may terminate a grant if the outreach
 33.17 effort does not increase enrollment in medical assistance, general assistance medical care,
 33.18 or the MinnesotaCare program.

33.19 (c) The commissioner shall develop an incentive program for individuals and
 33.20 families in geographic areas and high uninsured populations with high uninsured rates
 33.21 who enroll in MinnesotaCare. The incentives may include gift certificates for groceries,
 33.22 household items, or other sundries.

33.23 Sec. 30. Minnesota Statutes 2006, section 256L.05, subdivision 1b, is amended to read:

33.24 Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September
 33.25 1, 2006, county agencies shall enroll single adults and households with no children
 33.26 formerly enrolled in general assistance medical care in MinnesotaCare according to
 33.27 section 256D.03, subdivision 3. County agencies shall perform all duties necessary
 33.28 to administer the MinnesotaCare program ongoing for these enrollees, including the
 33.29 redetermination of MinnesotaCare eligibility at ~~six-month~~ renewal.

33.30 Sec. 31. Minnesota Statutes 2006, section 256L.05, subdivision 2, is amended to read:

33.31 Subd. 2. **Commissioner's duties.** ~~(a)~~ The commissioner or county agency shall
 33.32 use electronic verification as the primary method of income verification. If there is a
 33.33 discrepancy between reported income and electronically verified income, an individual

34.1 may be required to submit additional verification. In addition, the commissioner shall
 34.2 perform random audits to verify reported income and eligibility. The commissioner
 34.3 may execute data sharing arrangements with the Department of Revenue and any other
 34.4 governmental agency in order to perform income verification related to eligibility and
 34.5 premium payment under the MinnesotaCare program.

34.6 ~~(b) In determining eligibility for MinnesotaCare, the commissioner shall require~~
 34.7 ~~applicants and enrollees seeking renewal of eligibility to verify both earned and unearned~~
 34.8 ~~income. The commissioner shall also require applicants and enrollees to submit the names~~
 34.9 ~~of their employers and a contact name with a telephone number for each employer for~~
 34.10 ~~purposes of verifying whether the applicant or enrollee, and any dependents, are eligible~~
 34.11 ~~for employer-subsidized coverage. Data collected is nonpublic data as defined in section~~
 34.12 ~~13.02, subdivision 9.~~

34.13 Sec. 32. Minnesota Statutes 2006, section 256L.05, subdivision 3a, is amended to read:

34.14 Subd. 3a. **Renewal of eligibility.** (a) Beginning ~~January 1, 1999~~ July 1, 2007, an
 34.15 enrollee's eligibility must be renewed every 12 months. The 12-month period begins in
 34.16 the month after the month the application is approved.

34.17 ~~(b) Beginning October 1, 2004, an enrollee's eligibility must be renewed every~~
 34.18 ~~six months. The first six-month period of eligibility begins the month the application is~~
 34.19 ~~received by the commissioner. The effective date of coverage within the first six-month~~
 34.20 ~~period of eligibility is as provided in subdivision 3. Each new period of eligibility must~~
 34.21 take into account any changes in circumstances that impact eligibility and premium
 34.22 amount. An enrollee must provide all the information needed to redetermine eligibility by
 34.23 the first day of the month that ends the eligibility period. The premium for the new period
 34.24 of eligibility must be received as provided in section 256L.06 in order for eligibility to
 34.25 continue.

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

34.30 Sec. 33. Minnesota Statutes 2006, section 256L.07, subdivision 1, is amended to read:

34.31 Subdivision 1. **General requirements.** ~~(a) Children enrolled in the original~~
 34.32 ~~children's health plan as of September 30, 1992, children who enrolled in the~~
 34.33 ~~MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,~~
 34.34 ~~article 4, section 17, and children who have family gross incomes that are equal to or~~

35.1 ~~less than 150 percent of the federal poverty guidelines are eligible without meeting~~
 35.2 ~~the requirements of subdivision 2 and the four-month requirement in subdivision 3, as~~
 35.3 ~~long as they maintain continuous coverage in the MinnesotaCare program or medical~~
 35.4 ~~assistance. Children who apply for MinnesotaCare on or after the implementation date~~
 35.5 ~~of the employer-subsidized health coverage program as described in Laws 1998, chapter~~
 35.6 ~~407, article 5, section 45, who have family gross incomes that are equal to or less than 150~~
 35.7 ~~percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to~~
 35.8 ~~be eligible for MinnesotaCare.~~

35.9 ~~(b)~~ (a) Families enrolled in MinnesotaCare under section 256L.04, subdivision
 35.10 1, whose income increases above 275 percent of the federal poverty guidelines, are no
 35.11 longer eligible for the program and shall be disenrolled by the commissioner. Individuals
 35.12 enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases
 35.13 above ~~175~~ 200 percent of the federal poverty guidelines are no longer eligible for the
 35.14 program and shall be disenrolled by the commissioner. For persons disenrolled under
 35.15 this subdivision, MinnesotaCare coverage terminates the last day of the calendar month
 35.16 following the month in which the commissioner determines that the income of a family or
 35.17 individual exceeds program income limits.

