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State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH SESSION

HOUSE FILE NO. 297

January 22, 2007
Authored by Huntley, Abeler, Walker, Thissen, Otremba and others
The bill was read for the first time and referred to the Committee on Health and Human Services
March 19, 2007
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Finance

1.1 A bill for an act
1.2 relating to health care; establishing uniform claims standards; requiring an
1.3 interoperable electronic health records system; extending an advisory task force
1.4 expiration date; establishing an electronic health record revolving account and
1.5 loan program; modifying hospital information reporting; establishing the Health
1.6 Care Transformation Task Force; providing subsidies to federally qualified
1.7 health centers; establishing a prescription drug discount program; requiring a
1.8 health care program outreach; establishing a primary care access initiative;
1.9 changing eligibility verification for medical assistance; modifying provisions
1.10 for medical assistance, general assistance medical care, and MinnesotaCare;
1.11 repealing the family planning base reduction; establishing the Minnesota Health
1.12 Insurance Exchange; requiring certain employers to offer a Section 125 Plan;
1.13 modifying provisions for health plans and establishing a premium discount
1.14 incentive; appropriating money; amending Minnesota Statutes 2006, sections
1.15 13.46, subdivision 2; 62E.02, subdivision 7; 62E.141; 62J.495; 62J.82; 62L.02,
1.16 subdivision 11; 62L.12, subdivision 2; 62Q.165, subdivisions 1, 2; 256B.056,
1.17 subdivision 10; 256B.0625, subdivisions 3b, 30, by adding a subdivision;
1.18 256D.03, subdivisions 3, 4; 256L.01, subdivisions 1, 4; 256L.02, subdivision 3,
1.19 by adding subdivisions; 256L.03, subdivisions 1, 3, 5; 256L.04, subdivisions 1a,
1.20 7, 10; 256L.05, subdivisions 1, 1b, 2, 3a, 3c, 5, by adding subdivisions; 256L.07,
1.21 subdivisions 1, 2, 3, 6; 256L.09, subdivision 4; 256L.12, subdivision 7; 256L.15,
1.22 subdivisions 1, 1a, 2, by adding a subdivision; 256L.17, subdivisions 2, 3, 7;
1.23 Laws 2005, First Special Session chapter 4, article 9, section 3, subdivision 2;
1.24 proposing coding for new law in Minnesota Statutes, chapters 62A; 62J; 145;
1.25 256; 256B; repealing Minnesota Statutes 2006, sections 62A.301; 256B.0631;
1.26 256L.035.

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

1.28 **ARTICLE 1**

1.29 **HEALTH CARE**

1.30 Section 1. **[62J.536] UNIFORM CLAIM STANDARDS.**

1.31 Subdivision 1. **Definitions.** For purposes of this section, the terms in this subdivision
1.32 have the meanings given them.

2.1 (1) "Uniform claims standards" means the data and codes required to complete
2.2 health care transactions.
2.3 (2) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.
2.4 (3) "Health care provider" has the meaning given in section 62J.03, subdivision 8.
2.5 Subd. 2. **Uniform claims forms.** Beginning January 15, 2009, health care providers
2.6 shall submit HIPAA compliant uniform claims forms using HIPAA compliant uniform
2.7 claims standards to group purchasers and all group purchasers shall accept these forms.
2.8 Subd. 3. **Electronic claims submission.** (a) By January 15, 2009, all group
2.9 purchasers and health care providers shall use electronic claims submission and processing
2.10 systems.
2.11 (b) Electronic claims submission and processing systems shall include the capacity
2.12 to monitor and disseminate information concerning eligibility and coverage of individuals.
2.13 (c) Group purchasers may not impose any fee for use of these systems.
2.14 Subd. 4. **Rules.** The commissioner of commerce shall consult with the Minnesota
2.15 Administrative Uniformity Committee on development of uniform claims forms
2.16 and uniform claims standards. The commissioner shall use standards based on the
2.17 Medicare program with modifications as recommended by the Administrative Uniformity
2.18 Committee to promulgate rules. The commissioner shall issue rules, pursuant to sections
2.19 14.001 to 14.28 or section 14.389, establishing and requiring group purchasers and health
2.20 care providers to use uniform claims standards. The commissioner shall promulgate rules
2.21 by January 15, 2008, or report to the legislature on the status of rule development by
2.22 January 15, 2008.
2.23 Subd. 5. **Modification prohibited.** No group purchaser or health care provider may
2.24 add to or modify the requirements of this section.

2.25 Sec. 2. Minnesota Statutes 2006, section 62E.02, subdivision 7, is amended to read:
2.26 Subd. 7. **Dependent.** "Dependent" means a spouse or unmarried child ~~under the~~
2.27 ~~age of 19 years, a dependent child~~ who is ~~a student~~ under the age of 25 regardless of
2.28 whether the dependent child is enrolled in an educational institution, or a dependent
2.29 child of any age who is disabled.

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

2.31 Sec. 3. Minnesota Statutes 2006, section 62J.495, is amended to read:
2.32 **62J.495 HEALTH INFORMATION TECHNOLOGY AND**
2.33 **INFRASTRUCTURE ~~ADVISORY COMMITTEE~~.**

3.1 Subdivision 1. ~~**Establishment; members; duties**~~ **Implementation.** By January
3.2 1, 2012, all hospitals and health care providers must have in place an interoperable
3.3 electronic health records system within their hospital system or clinical practice setting.
3.4 The commissioner of health, in consultation with the Health Information Technology and
3.5 Infrastructure Advisory Committee, shall develop a statewide plan to meet this goal,
3.6 including uniform standards to be used for the interoperable system for sharing and
3.7 synchronizing patient data across systems. The standards must be compatible with federal
3.8 efforts. The uniform standards must be developed by January 1, 2009, with a status report
3.9 on the development of these standards submitted to the legislature by January 15, 2008.

3.10 Subd. 2. **Health Information Technology and Infrastructure Advisory**
3.11 **Committee.** (a) The commissioner shall establish a Health Information Technology
3.12 and Infrastructure Advisory Committee governed by section 15.059 to advise the
3.13 commissioner on the following matters:

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

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

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

3.21 (b) The members of the Health Information Technology and Infrastructure Advisory
3.22 Committee shall include the commissioners, or commissioners' designees, of health,
3.23 human services, administration, and commerce and additional members to be appointed
3.24 by the commissioner to include persons representing Minnesota's local public health
3.25 agencies, licensed hospitals and other licensed facilities and providers, private purchasers,
3.26 the medical and nursing professions, health insurers and health plans, the state quality
3.27 improvement organization, academic and research institutions, consumer advisory
3.28 organizations with an interest and expertise in health information technology, and other
3.29 stakeholders as identified by the Health Information Technology and Infrastructure
3.30 Advisory Committee.

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

3.34 ~~Subd. 3.~~ ~~Expiration.~~ (d) Notwithstanding section 15.059, this ~~section~~ subdivision
3.35 expires June 30, ~~2009~~ 2012.

4.1 Sec. 4. **[62J.496] ELECTRONIC HEALTH RECORD SYSTEM REVOLVING**
4.2 **ACCOUNT AND LOAN PROGRAM.**

4.3 Subdivision 1. **Account establishment.** The commissioner of finance shall
4.4 establish and implement a revolving account in the state government special revenue
4.5 fund to provide loans to physicians or physician group practices to assist in financing the
4.6 installation or support of an interoperable health record system. The system must provide
4.7 for the interoperable exchange of health care information between the applicant and, at a
4.8 minimum, a hospital system, pharmacy, and a health care clinic or other physician group.

4.9 Subd. 2. **Eligibility.** To be eligible for a loan under this section, the applicant
4.10 must submit a loan application to the commissioner of health on forms prescribed by the
4.11 commissioner. The application must include, at a minimum:

4.12 (1) the amount of the loan requested and a description of the purpose or project
4.13 for which the loan proceeds will be used;

4.14 (2) a signed contract with a vendor;

4.15 (3) a description of the health care entities and other groups participating in the
4.16 project;

4.17 (4) evidence of financial stability and a demonstrated ability to repay the loan; and

4.18 (5) a description of how the system to be financed interconnects or plans in the
4.19 future to interconnect with other health care entities and provider groups located in the
4.20 same geographical area.

4.21 Subd. 3. **Loans.** (a) The commissioner of health may make a no interest loan
4.22 to a provider or provider group who is eligible under subdivision 2 on a first-come,
4.23 first-served basis provided that the applicant is able to comply with this section. The total
4.24 accumulative loan principal must not exceed $....... per loan. The commissioner of health
4.25 has discretion over the size and number of loans made.

4.26 (b) The commissioner of health may prescribe forms and establish an application
4.27 process and, notwithstanding section 16A.1283, may impose a reasonable nonrefundable
4.28 application fee to cover the cost of administering the loan program.

4.29 (c) The borrower must begin repaying the principal no later than two years from the
4.30 date of the loan. Loans must be amortized no later than 15 years from the date of the loan.

4.31 (d) Repayments must be credited to the account.