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

35.26 ~~(d)~~ Notwithstanding paragraphs ~~(b)~~ and ~~(c)~~, parents are not eligible for
 35.27 MinnesotaCare if gross household income exceeds \$25,000 for the six-month period
 35.28 of eligibility.

35.29 Sec. 34. Minnesota Statutes 2006, section 256L.07, subdivision 2, is amended to read:

35.30 Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be
 35.31 eligible, ~~a family or individual~~ an adult must not have access to subsidized health coverage
 35.32 through an employer and must not have had access to employer-subsidized coverage
 35.33 through a current employer for 18 months prior to application or reapplication. ~~A family~~
 35.34 ~~or individual~~ An adult whose employer-subsidized coverage is lost due to an employer

36.1 terminating health care coverage as an employee benefit during the previous 18 months
36.2 is not eligible.

36.3 (b) This subdivision does not apply to ~~a family or individual~~ an adult who was
36.4 enrolled in MinnesotaCare within six months or less of reapplication and who no longer
36.5 has employer-subsidized coverage due to the employer terminating health care coverage
36.6 as an employee benefit.

36.7 (c) For purposes of this requirement, subsidized health coverage means health
36.8 coverage for which the employer pays at least 50 percent of the cost of coverage for
36.9 the employee or dependent, or a higher percentage as specified by the commissioner.
36.10 ~~Children are eligible for employer-subsidized coverage through either parent, including~~
36.11 ~~the noncustodial parent.~~ The commissioner must treat employer contributions to Internal
36.12 Revenue Code Section 125 plans and any other employer benefits intended to pay
36.13 health care costs as qualified employer subsidies toward the cost of health coverage for
36.14 employees for purposes of this subdivision.

36.15 (d) Notwithstanding paragraph (c), if an employer-subsidized health plan requires
36.16 the employee to pay more than eight percent of the employee's family gross income in
36.17 co-payments, deductibles, or coinsurance, the health coverage offered shall not constitute
36.18 employer-subsidized coverage for purposes of determining eligibility for MinnesotaCare.

36.19 (e) This subdivision does not apply to children.

36.20 Sec. 35. Minnesota Statutes 2006, section 256L.07, subdivision 3, is amended to read:

36.21 Subd. 3. **Other health coverage.** (a) ~~Families and individuals~~ Adults enrolled in the
36.22 MinnesotaCare program must have no health coverage while enrolled or for at least four
36.23 months prior to application and renewal. ~~Children enrolled in the original children's health~~
36.24 ~~plan and children in families with income equal to or less than 150 percent of the federal~~
36.25 ~~poverty guidelines, who have other health insurance, are eligible if the coverage:~~

36.26 (1) ~~lacks two or more of the following:~~

36.27 (i) ~~basic hospital insurance;~~

36.28 (ii) ~~medical-surgical insurance;~~

36.29 (iii) ~~prescription drug coverage;~~

36.30 (iv) ~~dental coverage; or~~

36.31 (v) ~~vision coverage;~~

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

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

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

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

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

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

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

37.21 Sec. 36. Minnesota Statutes 2006, section 256L.07, subdivision 6, is amended to read:

37.22 Subd. 6. **Exception for certain adults.** Single adults and households with
 37.23 no children formerly enrolled in general assistance medical care and enrolled in
 37.24 MinnesotaCare according to section 256D.03, subdivision 3, are eligible without meeting
 37.25 the requirements of this section until ~~six-month~~ renewal.

37.26 Sec. 37. Minnesota Statutes 2006, section 256L.15, subdivision 1, is amended to read:

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

37.29 (b) Pregnant women and children under age two are exempt from the provisions
 37.30 of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment
 37.31 for failure to pay premiums. For pregnant women, this exemption continues until the
 37.32 first day of the month following the 60th day postpartum. Women who remain enrolled
 37.33 during pregnancy or the postpartum period, despite nonpayment of premiums, shall be

38.1 disenrolled on the first of the month following the 60th day postpartum for the penalty
38.2 period that otherwise applies under section 256L.06, unless they begin paying premiums.