4.32 Sec. 5. Minnesota Statutes 2006, section 62J.82, is amended to read:

4.33 **62J.82 HOSPITAL ~~CHARGE~~ INFORMATION REPORTING DISCLOSURE.**

5.1 Subdivision 1. **Required information.** The Minnesota Hospital Association shall
5.2 develop a Web-based system, available to the public free of charge, for reporting ~~charge~~
5.3 ~~information~~ the following, for Minnesota residents~~,~~:
5.4 (1) hospital-specific performance on the measures of care developed under section
5.5 256B.072 for acute myocardial infarction, heart failure, and pneumonia;
5.6 (2) by January 1, 2009, hospital-specific performance on the public reporting
5.7 measures for hospital-acquired infections as published by the National Quality Forum
5.8 and collected by the Minnesota Hospital Association and Stratis Health in collaboration
5.9 with infection control practitioners; and
5.10 (3) charge information, including, but not limited to, number of discharges, average
5.11 length of stay, average charge, average charge per day, and median charge, for each of the
5.12 50 most common inpatient diagnosis-related groups and the 25 most common outpatient
5.13 surgical procedures as specified by the Minnesota Hospital Association.
5.14 Subd. 2. **Web site.** The Web site must provide information that compares
5.15 hospital-specific data to hospital statewide data. The Web site must be ~~established by~~
5.16 ~~October 1, 2006, and must be~~ updated annually. The commissioner shall provide a link to
5.17 this reporting information on the department's Web site.
5.18 Subd. 3. **Enforcement.** The commissioner shall provide a link to this information
5.19 on the department's Web site. If a hospital does not provide this information to the
5.20 Minnesota Hospital Association, the commissioner of health may require the hospital to
5.21 do so in accordance with section 144.55, subdivision 6. ~~The commissioner shall provide a~~
5.22 ~~link to this information on the department's Web site.~~

5.23 Sec. 6. **[62J.84] HEALTH CARE TRANSFORMATION TASK FORCE.**
5.24 Subdivision 1. **Task force.** The Health Care Transformation Task Force consists of:
5.25 (1) the Legislative Commission on Health Care Access established under section
5.26 62J.07;
5.27 (2) the commissioners of human services, health, and commerce;
5.28 (3) four persons designated by the SmartBuy alliance to represent private sector
5.29 purchasers, including one representing public employers, one representing large
5.30 employers, one representing small employers, and one representing labor unions; and
5.31 (4) six persons designated by the partnership for action to transform health care,
5.32 a multisector policy alliance of hospitals and health systems, health plan companies,
5.33 physicians, and other health care organizations.
5.34 Subd. 2. **Public input.** The commissioner of health shall review available research
5.35 and conduct statewide, regional, and local surveys, focus groups, and other activities to

6.1 determine Minnesotans' values, preferences, opinions, and perceptions related to health
6.2 care and to the issues confronting the task force, and shall report the findings to the task
6.3 force.

6.4 Subd. 3. **Inventory and assessment of existing activities.** The task force shall
6.5 complete an inventory and assessment of all public and private organized activities,
6.6 coalitions, and collaboratives working on tasks relating to health system improvement
6.7 including, but not limited to, patient safety, quality measurement and reporting,
6.8 evidence-based practice, adoption of health information technology, disease management
6.9 and chronic care coordination, medical homes, access to health care, cultural competence,
6.10 prevention and public health, consumer incentives, price and cost transparency, nonprofit
6.11 organization community benefits, education, research, and health care workforce. By
6.12 December 15, 2007, the task force shall present recommendations to the legislature, the
6.13 governor, and to those working on these activities on how these activities may be made
6.14 more effective and how coordination and communication may be improved.

6.15 Subd. 4. **Action plan.** By December 15, 2007, the task force shall develop and
6.16 present, to the legislature and the governor, a statewide action plan for transforming the
6.17 health care system to improve affordability, quality, and access. The plan may consist of
6.18 legislative actions, administrative actions of governmental entities, collaborative actions,
6.19 and actions of individuals and individual organizations. The plan must include specific
6.20 and measurable goals and deadlines for affordability, quality, and access. The plan must
6.21 include a method of coordination and communication among the activities identified
6.22 under subdivision 3.

6.23 Subd. 5. **Local school wellness.** The task force shall evaluate local school wellness
6.24 policies in order to understand the differences between policies, highlight innovation,
6.25 and encourage improvement, and shall evaluate continuing education requirements for
6.26 nutrition for school lunch program staff. The task force shall present recommendations
6.27 to the legislature and the governor by February 1, 2008.

6.28 Subd. 6. **Health communities initiative.** The task force shall evaluate the use of
6.29 grants and financial incentive programs to encourage communities to implement urban
6.30 and community planning designs and templates that foster healthy lifestyles. By February
6.31 1, 2008, the task force shall submit a report to the governor and the legislature containing
6.32 recommendations on the administration, funding, and requirements for the programs.

6.33 Sec. 7. Minnesota Statutes 2006, section 62L.02, subdivision 11, is amended to read:

6.34 Subd. 11. **Dependent.** "Dependent" means an eligible employee's spouse,
6.35 unmarried child who is ~~under the age of 19 years, unmarried child~~ under the age of 25

7.1 years ~~who is a full-time student as defined in section 62A.301~~ regardless of whether
7.2 the dependent child is enrolled in an educational institution, dependent child of any age
7.3 who is disabled and who meets the eligibility criteria in section 62A.14, subdivision 2,
7.4 or any other person whom state or federal law requires to be treated as a dependent for
7.5 purposes of health plans. For the purpose of this definition, a child includes a child for
7.6 whom the employee or the employee's spouse has been appointed legal guardian and an
7.7 adoptive child as provided in section 62A.27.

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

7.9 Sec. 8. Minnesota Statutes 2006, section 62Q.165, subdivision 1, is amended to read:
7.10 Subdivision 1. **Definition.** It is the commitment of the state to achieve universal
7.11 health coverage for all Minnesotans by the year 2010. Universal coverage is achieved
7.12 when:
7.13 (1) every Minnesotan has access to a full range of quality health care services;
7.14 (2) every Minnesotan is able to obtain affordable health coverage which pays for the
7.15 full range of services, including preventive and primary care; and
7.16 (3) every Minnesotan pays into the health care system according to that person's
7.17 ability.

7.18 Sec. 9. Minnesota Statutes 2006, section 62Q.165, subdivision 2, is amended to read:
7.19 Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward
7.20 reducing the number of Minnesotans who do not have health coverage so that by January
7.21 1, ~~2000~~ 2010, ~~fewer than four percent of the state's population will be without health~~
7.22 ~~coverage~~ all Minnesota residents have access to affordable health care. ~~The goal will be~~
7.23 ~~achieved by~~ In achieving this goal, a number of options shall be considered, including
7.24 improving access to private health coverage through insurance reforms and market
7.25 reforms, ~~by~~ making health coverage more affordable for low-income Minnesotans through
7.26 purchasing pools and state subsidies, and ~~by~~ reducing the cost of health coverage through
7.27 cost containment programs and methods of ensuring that all Minnesotans are paying
7.28 into the system according to their ability.

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

7.30 Sec. 10. **[145.9269] FEDERALLY QUALIFIED HEALTH CENTERS.**
7.31 Subdivision 1. **Definitions.** For purposes of this section, "federally qualified health
7.32 center" means an entity that is receiving a grant under United States Code, title 42,

8.1 section 254b, or, based on the recommendation of the Health Resources and Services
8.2 Administration within the Public Health Service, is determined by the secretary to meet
8.3 the requirements for receiving such a grant.
8.4 Subd. 2. **Allocation of subsidies.** The commissioner of health shall distribute
8.5 subsidies to federally qualified health centers operating in Minnesota to continue, expand,
8.6 and improve federally qualified health center services to low-income populations. The
8.7 commissioner shall distribute the funds appropriated under this section to federally
8.8 qualified health centers operating in Minnesota as of January 1, 2007. The amount of
8.9 each subsidy shall be in proportion to each federally qualified health center's amount of
8.10 discounts granted to patients during calendar year 2006 as reported on the federal Uniform
8.11 Data System report in conformance with the Bureau of Primary Health Care Program
8.12 Expectations Policy Information Notice 98-23, except that each eligible federally qualified
8.13 health center shall receive at least two percent but no more than 30 percent of the total
8.14 amount of money available under this section.

8.15 Sec. 11. **[256.9545] PRESCRIPTION DRUG DISCOUNT PROGRAM.**
8.16 Subdivision 1. **Establishment; administration.** The commissioner shall establish
8.17 and administer the prescription drug discount program.
8.18 Subd. 2. **Commissioner's authority.** The commissioner shall administer a drug
8.19 rebate program for drugs purchased according to the prescription drug discount program.
8.20 The commissioner shall execute a rebate agreement from all manufacturers that choose to
8.21 participate in the program for those drugs covered under the medical assistance program.
8.22 For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes
8.23 of the federal rebate program in United States Code, title 42, section 1396r-8. The
8.24 rebate program shall utilize the terms and conditions used for the federal rebate program
8.25 established according to section 1927 of title XIX of the federal Social Security Act.
8.26 Subd. 3. **Definitions.** For purposes of this section, the following terms have the
8.27 meanings given them.
8.28 (a) "Commissioner" means the commissioner of human services.
8.29 (b) "Covered prescription drug" means a prescription drug as defined in section
8.30 151.44, paragraph (d), that is covered under medical assistance as described in section
8.31 256B.0625, subdivision 13, and that is provided by a participating manufacturer that has a
8.32 fully executed rebate agreement with the commissioner under this section and complies
8.33 with that agreement.
8.34 (c) "Enrolled individual" means a person who is eligible for the program under
8.35 subdivision 4 and has enrolled in the program according to subdivision 5.

9.1 (d) "Health carrier" means an insurance company licensed under chapter 60A to
9.2 offer, sell, or issue an individual or group policy of accident and sickness insurance as
9.3 defined in section 62A.01; a nonprofit health service plan corporation operating under
9.4 chapter 62C; a health maintenance organization operating under chapter 62D; a joint
9.5 self-insurance employee health plan operating under chapter 62H; a community integrated
9.6 service network licensed under chapter 62N; a fraternal benefit society operating under
9.7 chapter 64B; a city, county, school district, or other political subdivision providing
9.8 self-insured health coverage under section 471.617 or sections 471.98 to 471.982; and a
9.9 self-funded health plan under the Employee Retirement Income Security Act of 1974, as
9.10 amended.

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

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

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

9.16 (1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision
9.17 4;

9.18 (2) not be enrolled in medical assistance, general assistance medical care, or
9.19 MinnesotaCare;

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

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

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

9.34 Subd. 5. **Application procedure.** (a) Applications and information on the program
9.35 must be made available at county social services agencies, health care provider offices, and
9.36 agencies and organizations serving senior citizens. Individuals shall submit applications

10.1 and any information specified by the commissioner as being necessary to verify eligibility
10.2 directly to the commissioner. The commissioner shall determine an applicant's eligibility
10.3 for the program within 30 days from the date the application is received. Upon notice of
10.4 approval, the applicant must submit to the commissioner the enrollment fee specified in
10.5 subdivision 10. Eligibility begins the month after the enrollment fee is received by the
10.6 commissioner.

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

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

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

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

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

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

10.27 Subd. 8. **Provision of rebate.** To the extent that a participating manufacturer's
10.28 prescription drugs are prescribed to a resident of this state, the manufacturer must provide
10.29 a rebate equal to the rebate provided under the medical assistance program for any
10.30 prescription drug distributed by the manufacturer that is purchased at a participating
10.31 pharmacy by an enrolled individual. The participating manufacturer must provide full
10.32 payment within 38 days of receipt of the state invoice for the rebate, or according to
10.33 a schedule to be established by the commissioner. The commissioner shall deposit all
10.34 rebates received into the Minnesota prescription drug dedicated fund established under
10.35 subdivision 11. The manufacturer must provide the commissioner with any information
10.36 necessary to verify the rebate determined per drug.

11.1 Subd. 9. **Payment to pharmacies.** Beginning January 1, 2009, the commissioner
11.2 shall distribute on a biweekly basis an amount that is equal to an amount collected under
11.3 subdivision 8 to each participating pharmacy based on the prescription drugs sold by that
11.4 pharmacy to enrolled individuals on or after January 1, 2009.

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

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

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

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

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

11.27 Sec. 12. **[256.962] MINNESOTA HEALTH CARE PROGRAMS OUTREACH.**

11.28 Subdivision 1. **Public awareness and education.** (a) The commissioner shall
11.29 design and implement a statewide campaign to raise public awareness on the availability
11.30 of health coverage through medical assistance, general assistance medical care, and
11.31 MinnesotaCare and to educate the public on the importance of obtaining and maintaining
11.32 health care coverage. The campaign shall include multimedia messages directed to the
11.33 general population and messages that are culturally specific and community-based,
11.34 directed to high-uninsured population areas.

12.1 (b) The commissioner shall collaborate with public and private entities, including,
12.2 but not limited to, hospitals, providers, health plans, legal aid offices, pharmacies,
12.3 insurance agencies, and faith-based organizations to develop outreach activities and
12.4 partnerships to ensure the distribution of information and applications.
12.5 (c) The commissioner shall ensure that all outreach materials are available in
12.6 languages other than English.
12.7 Subd. 2. **Outreach grants.** The commissioner shall award grants to public and
12.8 private organizations to provide information, applications, and assistance in obtaining
12.9 coverage through Minnesota public health care programs. In awarding these grants, the
12.10 commissioner shall give priority to community organizations with a proven ability to
12.11 provide multilingual and cultural outreach efforts in areas of high-uninsured populations.
12.12 Subd. 3. **Application and assistance.** (a) The Minnesota health care programs
12.13 application must be made available at provider offices, local human services agencies,
12.14 school districts, public and private elementary schools in which 25 percent or more of
12.15 the students receive free or reduced price lunches, community health offices, Women,
12.16 Infants and Children (WIC) program sites, Head Start program sites, public housing
12.17 councils, child care centers, early childhood education and preschool program sites, legal
12.18 aid offices, and libraries. The commissioner shall ensure that applications are available in
12.19 languages other than English and that individuals and families who need assistance due to
12.20 language or cultural barriers receive the necessary services.
12.21 (b) Local human service agencies, hospitals, and health care community clinics
12.22 receiving state funds must provide direct assistance in completing the application form,
12.23 including the free use of a copy machine and a drop box for applications. Other locations
12.24 where applications are required to be available shall either provide direct assistance in
12.25 completing the application form or provide information on where an applicant can receive
12.26 application assistance.
12.27 (c) Counties must offer applications and application assistance when providing
12.28 child support collection services.
12.29 (d) Local public health agencies and counties that provide immunization clinics must
12.30 offer applications and application assistance during these clinics.
12.31 Subd. 4. **Statewide toll-free telephone number.** The commissioner shall provide
12.32 funds to establish a statewide toll-free telephone number to provide information on public
12.33 and private health coverage options and sources of free and low-cost health care.
12.34 Subd. 5. **Incentive program.** The commissioner shall establish an incentive
12.35 program for organizations that directly identify and assist potential enrollees in filling
12.36 out and submitting an application. For each applicant who is successfully enrolled in

13.1 MinnesotaCare, medical assistance, or general assistance medical care, the commissioner
13.2 shall pay the organization a $25 application assistance fee. The organization may provide
13.3 an applicant a gift certificate or other incentive upon enrollment.

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

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

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

13.13 (d) Each district shall designate an enrollment specialist to provide application
13.14 assistance and follow-up services with families who are eligible for the reduced or free
13.15 lunch program or who have indicated an interest in receiving information or an application
13.16 for the Minnesota health care program.

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

13.19 Subd. 7. **Renewal notice.** (a) The commissioner shall mail a renewal notice to
13.20 enrollees notifying the enrollee that their eligibility must be renewed. A notice shall be
13.21 sent at 90 days prior to the renewal date and at 60 days prior to the renewal date.

13.22 (b) For enrollees who are receiving services through managed care plans, the
13.23 managed care plan must provide a follow-up renewal call at least 60 days prior to the
13.24 enrollee's renewal date.

13.25 (c) The commissioner shall include the end of coverage dates on the monthly rosters
13.26 of enrollees provided to managed care organizations.

13.27 Sec. 13. **[256.963] PRIMARY CARE ACCESS INITIATIVE.**

13.28 Subdivision 1. **Establishment.** (a) The commissioner shall award a grant to
13.29 implement in Hennepin and Ramsey Counties a Web-based primary care access pilot
13.30 project designed as a collaboration between private and public sectors to connect, where
13.31 appropriate, a patient with a primary care medical home and schedule patients into
13.32 available community-based appointments as an alternative to nonemergency use of the
13.33 hospital emergency room. The grantee must establish a program that diverts patients
13.34 presenting at an emergency room for nonemergency care to more appropriate outpatient
13.35 settings. The program must refer the patient to an appropriate health care professional

14.1 based on the patient's health care needs and situation. The program must provide the
14.2 patient with a scheduled appointment that is timely, with an appropriate provider who is
14.3 conveniently located. If the patient is uninsured and potentially eligible for a Minnesota
14.4 health care program, the program must connect the patient to a primary care provider,
14.5 community clinic, or agency that can assist the patient with the application process. The
14.6 program must also ensure that discharged patients are connected with a community-based
14.7 primary care provider and assist in scheduling any necessary follow-up visits before
14.8 the patient is discharged.

14.9 (b) The program must not require a provider to pay a fee for accepting charity care
14.10 patients or patients enrolled in a Minnesota public health care program.

14.11 Subd. 2. **Evaluation.** (a) The grantee must report to the commissioner on a quarterly
14.12 basis the following information:

14.13 (1) total number of appointments available for scheduling by specialty;

14.14 (2) average length of time between scheduling and actual appointment; and

14.15 (3) total number of patients referred and whether the patient was insured or
14.16 uninsured.

14.17 (b) The commissioner, in consultation with the Minnesota Hospital Association,
14.18 shall conduct an evaluation of the emergency room diversion pilot project and submit the
14.19 results to the legislature by January 15, 2009. The evaluation shall compare the number of
14.20 nonemergency visits and repeat visits to hospital emergency rooms for the period before
14.21 the commencement of the project and one year after the commencement, and an estimate
14.22 of the costs saved from any documented reductions.

14.23 Sec. 14. Minnesota Statutes 2006, section 256B.056, subdivision 10, is amended to
14.24 read:

14.25 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who
14.26 are applying for the continuation of medical assistance coverage following the end of the
14.27 60-day postpartum period to update their income and asset information and to submit
14.28 any required income or asset verification.

14.29 (b) The commissioner shall determine the eligibility of private-sector health care
14.30 coverage for infants less than one year of age eligible under section 256B.055, subdivision
14.31 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage
14.32 if this is determined to be cost-effective.