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

38.9 **EFFECTIVE DATE.** This section is effective July 1, 2007, or upon federal
38.10 approval, whichever is later.

38.11 Sec. 38. Minnesota Statutes 2006, section 256L.15, subdivision 2, is amended to read:

38.12 **Subd. 2. Sliding fee scale; monthly gross individual or family income.** (a) The
38.13 commissioner shall establish a sliding fee scale to determine the percentage of monthly
38.14 gross individual or family income that households at different income levels must pay
38.15 to obtain coverage through the MinnesotaCare program. The sliding fee scale must be
38.16 based on the enrollee's monthly gross individual or family income. The sliding fee scale
38.17 must contain separate tables based on enrollment of one, two, or three or more persons.
38.18 The sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or
38.19 family income for individuals or families with incomes below the limits for the medical
38.20 assistance program for families and children in effect on January 1, 1999, and proceeds
38.21 through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent.
38.22 These percentages are matched to evenly spaced income steps ranging from the medical
38.23 assistance income limit for families and children in effect on January 1, 1999, to 275
38.24 percent of the federal poverty guidelines for the applicable family size, up to a family size
38.25 of five. The sliding fee scale for a family of five must be used for families of more than
38.26 five. ~~Effective October 1, 2003, the commissioner shall increase each percentage by 0.5~~
38.27 ~~percentage points for enrollees with income greater than 100 percent but not exceeding~~
38.28 ~~200 percent of the federal poverty guidelines and shall increase each percentage by 1.0~~
38.29 ~~percentage points for families and children with incomes greater than 200 percent of~~
38.30 ~~the federal poverty guidelines.~~ The sliding fee scale and percentages are not subject to
38.31 the provisions of chapter 14. If a family or individual reports increased income after
38.32 enrollment, premiums shall be adjusted at the time the change in income is reported.

38.33 (b) ~~Children in~~ Families whose gross income is above 275 percent of the federal
38.34 poverty guidelines shall pay the maximum premium. The maximum premium is defined
38.35 as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare

39.1 cases paid the maximum premium, the total revenue would equal the total cost of
 39.2 MinnesotaCare medical coverage and administration. In this calculation, administrative
 39.3 costs shall be assumed to equal ten percent of the total. The costs of medical coverage
 39.4 for pregnant women and children under age two and the enrollees in these groups shall
 39.5 be excluded from the total. The maximum premium for two enrollees shall be twice the
 39.6 maximum premium for one, and the maximum premium for three or more enrollees shall
 39.7 be three times the maximum premium for one.

39.8 ~~(c) After calculating the percentage of premium each enrollee shall pay under~~
 39.9 ~~paragraph (a), eight percent shall be added to the premium.~~

39.10 **EFFECTIVE DATE.** This section is effective July 1, 2007.

39.11 Sec. 39. Minnesota Statutes 2006, section 256L.15, subdivision 4, is amended to read:

39.12 Subd. 4. **Exception for transitioned adults.** County agencies shall pay premiums
 39.13 for single adults and households with no children formerly enrolled in general assistance
 39.14 medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3,
 39.15 ~~until six-month renewal~~ for six months. The county agency has the option of continuing to
 39.16 pay premiums for these enrollees past the first ~~six-month~~ six months until the 12-month
 39.17 renewal period.

39.18 Sec. 40. Minnesota Statutes 2006, section 256L.17, subdivision 7, is amended to read:

39.19 Subd. 7. **Exception for certain adults.** Single adults and households with
 39.20 no children formerly enrolled in general assistance medical care and enrolled in
 39.21 MinnesotaCare according to section 256D.03, subdivision 3, are exempt from the
 39.22 requirements of this section until ~~six-month~~ renewal.

39.23 Sec. 41. **[256L.20] MINNESOTACARE OPTION FOR SMALL EMPLOYERS.**

39.24 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms used
 39.25 have the meanings given them.

39.26 (b) "Dependent" means an unmarried child under the age of 21.

39.27 (c) "Eligible employee" means an employee who works at least 20 hours per week
 39.28 for an eligible employer. Eligible employee does not include an employee who works
 39.29 on a temporary or substitute basis or who does not work more than 26 weeks annually.
 39.30 Coverage of an eligible employee includes the employee's spouse.

39.31 (d) "Eligible employer" means a business that employs at least two, but not more
 39.32 than 50, eligible employees, the majority of whom are employed in the state, and includes
 39.33 a municipality that has 50 or fewer employees.