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

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

Sec. 15. Minnesota Statutes 2006, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services, and the services of a clinic meeting the criteria established in rule by the commissioner. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) ~~In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential~~

16.1 ~~community provider status for three years, medical assistance payments for health services~~
16.2 ~~provided by these entities shall be according to the same rates and conditions applicable~~
16.3 ~~to the same service provided by health care providers that are not federally qualified~~
16.4 ~~health centers or rural health clinics.~~

16.5 ~~(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally~~
16.6 ~~qualified health center or a rural health clinic to make application for an essential~~
16.7 ~~community provider designation in order to have cost-based payments made according~~
16.8 ~~to paragraphs (a) and (b) no longer apply.~~

16.9 ~~(e)~~ Effective January 1, 2000, payments made according to paragraphs (a) and (b)
16.10 shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

16.11 ~~(f)~~ (d) Effective January 1, 2001, each federally qualified health center and
16.12 rural health clinic may elect to be paid either under the prospective payment system
16.13 established in United States Code, title 42, section 1396a(aa), or under an alternative
16.14 payment methodology consistent with the requirements of United States Code, title 42,
16.15 section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services.
16.16 The alternative payment methodology shall be 100 percent of ~~cost~~ costs as determined
16.17 ~~according to~~ by generally accepted accounting principles and annual Medicare cost
16.18 ~~principles~~ reports, including Medicaid-eligible cost add-ons.

16.19 Sec. 16. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
16.20 subdivision to read:

16.21 Subd. 49. **Community health worker.** Medical assistance covers the care
16.22 coordination and patient education services of a community health worker if the
16.23 community health worker has earned a certificate from the Minnesota State Colleges
16.24 and University System approved community health worker curriculum or equivalent.
16.25 Services provided by community health workers who have at least five years of supervised
16.26 experience must be considered eligible for payment but these workers must complete the
16.27 certificate program by January 1, 2010. Community health workers must work under the
16.28 supervision of a medical assistance enrolled provider.

16.29 Sec. 17. **[256B.0632] MEDICAL ASSISTANCE CO-PAYMENTS.**

16.30 Subdivision 1. **Co-payment.** The medical assistance benefit plan shall include a
16.31 $6 co-payment for nonemergency visits to a hospital-based emergency room, except as
16.32 provided in subdivision 2.

16.33 Subd. 2. **Exceptions.** A co-payment shall not be charged to:

16.34 (1) children under the age of 21;

17.1 (2) pregnant women for services that relate to the pregnancy or any other medical
17.2 condition that may complicate the pregnancy;
17.3 (3) recipients expected to reside for at least 30 days in a hospital, nursing facility, or
17.4 intermediate care facility for the developmentally disabled; and
17.5 (4) recipients receiving hospice care.

17.6 Sec. 18. Minnesota Statutes 2006, section 256D.03, subdivision 3, is amended to read:
17.7 Subd. 3. **General assistance medical care; eligibility.** (a) General assistance
17.8 medical care may be paid for any person who is not eligible for medical assistance under
17.9 chapter 256B, including eligibility for medical assistance based on a spenddown of excess
17.10 income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in
17.11 paragraph (b), except as provided in paragraph (c), and:
17.12 (1) who is receiving assistance under section 256D.05, except for families with
17.13 children who are eligible under Minnesota family investment program (MFIP), or who is
17.14 having a payment made on the person's behalf under sections 256I.01 to 256I.06; or
17.15 (2) who is a resident of Minnesota; and
17.16 (i) who has gross countable income not in excess of 75 percent of the federal poverty
17.17 guidelines for the family size, using a six-month budget period and whose equity in assets
17.18 is not in excess of $1,000 per assistance unit. General assistance medical care is not
17.19 available for applicants or enrollees who are otherwise eligible for medical assistance but
17.20 fail to verify their assets. Enrollees who become eligible for medical assistance shall be
17.21 terminated and transferred to medical assistance. Exempt assets, the reduction of excess
17.22 assets, and the waiver of excess assets must conform to the medical assistance program in
17.23 section 256B.056, subdivision 3, with the following exception: the maximum amount of
17.24 undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by
17.25 the trustee, assuming the full exercise of the trustee's discretion under the terms of the
17.26 trust, must be applied toward the asset maximum;
17.27 (ii) who has gross countable income above 75 percent of the federal poverty
17.28 guidelines but not in excess of 175 percent of the federal poverty guidelines for the
17.29 family size, using a six-month budget period, whose equity in assets is not in excess
17.30 of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient
17.31 hospitalization; or
17.32 (iii) the commissioner shall adjust the income standards under this section each July
17.33 1 by the annual update of the federal poverty guidelines following publication by the
17.34 United States Department of Health and Human Services.

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

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

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

18.15 (e) Applicants and recipients eligible under paragraph (a), clause (1); who have
18.16 applied for and are awaiting a determination of blindness or disability by the state medical
18.17 review team or a determination of eligibility for Supplemental Security Income or Social
18.18 Security Disability Insurance by the Social Security Administration; who fail to meet the
18.19 requirements of section 256L.09, subdivision 2; who are homeless as defined by United
18.20 States Code, title 42, section 11301, et seq.; who are classified as end-stage renal disease
18.21 beneficiaries in the Medicare program; who are enrolled in private health care coverage as
18.22 defined in section 256B.02, subdivision 9; who are eligible under paragraph (j); or who
18.23 receive treatment funded pursuant to section 254B.02 are exempt from the MinnesotaCare
18.24 enrollment requirements of this subdivision.

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

18.30 (g) Beginning September 1, 2006, Minnesota health care program applications and
18.31 renewals completed by recipients and applicants who are persons described in paragraph
18.32 (c) and submitted to the county agency shall be determined for MinnesotaCare eligibility
18.33 by the county agency. If all other eligibility requirements of this subdivision are met,
18.34 eligibility for general assistance medical care shall be available in any month during which
18.35 MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare,
18.36 notice of termination for eligibility for general assistance medical care shall be sent to

19.1 an applicant or recipient. If all other eligibility requirements of this subdivision are
19.2 met, eligibility for general assistance medical care shall be available until enrollment in
19.3 MinnesotaCare subject to the provisions of paragraphs (c), (e), and (f).

19.4 (h) The date of an initial Minnesota health care program application necessary to
19.5 begin a determination of eligibility shall be the date the applicant has provided a name,
19.6 address, and Social Security number, signed and dated, to the county agency or the
19.7 Department of Human Services. If the applicant is unable to provide a name, address,
19.8 Social Security number, and signature when health care is delivered due to a medical
19.9 condition or disability, a health care provider may act on an applicant's behalf to establish
19.10 the date of an initial Minnesota health care program application by providing the county
19.11 agency or Department of Human Services with provider identification and a temporary
19.12 unique identifier for the applicant. The applicant must complete the remainder of the
19.13 application and provide necessary verification before eligibility can be determined. The
19.14 county agency must assist the applicant in obtaining verification if necessary.

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

19.19 (j) General assistance medical care is not available for a person in a correctional
19.20 facility unless the person is detained by law for less than one year in a county correctional
19.21 or detention facility as a person accused or convicted of a crime, or admitted as an
19.22 inpatient to a hospital on a criminal hold order, and the person is a recipient of general
19.23 assistance medical care at the time the person is detained by law or admitted on a criminal
19.24 hold order and as long as the person continues to meet other eligibility requirements
19.25 of this subdivision.

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

19.28 (l) In determining the amount of assets of an individual eligible under paragraph
19.29 (a), clause (2), item (i), there shall be included any asset or interest in an asset, including
19.30 an asset excluded under paragraph (a), that was given away, sold, or disposed of for
19.31 less than fair market value within the 60 months preceding application for general
19.32 assistance medical care or during the period of eligibility. Any transfer described in this
19.33 paragraph shall be presumed to have been for the purpose of establishing eligibility for
19.34 general assistance medical care, unless the individual furnishes convincing evidence to
19.35 establish that the transaction was exclusively for another purpose. For purposes of this
19.36 paragraph, the value of the asset or interest shall be the fair market value at the time it

20.1 was given away, sold, or disposed of, less the amount of compensation received. For any
20.2 uncompensated transfer, the number of months of ineligibility, including partial months,
20.3 shall be calculated by dividing the uncompensated transfer amount by the average monthly
20.4 per person payment made by the medical assistance program to skilled nursing facilities
20.5 for the previous calendar year. The individual shall remain ineligible until this fixed period
20.6 has expired. The period of ineligibility may exceed 30 months, and a reapplication for
20.7 benefits after 30 months from the date of the transfer shall not result in eligibility unless
20.8 and until the period of ineligibility has expired. The period of ineligibility begins in the
20.9 month the transfer was reported to the county agency, or if the transfer was not reported,
20.10 the month in which the county agency discovered the transfer, whichever comes first. For
20.11 applicants, the period of ineligibility begins on the date of the first approved application.

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

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

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

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

20.26 Sec. 19. Minnesota Statutes 2006, section 256D.03, subdivision 4, is amended to read:

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

20.30 (1) inpatient hospital services;

20.31 (2) outpatient hospital services;

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

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

21.1 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
21.2 for diabetics to monitor blood sugar level;
21.3 (6) eyeglasses and eye examinations provided by a physician or optometrist;
21.4 (7) hearing aids;
21.5 (8) prosthetic devices;
21.6 (9) laboratory and X-ray services;
21.7 (10) physician's services;
21.8 (11) medical transportation except special transportation;
21.9 (12) chiropractic services as covered under the medical assistance program;
21.10 (13) podiatric services;
21.11 (14) dental services as covered under the medical assistance program;
21.12 (15) outpatient services provided by a mental health center or clinic that is under
21.13 contract with the county board and is established under section 245.62;
21.14 (16) day treatment services for mental illness provided under contract with the
21.15 county board;
21.16 (17) prescribed medications for persons who have been diagnosed as mentally ill as
21.17 necessary to prevent more restrictive institutionalization;
21.18 (18) psychological services, medical supplies and equipment, and Medicare
21.19 premiums, coinsurance and deductible payments;
21.20 (19) medical equipment not specifically listed in this paragraph when the use of
21.21 the equipment will prevent the need for costlier services that are reimbursable under
21.22 this subdivision;
21.23 (20) services performed by a certified pediatric nurse practitioner, a certified family
21.24 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
21.25 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
21.26 practitioner in independent practice, if (1) the service is otherwise covered under this
21.27 chapter as a physician service, (2) the service provided on an inpatient basis is not included
21.28 as part of the cost for inpatient services included in the operating payment rate, and (3) the
21.29 service is within the scope of practice of the nurse practitioner's license as a registered
21.30 nurse, as defined in section 148.171;
21.31 (21) services of a certified public health nurse or a registered nurse practicing in
21.32 a public health nursing clinic that is a department of, or that operates under the direct
21.33 authority of, a unit of government, if the service is within the scope of practice of the
21.34 public health nurse's license as a registered nurse, as defined in section 148.171;
21.35 (22) telemedicine consultations, to the extent they are covered under section
21.36 256B.0625, subdivision 3b; ~~and~~

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

(24) care coordination and patient education services of a community health worker, if the community health worker has earned a certificate from the Minnesota State Colleges and University System approved community health worker curriculum or equivalent. Services provided by community health workers who have at least five years of supervised experience must be considered eligible for payment but these workers must complete the certificate program by January 1, 2010. Community health workers must work under the supervision of a medical assistance enrolled provider.

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

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

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

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

23.1 (1) $25 for eyeglasses;
23.2 (2) $25 for nonemergency visits to a hospital-based emergency room;
23.3 (3) $3 per brand-name drug prescription and $1 per generic drug prescription,
23.4 subject to a $12 per month maximum for prescription drug co-payments. No co-payments
23.5 shall apply to antipsychotic drugs when used for the treatment of mental illness; and
23.6 (4) 50 percent coinsurance on restorative dental services.
23.7 (e) Co-payments shall be limited to one per day per provider for nonpreventive visits,
23.8 eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of
23.9 general assistance medical care are responsible for all co-payments in this subdivision.
23.10 The general assistance medical care reimbursement to the provider shall be reduced by
23.11 the amount of the co-payment, except that reimbursement for prescription drugs shall not
23.12 be reduced once a recipient has reached the $12 per month maximum for prescription
23.13 drug co-payments. The provider collects the co-payment from the recipient. Providers
23.14 may not deny services to recipients who are unable to pay the co-payment, except as
23.15 provided in paragraph (f).
23.16 (f) If it is the routine business practice of a provider to refuse service to an individual
23.17 with uncollected debt, the provider may include uncollected co-payments under this
23.18 section. A provider must give advance notice to a recipient with uncollected debt before
23.19 services can be denied.
23.20 (g) Any county may, from its own resources, provide medical payments for which
23.21 state payments are not made.
23.22 (h) Chemical dependency services that are reimbursed under chapter 254B must not
23.23 be reimbursed under general assistance medical care.
23.24 (i) The maximum payment for new vendors enrolled in the general assistance
23.25 medical care program after the base year shall be determined from the average usual and
23.26 customary charge of the same vendor type enrolled in the base year.
23.27 (j) The conditions of payment for services under this subdivision are the same as the
23.28 conditions specified in rules adopted under chapter 256B governing the medical assistance
23.29 program, unless otherwise provided by statute or rule.
23.30 (k) Inpatient and outpatient payments shall be reduced by five percent, effective July
23.31 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003,
23.32 and incorporated by reference in paragraph (i).
23.33 (l) Payments for all other health services except inpatient, outpatient, and pharmacy
23.34 services shall be reduced by five percent, effective July 1, 2003.
23.35 (m) Payments to managed care plans shall be reduced by five percent for services
23.36 provided on or after October 1, 2003.

24.1 (n) A hospital receiving a reduced payment as a result of this section may apply the
24.2 unpaid balance toward satisfaction of the hospital's bad debts.
24.3 (o) Fee-for-service payments for nonpreventive visits shall be reduced by $3
24.4 for services provided on or after January 1, 2006. For purposes of this subdivision, a
24.5 visit means an episode of service which is required because of a recipient's symptoms,
24.6 diagnosis, or established illness, and which is delivered in an ambulatory setting by
24.7 a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse,
24.8 audiologist, optician, or optometrist.
24.9 (p) Payments to managed care plans shall not be increased as a result of the removal
24.10 of the $3 nonpreventive visit co-payment effective January 1, 2006.
24.11 (q) Recipients eligible under subdivision 3, paragraph (a), shall pay a $25
24.12 co-payment for nonemergency visits to a hospital-based emergency room.

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

24.14 Sec. 20. Minnesota Statutes 2006, section 256L.01, subdivision 1, is amended to read:
24.15 Subdivision 1. **Scope.** For purposes of ~~sections 256L.01 to 256L.18~~ this chapter,
24.16 the following terms shall have the meanings given them.

24.17 Sec. 21. Minnesota Statutes 2006, section 256L.01, subdivision 4, is amended to read:
24.18 Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross
24.19 family income" for nonfarm self-employed means income calculated for the ~~six-month~~
24.20 12-month period of eligibility using the net profit or loss reported on the applicant's
24.21 federal income tax form for the previous year and using the medical assistance families
24.22 with children methodology for determining allowable and nonallowable self-employment
24.23 expenses and countable income.
24.24 (b) "Gross individual or gross family income" for farm self-employed means income
24.25 calculated for the ~~six-month~~ 12-month period of eligibility using as the baseline the
24.26 adjusted gross income reported on the applicant's federal income tax form for the previous
24.27 year ~~and adding back in reported depreciation amounts that apply to the business in which~~
24.28 ~~the family is currently engaged~~.
24.29 (c) "Gross individual or gross family income" means the total income for all family
24.30 members, calculated for the ~~six-month~~ 12-month period of eligibility.

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

24.32 Sec. 22. Minnesota Statutes 2006, section 256L.03, subdivision 1, is amended to read:

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

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

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

Sec. 23. Minnesota Statutes 2006, section 256L.03, subdivision 3, is amended to read:

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

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

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

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

26.5 Sec. 24. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:
26.6 Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b)
26.7 and (c), the MinnesotaCare benefit plan shall include the following co-payments and
26.8 coinsurance requirements for all enrollees:
26.9 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
26.10 subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and
26.11 $3,000 per family;
26.12 (2) $3 per prescription for adult enrollees;
26.13 (3) $25 for eyeglasses for adult enrollees;
26.14 (4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
26.15 episode of service which is required because of a recipient's symptoms, diagnosis, or
26.16 established illness, and which is delivered in an ambulatory setting by a physician or
26.17 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
26.18 audiologist, optician, or optometrist; and
26.19 (5) $6 for nonemergency visits to a hospital-based emergency room.
26.20 (b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of
26.21 children under the age of 21 ~~in households with family income equal to or less than 175~~
26.22 ~~percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to~~
26.23 ~~parents and relative caretakers of children under the age of 21 in households with family~~
26.24 ~~income greater than 175 percent of the federal poverty guidelines for inpatient hospital~~
26.25 ~~admissions occurring on or after January 1, 2001~~.
26.26 (c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children
26.27 under the age of 21.
26.28 (d) Adult enrollees with family gross income that exceeds ~~175~~ 200 percent of the
26.29 federal poverty guidelines and who are not pregnant shall be financially responsible for
26.30 the coinsurance amount, if applicable, and amounts which exceed the ~~$10,000~~ $20,000
26.31 inpatient hospital benefit limit.
26.32 (e) When a MinnesotaCare enrollee becomes a member of a prepaid health
26.33 plan, or changes from one prepaid health plan to another during a calendar year, any
26.34 charges submitted towards the ~~$10,000~~ $20,000 annual inpatient benefit limit, and any

27.1 out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted
27.2 or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

27.3 Sec. 25. Minnesota Statutes 2006, section 256L.04, subdivision 1a, is amended to read:
27.4 Subd. 1a. **Social Security number required.** (a) Individuals and families applying
27.5 for MinnesotaCare coverage must provide a Social Security number. This requirement
27.6 does not apply to an undocumented noncitizen or nonimmigrant who is eligible for
27.7 MinnesotaCare.
27.8 (b) The commissioner shall not deny eligibility to an otherwise eligible applicant
27.9 who has applied for a Social Security number and is awaiting issuance of that Social
27.10 Security number.
27.11 (c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the
27.12 requirements of this subdivision.
27.13 (d) Individuals who refuse to provide a Social Security number because of
27.14 well-established religious objections are exempt from the requirements of this subdivision.
27.15 The term "well-established religious objections" has the meaning given in Code of Federal
27.16 Regulations, title 42, section 435.910.

27.17 Sec. 26. Minnesota Statutes 2006, section 256L.04, subdivision 7, is amended to read:
27.18 Subd. 7. **Single adults and households with no children.** The definition of eligible
27.19 persons includes all individuals and households with no children who have gross family
27.20 incomes that are equal to or less than ~~175~~ 200 percent of the federal poverty guidelines.