40.1 (e) "Maximum premium" has the meaning given under section 256L.15, subdivision
40.2 2, paragraph (b), clause (3).

40.3 (f) "Participating employer" means an eligible employer who meets the requirements
40.4 in subdivision 3 and applies to the commissioner to enroll its eligible employees and their
40.5 dependents in the MinnesotaCare program.

40.6 (g) "Program" means the MinnesotaCare program.

40.7 Subd. 2. **Option.** Eligible employees and their dependents may enroll in
40.8 MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The
40.9 effective date of coverage is as defined in section 256L.05, subdivision 3.

40.10 Subd. 3. **Employer requirements.** The commissioner shall establish procedures for
40.11 an eligible employer to apply for coverage through the program. In order to participate, an
40.12 eligible employer must meet the following requirements:

40.13 (1) agree to contribute toward the cost of the premium for the employee, the
40.14 employee's spouse, and the employee's dependents according to subdivision 4;

40.15 (2) certify that at least 75 percent of its eligible employees who do not have other
40.16 creditable health coverage are enrolled in the program;

40.17 (3) offer coverage to all eligible employees, spouses, and dependents of eligible
40.18 employees; and

40.19 (4) have not provided employer-subsidized health coverage as an employee benefit
40.20 during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

40.21 Subd. 4. **Premiums.** (a) The premium for coverage provided under this section is
40.22 equal to the maximum premium regardless of the income of the eligible employee, as
40.23 defined in section 256L.15, subdivision 2, paragraph (b).

40.24 (b) For eligible employees without dependents with income equal to or less than 200
40.25 percent of the federal poverty guidelines and for eligible employees with dependents with
40.26 income equal to or less than 275 percent of the federal poverty guidelines, the participating
40.27 employer shall pay 50 percent of the premium established under paragraph (a) for the
40.28 eligible employee, the employee's spouse, and any dependents, if applicable.

40.29 (c) For eligible employees without dependents with income over 200 percent of the
40.30 federal poverty guidelines and for eligible employees with dependents with income over
40.31 275 percent of the federal poverty guidelines, the participating employer shall pay the
40.32 full cost of the premium established under paragraph (a) for the eligible employee, the
40.33 employee's spouse, and any dependents, if applicable. The participating employer may
40.34 require the employee to pay a portion of the cost of the premium so long as the employer
40.35 pays 50 percent. If the employer requires the employee to pay a portion of the premium,
40.36 the employee shall pay the portion of the cost to the employer.

41.1 (d) The commissioner shall collect premium payments from participating employers
 41.2 for eligible employees, spouses, and dependents who are covered by the program as
 41.3 provided under this section. All premiums collected shall be deposited in the health care
 41.4 access fund.

41.5 Subd. 5. Coverage. The coverage offered to those enrolled in the program under
 41.6 this section must include all health services described under section 256L.03 and all
 41.7 co-payments and coinsurance requirements under section 256L.03, subdivision 5, apply.

41.8 Subd. 6. Enrollment. Upon payment of the premium, according to this section
 41.9 and section 256L.06, eligible employees, spouses, and dependents shall be enrolled in
 41.10 MinnesotaCare. For purposes of enrollment under this section, income eligibility limits
 41.11 established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established
 41.12 under section 256L.17, do not apply. The barriers established under section 256L.07,
 41.13 subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner
 41.14 may require eligible employees to provide income verification to determine premiums.

41.15 Sec. 42. Laws 2005, First Special Session chapter 4, article 9, section 3, subdivision 2,
 41.16 is amended to read:

41.17 **Subd. 2. Community and Family Health**
 41.18 **Improvement**

41.19 Summary by Fund

41.20 General	40,413,000	40,382,000
41.21 State Government		
41.22 Special Revenue	141,000	128,000
41.23 Health Care Access	3,510,000	3,516,000
41.24 Federal TANF	6,000,000	6,000,000

41.25 ~~**FAMILY PLANNING BASE**~~
 41.26 ~~**REDUCTION.** Base level funding for~~
 41.27 ~~the family planning special projects grant~~
 41.28 ~~program is reduced by \$1,877,000 each~~
 41.29 ~~year of the biennium beginning July 1,~~
 41.30 ~~2007, provided that this reduction shall~~
 41.31 ~~only take place upon full implementation of~~
 41.32 ~~the family planning project section of the~~
 41.33 ~~1115 waiver. Notwithstanding Minnesota~~
 41.34 ~~Statutes, section 145.925, the commissioner~~
 41.35 ~~shall give priority to community health care~~
 41.36 ~~clinics providing family planning services~~