27.21 Sec. 27. Minnesota Statutes 2006, section 256L.04, subdivision 10, is amended to read:
27.22 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited
27.23 to citizens or nationals of the United States, qualified noncitizens, and other persons
27.24 residing lawfully in the United States as described in section 256B.06, subdivision 4,
27.25 paragraphs (a) to (e) and (j). Undocumented noncitizens and nonimmigrants are ineligible
27.26 for MinnesotaCare. This paragraph does not apply to children.
27.27 (b) For purposes of this subdivision, a nonimmigrant is an individual in one or
27.28 more of the classes listed in United States Code, title 8, section 1101(a)(15), and an
27.29 undocumented noncitizen is an individual who resides in the United States without the
27.30 approval or acquiescence of the Immigration and Naturalization Service.
27.31 (c) Families with children who are citizens or nationals of the United States must
27.32 cooperate in obtaining satisfactory documentary evidence of citizenship or nationality
27.33 according to the requirements of the federal Deficit Reduction Act of 2005, Public Law

109-171. State and county workers must assist applicants in obtaining satisfactory documentary evidence of citizenship or nationality.

Sec. 28. Minnesota Statutes 2006, section 256L.05, subdivision 1, is amended to read:

Subdivision 1. **Application and information availability.** Applications and ~~other information~~ application assistance must be made available ~~to~~ at provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, ~~and~~ Women, Infants and Children (WIC) program sites, Head Start program sites, public housing councils, crisis nurseries, child care centers, early childhood education and preschool program sites, legal aid offices, libraries, and other sites willing to cooperate in program outreach. These sites may accept applications and forward the forms to the commissioner or local county human services agencies that choose to participate as an enrollment site. Otherwise, applicants may apply directly to the commissioner or to participating local county human services agencies. ~~Beginning January 1, 2000, MinnesotaCare enrollment sites will be expanded to include local county human services agencies which choose to participate.~~

Sec. 29. Minnesota Statutes 2006, section 256L.05, subdivision 1b, is amended to read:

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

Sec. 30. Minnesota Statutes 2006, section 256L.05, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** ~~(a)~~ The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

29.1 ~~(b) In determining eligibility for MinnesotaCare, the commissioner shall require~~
29.2 ~~applicants and enrollees seeking renewal of eligibility to verify both earned and unearned~~
29.3 ~~income. The commissioner shall also require applicants and enrollees to submit the names~~
29.4 ~~of their employers and a contact name with a telephone number for each employer for~~
29.5 ~~purposes of verifying whether the applicant or enrollee, and any dependents, are eligible~~
29.6 ~~for employer-subsidized coverage. Data collected is nonpublic data as defined in section~~
29.7 ~~13.02, subdivision 9.~~

29.8 Sec. 31. Minnesota Statutes 2006, section 256L.05, subdivision 3a, is amended to read:
29.9 Subd. 3a. **Renewal of eligibility.** (a) Beginning ~~January 1, 1999~~ July 1, 2007, an
29.10 enrollee's eligibility must be renewed every 12 months. The 12-month period begins in
29.11 the month after the month the application is approved.
29.12 (b) ~~Beginning October 1, 2004, an enrollee's eligibility must be renewed every~~
29.13 ~~six months. The first six-month period of eligibility begins the month the application is~~
29.14 ~~received by the commissioner. The effective date of coverage within the first six-month~~
29.15 ~~period of eligibility is as provided in subdivision 3.~~ Each new period of eligibility must
29.16 take into account any changes in circumstances that impact eligibility and premium
29.17 amount. An enrollee must provide all the information needed to redetermine eligibility by
29.18 the first day of the month that ends the eligibility period. The premium for the new period
29.19 of eligibility must be received as provided in section 256L.06 in order for eligibility to
29.20 continue.
29.21 (c) For single adults and households with no children formerly enrolled in general
29.22 assistance medical care and enrolled in MinnesotaCare according to section 256D.03,
29.23 subdivision 3, the first ~~six-month~~ period of eligibility begins the month the enrollee
29.24 submitted the application or renewal for general assistance medical care.

29.25 Sec. 32. Minnesota Statutes 2006, section 256L.05, subdivision 3c, is amended to read:
29.26 Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective
29.27 date of coverage shall be the ~~first~~ day ~~of the month~~ following termination from medical
29.28 assistance or general assistance medical care for families and individuals who are eligible
29.29 for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare
29.30 coverage with a completed application within 30 days of the mailing of notification of
29.31 termination from medical assistance or general assistance medical care. The applicant
29.32 must provide all required verifications within 30 days of the written request for
29.33 verification. For retroactive coverage, premiums must be paid in full for any retroactive
29.34 month, current month, and next month within 30 days of the premium billing.

30.1 Sec. 33. Minnesota Statutes 2006, section 256L.05, is amended by adding a subdivision
30.2 to read:
30.3 Subd. 3d. **Presumptive eligibility.** Coverage under the program is available during
30.4 a presumptive eligibility period for children whose family income does not exceed the
30.5 applicable income standard. The presumptive eligibility period begins on the date on
30.6 which a health care provider enrolled in the program, or other entity designated by the
30.7 commissioner, determines, based on preliminary information, that the child's family
30.8 income does not exceed the applicable income standard. The presumptive eligibility period
30.9 ends the earlier of the day on which a determination is made of eligibility under this section
30.10 or the last day of the month following the month presumptive eligibility was determined.

30.11 Sec. 34. Minnesota Statutes 2006, section 256L.05, is amended by adding a subdivision
30.12 to read:
30.13 Subd. 3e. **Continuous eligibility.** Children who are eligible under this section
30.14 shall be continuously eligible until the earlier of the next renewal period, or the time that
30.15 a child exceeds age 21.

30.16 Sec. 35. Minnesota Statutes 2006, section 256L.07, subdivision 1, is amended to read:
30.17 Subdivision 1. **General requirements.** (a) ~~Children enrolled in the original~~
30.18 ~~children's health plan as of September 30, 1992, children who enrolled in the~~
30.19 ~~MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,~~
30.20 ~~article 4, section 17, and children who have family gross incomes that are equal to or~~
30.21 ~~less than 150 percent of the federal poverty guidelines are eligible without meeting~~
30.22 ~~the requirements of subdivision 2 and the four-month requirement in subdivision 3, as~~
30.23 ~~long as they maintain continuous coverage in the MinnesotaCare program or medical~~
30.24 ~~assistance. Children who apply for MinnesotaCare on or after the implementation date~~
30.25 ~~of the employer-subsidized health coverage program as described in Laws 1998, chapter~~
30.26 ~~407, article 5, section 45, who have family gross incomes that are equal to or less than 150~~
30.27 ~~percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to~~
30.28 ~~be eligible for MinnesotaCare.~~
30.29 ~~(b)~~ Families enrolled in MinnesotaCare under section 256L.04, subdivision 1,
30.30 whose income increases above 275 percent of the federal poverty guidelines, are no
30.31 longer eligible for the program and shall be disenrolled by the commissioner, subject to
30.32 the continuous eligibility requirement for children under section 256L.05, subdivision
30.33 3e. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose
30.34 income increases above ~~175~~ 200 percent of the federal poverty guidelines are no longer

eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

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

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

Sec. 36. Minnesota Statutes 2006, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be eligible, ~~a family or individual~~ an adult must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. ~~A family or individual~~ An adult whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

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

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

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

(e) This subdivision does not apply to children.

Sec. 37. Minnesota Statutes 2006, section 256L.07, subdivision 3, is amended to read:

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

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

~~(i) basic hospital insurance;~~

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

~~(iii) prescription drug coverage;~~

~~(iv) dental coverage; or~~

~~(v) vision coverage;~~

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

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

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

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

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

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

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

33.8 Sec. 38. Minnesota Statutes 2006, section 256L.07, subdivision 6, is amended to read:

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

33.13 Sec. 39. Minnesota Statutes 2006, section 256L.09, subdivision 4, is amended to read:

33.14 Subd. 4. **Eligibility as Minnesota resident.** (a) For purposes of this section, a
33.15 permanent Minnesota resident is a person who has demonstrated, through persuasive and
33.16 objective evidence, that the person is domiciled in the state and intends to live in the
33.17 state permanently.

33.18 (b) To be eligible as a permanent resident, an applicant must demonstrate the
33.19 requisite intent to live in the state permanently by:

33.20 (1) showing that the applicant maintains a residence at a verified address ~~other than a~~
33.21 ~~place of public accommodation~~, through the use of evidence of residence described in
33.22 section 256D.02, subdivision 12a, paragraph (b), clause ~~(1)~~ (2);

33.23 (2) demonstrating that the applicant has been continuously domiciled in the state for
33.24 no less than 180 days immediately before the application; and

33.25 (3) signing an affidavit declaring that (A) the applicant currently resides in the state
33.26 and intends to reside in the state permanently; and (B) the applicant did not come to the
33.27 state for the primary purpose of obtaining medical coverage or treatment.

33.28 (c) A person who is temporarily absent from the state does not lose eligibility for
33.29 MinnesotaCare. "Temporarily absent from the state" means the person is out of the state
33.30 for a temporary purpose and intends to return when the purpose of the absence has been
33.31 accomplished. A person is not temporarily absent from the state if another state has
33.32 determined that the person is a resident for any purpose. If temporarily absent from the
33.33 state, the person must follow the requirements of the health plan in which the person is
33.34 enrolled to receive services.

34.1 Sec. 40. Minnesota Statutes 2006, section 256L.15, subdivision 1, is amended to read:

34.2 Subdivision 1. **Premium determination.** (a) Families with children and individuals
34.3 shall pay a premium determined according to subdivision 2, except that no premium shall
34.4 be charged to individuals under the age of 21.