42.1 ~~that either serve a high number of women~~
 42.2 ~~who do not qualify for medical assistance~~
 42.3 ~~or are unable to participate in the medical~~
 42.4 ~~assistance program as a medical assistance~~
 42.5 ~~provider when allocating the remaining~~
 42.6 ~~appropriations. Notwithstanding section 15,~~
 42.7 ~~this paragraph shall not expire.~~

42.8 **SHAKEN BABY VIDEO.** Of the
 42.9 state government special revenue fund
 42.10 appropriation, \$13,000 in 2006 is
 42.11 appropriated to the commissioner of health
 42.12 to provide a video to hospitals on shaken
 42.13 baby syndrome. The commissioner of health
 42.14 shall assess a fee to hospitals to cover the
 42.15 cost of the approved shaken baby video and
 42.16 the revenue received is to be deposited in the
 42.17 state government special revenue fund.

42.18 Sec. 43. **ADMINISTRATIVE SIMPLIFICATION.**

42.19 All health care providers and health plans that contract with the state of Minnesota
 42.20 to provide health care services either through the health care programs administered
 42.21 under Minnesota Statutes, chapters 256B, 256D, and 256L, or through the state employee
 42.22 group insurance program administered under Minnesota Statutes, chapter 43A, must
 42.23 use and accept the uniform billing forms and coding requirements established by the
 42.24 Administrative Uniformity Committee by January 1, 2009.

42.25 Sec. 44. **CONSTITUTIONAL AMENDMENT PROPOSED.**

42.26 An amendment to the Minnesota Constitution is proposed to the people. If the
 42.27 amendment is adopted, a section will be added to article XIII, to read:

42.28 Sec. 13. Every Minnesota resident has the right to health care. It is the responsibility of
 42.29 the governor and the legislature to implement all necessary legislation to ensure affordable
 42.30 health care.

42.31 Sec. 45. **SUBMISSION TO VOTERS.**

42.32 The proposed amendment shall be submitted to the people at the 2008 general
 42.33 election. The question submitted shall be:

43.1 "Shall the Minnesota Constitution be amended to state that every resident of
 43.2 Minnesota has the right to health care and that it is the responsibility of the governor and
 43.3 the legislature to implement all necessary legislation to ensure affordable health care?

43.4 Yes
 43.5 No"

43.6 **Sec. 46. ACTION BY LEGISLATURE AND GOVERNOR.**

43.7 If the constitutional amendment proposed in section 44 is approved by the people at
 43.8 the 2008 general election, the legislature and governor must enact legislation to implement
 43.9 the constitutional amendment by July 1, 2011.

43.10 **Sec. 47. APPROPRIATION.**

43.11 (a) \$..... is appropriated from the health care access fund to the commissioner of
 43.12 human services for the biennium beginning July 1, 2007, for the purpose of MinnesotaCare
 43.13 outreach grants and the enrollment incentive programs under Minnesota Statutes, section
 43.14 256L.04, subdivision 14.

43.15 (b) \$1,156,000 is appropriated each fiscal year beginning July 1, 2007, from the
 43.16 general fund to the commissioner of health for family planning grants under Minnesota
 43.17 Statutes, section 145.925.

43.18 (c) \$..... is appropriated for the biennium beginning July 1, 2007, from the general
 43.19 fund to the commissioner of human services for the intensive care management pilot
 43.20 program described in Minnesota Statutes, section 256B.075, subdivision 2, paragraph (d).

43.21 (d) \$..... is appropriated for the biennium beginning July 1, 2007, from the general
 43.22 fund to the commissioner of human services for the critical access dental providers
 43.23 reimbursement rates under Minnesota Statutes, section 256B.76, paragraph (c).

43.24 (e) \$..... is appropriated for the biennium beginning July 1, 2007, from the general
 43.25 fund to the commissioner of human services for the special hardship grants to nonprofit
 43.26 dental providers described in Minnesota Statutes, section 256B.76, paragraph (d).

43.27 (f) \$..... is appropriated for the biennium beginning July 1, 2007, from the general
 43.28 fund to the commissioner of human services for the patient incentive health program
 43.29 established in Minnesota Statutes, section 256.01, subdivision 2a, paragraph (b).

43.30 **Sec. 48. REPEALER.**

43.31 Minnesota Statutes 2006, sections 62A.301; 256B.0631; and 256L.035, are repealed.