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

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

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

34.20 Sec. 41. Minnesota Statutes 2006, section 256L.15, subdivision 2, is amended to read:

34.21 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The
34.22 commissioner shall establish a sliding fee scale to determine the percentage of monthly
34.23 gross individual or family income that households at different income levels must pay
34.24 to obtain coverage through the MinnesotaCare program. The sliding fee scale must be
34.25 based on the enrollee's monthly gross individual or family income. The sliding fee scale
34.26 must contain separate tables based on enrollment of one, two, or three or more persons.
34.27 The sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or
34.28 family income for individuals or families with incomes below the limits for the medical
34.29 assistance program for families and children in effect on January 1, 1999, and proceeds
34.30 through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent.
34.31 These percentages are matched to evenly spaced income steps ranging from the medical
34.32 assistance income limit for families and children in effect on January 1, 1999, to 275
34.33 percent of the federal poverty guidelines for the applicable family size, up to a family size
34.34 of five. The sliding fee scale for a family of five must be used for families of more than
34.35 five. ~~Effective October 1, 2003, the commissioner shall increase each percentage by 0.5~~

35.1 ~~percentage points for enrollees with income greater than 100 percent but not exceeding~~
35.2 ~~200 percent of the federal poverty guidelines and shall increase each percentage by 1.0~~
35.3 ~~percentage points for families and children with incomes greater than 200 percent of~~
35.4 ~~the federal poverty guidelines.~~ The sliding fee scale and percentages are not subject to
35.5 the provisions of chapter 14. If a family or individual reports increased income after
35.6 enrollment, premiums shall be adjusted at the time the change in income is reported.
35.7 (b) ~~Children in~~ Families whose gross income is above 275 percent of the federal
35.8 poverty guidelines shall pay the maximum premium. The maximum premium is defined
35.9 as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare
35.10 cases paid the maximum premium, the total revenue would equal the total cost of
35.11 MinnesotaCare medical coverage and administration. In this calculation, administrative
35.12 costs shall be assumed to equal ten percent of the total. The costs of medical coverage
35.13 for pregnant women and children under age two and the enrollees in these groups shall
35.14 be excluded from the total. The maximum premium for two enrollees shall be twice the
35.15 maximum premium for one, and the maximum premium for three or more enrollees shall
35.16 be three times the maximum premium for one.
35.17 ~~(c) After calculating the percentage of premium each enrollee shall pay under~~
35.18 ~~paragraph (a), eight percent shall be added to the premium.~~

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

35.20 Sec. 42. Minnesota Statutes 2006, section 256L.17, subdivision 2, is amended to read:
35.21 Subd. 2. **Limit on total assets.** (a) Effective July 1, 2002, or upon federal approval,
35.22 whichever is later, in order to be eligible for the MinnesotaCare program, a household of
35.23 two or more persons must not own more than $20,000 in total net assets, and a household
35.24 of one person must not own more than $10,000 in total net assets.
35.25 (b) For purposes of this subdivision, assets are determined according to section
35.26 256B.056, subdivision 3c, except that workers' compensation settlements received due to
35.27 a work-related injury shall not be considered.
35.28 (c) State-funded MinnesotaCare is not available for applicants or enrollees who are
35.29 otherwise eligible for medical assistance but fail to verify assets. Enrollees who become
35.30 eligible for federally funded medical assistance shall be terminated from state-funded
35.31 MinnesotaCare and transferred to medical assistance.

35.32 Sec. 43. Minnesota Statutes 2006, section 256L.17, subdivision 3, is amended to read:
35.33 Subd. 3. **Documentation.** (a) The commissioner of human services shall require
35.34 individuals and families, at the time of application or renewal, to indicate on a checkoff

form developed by the commissioner whether they satisfy the MinnesotaCare asset requirement. ~~This form must include the following or similar language: "To be eligible for MinnesotaCare, individuals and families must not own net assets in excess of $30,000 for a household of two or more persons or $15,000 for a household of one person, not including a homestead, household goods and personal effects, assets owned by children, vehicles used for employment, court-ordered settlements up to $10,000, individual retirement accounts, and capital and operating assets of a trade or business up to $200,000. Do you and your household own net assets in excess of these limits?"~~

(b) The commissioner may require individuals and families to provide any information the commissioner determines necessary to verify compliance with the asset requirement, if the commissioner determines that there is reason to believe that an individual or family has assets that exceed the program limit.

Sec. 44. Minnesota Statutes 2006, section 256L.17, subdivision 7, is amended to read:

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

Sec. 45. Laws 2005, First Special Session chapter 4, article 9, section 3, subdivision 2, is amended to read:

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

Summary by Fund		
General	40,413,000	40,382,000
State Government Special Revenue	141,000	128,000
Health Care Access	3,510,000	3,516,000
Federal TANF	6,000,000	6,000,000

~~**FAMILY PLANNING BASE REDUCTION.** Base level funding for the family planning special projects grant program is reduced by $1,877,000 each year of the biennium beginning July 1, 2007, provided that this reduction shall only take place upon full implementation of the family planning project section of the~~

37.1 ~~1115 waiver. Notwithstanding Minnesota~~
37.2 ~~Statutes, section 145.925, the commissioner~~
37.3 ~~shall give priority to community health care~~
37.4 ~~clinics providing family planning services~~
37.5 ~~that either serve a high number of women~~
37.6 ~~who do not qualify for medical assistance~~
37.7 ~~or are unable to participate in the medical~~
37.8 ~~assistance program as a medical assistance~~
37.9 ~~provider when allocating the remaining~~
37.10 ~~appropriations. Notwithstanding section 15,~~
37.11 ~~this paragraph shall not expire.~~

37.12 **SHAKEN BABY VIDEO.** Of the
37.13 state government special revenue fund
37.14 appropriation, $13,000 in 2006 is
37.15 appropriated to the commissioner of health
37.16 to provide a video to hospitals on shaken
37.17 baby syndrome. The commissioner of health
37.18 shall assess a fee to hospitals to cover the
37.19 cost of the approved shaken baby video and
37.20 the revenue received is to be deposited in the
37.21 state government special revenue fund.

37.22 Sec. 46. **APPROPRIATION.**

37.23 (a) $....... is appropriated from the health care access fund to the commissioner of
37.24 human services for the biennium beginning July 1, 2007, for the purpose of Minnesota
37.25 health care programs outreach grants and the enrollment incentive programs under
37.26 Minnesota Statutes, section 256.962.

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

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

37.33 (d) $....... is appropriated for the biennium beginning July 1, 2007, from the general
37.34 fund to the commissioner of health for the subsidies for federally qualified health centers
37.35 under Minnesota Statutes, section 145.9269.

38.1 (e) $....... is appropriated for the biennium beginning July 1, 2007, from the general
38.2 fund to the commissioner of human services for the patient incentive health program
38.3 established in Minnesota Statutes, section 256.01, subdivision 2b, paragraph (b).

38.4 Sec. 47. **REPEALER.**

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

38.6 **ARTICLE 2**

38.7 **MINNESOTA HEALTH INSURANCE EXCHANGE; SECTION 125 PLANS**

38.8 Section 1. Minnesota Statutes 2006, section 13.46, subdivision 2, is amended to read:
38.9 Subd. 2. **General.** (a) Unless the data is summary data or a statute specifically
38.10 provides a different classification, data on individuals collected, maintained, used, or
38.11 disseminated by the welfare system is private data on individuals, and shall not be
38.12 disclosed except:
38.13 (1) according to section 13.05;
38.14 (2) according to court order;
38.15 (3) according to a statute specifically authorizing access to the private data;
38.16 (4) to an agent of the welfare system, including a law enforcement person, attorney,
38.17 or investigator acting for it in the investigation or prosecution of a criminal or civil
38.18 proceeding relating to the administration of a program;
38.19 (5) to personnel of the welfare system who require the data to verify an individual's
38.20 identity; determine eligibility, amount of assistance, and the need to provide services to
38.21 an individual or family across programs; evaluate the effectiveness of programs; and
38.22 investigate suspected fraud;
38.23 (6) to administer federal funds or programs;
38.24 (7) between personnel of the welfare system working in the same program;
38.25 (8) to the Department of Revenue to administer and evaluate tax refund or tax credit
38.26 programs and to identify individuals who may benefit from these programs. The following
38.27 information may be disclosed under this paragraph: an individual's and their dependent's
38.28 names, dates of birth, Social Security numbers, income, addresses, and other data as
38.29 required, upon request by the Department of Revenue. Disclosures by the commissioner
38.30 of revenue to the commissioner of human services for the purposes described in this clause
38.31 are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include,
38.32 but are not limited to, the dependent care credit under section 290.067, the Minnesota
38.33 working family credit under section 290.0671, the property tax refund and rental credit
38.34 under section 290A.04, and the Minnesota education credit under section 290.0674;

39.1 (9) between the Department of Human Services, the Department of Education, and
39.2 the Department of Employment and Economic Development for the purpose of monitoring
39.3 the eligibility of the data subject for unemployment benefits, for any employment or
39.4 training program administered, supervised, or certified by that agency, for the purpose of
39.5 administering any rehabilitation program or child care assistance program, whether alone
39.6 or in conjunction with the welfare system, or to monitor and evaluate the Minnesota
39.7 family investment program by exchanging data on recipients and former recipients of food
39.8 support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance
39.9 under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;
39.10 (10) to appropriate parties in connection with an emergency if knowledge of
39.11 the information is necessary to protect the health or safety of the individual or other
39.12 individuals or persons;
39.13 (11) data maintained by residential programs as defined in section 245A.02 may
39.14 be disclosed to the protection and advocacy system established in this state according
39.15 to Part C of Public Law 98-527 to protect the legal and human rights of persons with
39.16 developmental disabilities or other related conditions who live in residential facilities for
39.17 these persons if the protection and advocacy system receives a complaint by or on behalf
39.18 of that person and the person does not have a legal guardian or the state or a designee of
39.19 the state is the legal guardian of the person;
39.20 (12) to the county medical examiner or the county coroner for identifying or locating
39.21 relatives or friends of a deceased person;
39.22 (13) data on a child support obligor who makes payments to the public agency
39.23 may be disclosed to the Minnesota Office of Higher Education to the extent necessary to
39.24 determine eligibility under section 136A.121, subdivision 2, clause (5);
39.25 (14) participant Social Security numbers and names collected by the telephone
39.26 assistance program may be disclosed to the Department of Revenue to conduct an
39.27 electronic data match with the property tax refund database to determine eligibility under
39.28 section 237.70, subdivision 4a;
39.29 (15) the current address of a Minnesota family investment program participant
39.30 may be disclosed to law enforcement officers who provide the name of the participant
39.31 and notify the agency that:
39.32 (i) the participant:
39.33 (A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after
39.34 conviction, for a crime or attempt to commit a crime that is a felony under the laws of the
39.35 jurisdiction from which the individual is fleeing; or
39.36 (B) is violating a condition of probation or parole imposed under state or federal law;

40.1 (ii) the location or apprehension of the felon is within the law enforcement officer's
40.2 official duties; and
40.3 (iii) the request is made in writing and in the proper exercise of those duties;
40.4 (16) the current address of a recipient of general assistance or general assistance
40.5 medical care may be disclosed to probation officers and corrections agents who are
40.6 supervising the recipient and to law enforcement officers who are investigating the
40.7 recipient in connection with a felony level offense;
40.8 (17) information obtained from food support applicant or recipient households may
40.9 be disclosed to local, state, or federal law enforcement officials, upon their written request,
40.10 for the purpose of investigating an alleged violation of the Food Stamp Act, according
40.11 to Code of Federal Regulations, title 7, section 272.1(c);
40.12 (18) the address, Social Security number, and, if available, photograph of any
40.13 member of a household receiving food support shall be made available, on request, to a
40.14 local, state, or federal law enforcement officer if the officer furnishes the agency with the
40.15 name of the member and notifies the agency that:
40.16 (i) the member:
40.17 (A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a
40.18 crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;
40.19 (B) is violating a condition of probation or parole imposed under state or federal
40.20 law; or
40.21 (C) has information that is necessary for the officer to conduct an official duty related
40.22 to conduct described in subitem (A) or (B);
40.23 (ii) locating or apprehending the member is within the officer's official duties; and
40.24 (iii) the request is made in writing and in the proper exercise of the officer's official
40.25 duty;
40.26 (19) the current address of a recipient of Minnesota family investment program,
40.27 general assistance, general assistance medical care, or food support may be disclosed to
40.28 law enforcement officers who, in writing, provide the name of the recipient and notify the
40.29 agency that the recipient is a person required to register under section 243.166, but is not
40.30 residing at the address at which the recipient is registered under section 243.166;
40.31 (20) certain information regarding child support obligors who are in arrears may be
40.32 made public according to section 518A.74;
40.33 (21) data on child support payments made by a child support obligor and data on
40.34 the distribution of those payments excluding identifying information on obligees may be
40.35 disclosed to all obligees to whom the obligor owes support, and data on the enforcement

41.1 actions undertaken by the public authority, the status of those actions, and data on the
41.2 income of the obligor or obligee may be disclosed to the other party;

41.3 (22) data in the work reporting system may be disclosed under section 256.998,
41.4 subdivision 7;

41.5 (23) to the Department of Education for the purpose of matching Department of
41.6 Education student data with public assistance data to determine students eligible for free
41.7 and reduced price meals, meal supplements, and free milk according to United States
41.8 Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and
41.9 state funds that are distributed based on income of the student's family; and to verify
41.10 receipt of energy assistance for the telephone assistance plan;

41.11 (24) the current address and telephone number of program recipients and emergency
41.12 contacts may be released to the commissioner of health or a local board of health as
41.13 defined in section 145A.02, subdivision 2, when the commissioner or local board of health
41.14 has reason to believe that a program recipient is a disease case, carrier, suspect case, or at
41.15 risk of illness, and the data are necessary to locate the person;

41.16 (25) to other state agencies, statewide systems, and political subdivisions of this
41.17 state, including the attorney general, and agencies of other states, interstate information
41.18 networks, federal agencies, and other entities as required by federal regulation or law for
41.19 the administration of the child support enforcement program;

41.20 (26) to personnel of public assistance programs as defined in section 256.741, for
41.21 access to the child support system database for the purpose of administration, including
41.22 monitoring and evaluation of those public assistance programs;

41.23 (27) to monitor and evaluate the Minnesota family investment program by
41.24 exchanging data between the Departments of Human Services and Education, on
41.25 recipients and former recipients of food support, cash assistance under chapter 256, 256D,
41.26 256J, or 256K, child care assistance under chapter 119B, or medical programs under
41.27 chapter 256B, 256D, or 256L;

41.28 (28) to evaluate child support program performance and to identify and prevent
41.29 fraud in the child support program by exchanging data between the Department of Human
41.30 Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a)
41.31 and (b), without regard to the limitation of use in paragraph (c), Department of Health,
41.32 Department of Employment and Economic Development, and other state agencies as is
41.33 reasonably necessary to perform these functions; ~~or~~

41.34 (29) counties operating child care assistance programs under chapter 119B may
41.35 disseminate data on program participants, applicants, and providers to the commissioner
41.36 of education~~.~~; or

42.1 (30) pursuant to section 256L.02, subdivision 6, between the welfare system and
42.2 the Minnesota Health Insurance Exchange, under section 62A.67, in order to enroll and
42.3 collect premiums from individuals in the MinnesotaCare program under chapter 256L and
42.4 to administer the individual's and their families' participation in the program.

42.5 (b) Information on persons who have been treated for drug or alcohol abuse may
42.6 only be disclosed according to the requirements of Code of Federal Regulations, title
42.7 42, sections 2.1 to 2.67.

42.8 (c) Data provided to law enforcement agencies under paragraph (a), clause (15),
42.9 (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected
42.10 nonpublic while the investigation is active. The data are private after the investigation
42.11 becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

42.12 (d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but is
42.13 not subject to the access provisions of subdivision 10, paragraph (b).

42.14 For the purposes of this subdivision, a request will be deemed to be made in writing
42.15 if made through a computer interface system.

42.16 Sec. 2. **[62A.67] MINNESOTA HEALTH INSURANCE EXCHANGE.**

42.17 Subdivision 1. **Title; citation.** This section may be cited as the "Minnesota Health
42.18 Insurance Exchange."

42.19 Subd. 2. **Creation; tax exemption.** The Minnesota Health Insurance Exchange
42.20 is created for the limited purpose of providing individuals with greater access, choice,
42.21 portability, and affordability of health insurance products. The Minnesota Health
42.22 Insurance Exchange is a not-for-profit corporation under chapter 317A and section 501(c)
42.23 of the Internal Revenue Code.

42.24 Subd. 3. **Definitions.** The following terms have the meanings given them unless
42.25 otherwise provided in text.

42.26 (a) "Board" means the board of directors of the Minnesota Health Insurance
42.27 Exchange under subdivision 13.

42.28 (b) "Commissioner" means:

42.29 (1) the commissioner of commerce for health insurers subject to the jurisdiction
42.30 of the Department of Commerce;

42.31 (2) the commissioner of health for health insurers subject to the jurisdiction of the
42.32 Department of Health; or

42.33 (3) either commissioner's designated representative.

42.34 (c) "Exchange" means the Minnesota Health Insurance Exchange.

42.35 (d) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

43.1 (e) "Individual market health plans," unless otherwise specified, means individual
43.2 market health plans defined in section 62A.011.
43.3 (f) "Section 125 Plan" means a Premium Only Plan under section 125 of the Internal
43.4 Revenue Code.
43.5 Subd. 4. **Insurer and health plan participation.** All health plans as defined in
43.6 section 62A.011, subdivision 3, issued or renewed in the individual market shall participate
43.7 in the exchange. No health plans in the individual market may be issued or renewed
43.8 outside of the exchange. Group health plans as defined in section 62A.10 shall not be
43.9 offered through the exchange. Health plans offered through the Minnesota Comprehensive
43.10 Health Association as defined in section 62E.10 are offered through the exchange to
43.11 eligible enrollees as determined by the Minnesota Comprehensive Health Association.
43.12 Health plans offered through MinnesotaCare under chapter 256L are offered through the
43.13 exchange to eligible enrollees as determined by the commissioner of human services.
43.14 Subd. 5. **Approval of health plans.** No health plan may be offered through the
43.15 exchange unless the commissioner has first certified that:
43.16 (1) the insurer seeking to offer the health plan is licensed to issue health insurance in
43.17 the state; and
43.18 (2) the health plan meets the requirements of this section, and the health plan and the
43.19 insurer are in compliance with all other applicable health insurance laws.
43.20 Subd. 6. **Individual market health plans.** Individual market health plans offered
43.21 through the exchange continue to be regulated by the commissioner as specified in
43.22 chapters 62A, 62C, 62D, 62E, 62Q, and 72A, and must include the following provisions
43.23 that apply to all health plans issued or renewed through the exchange:
43.24 (1) premiums for children under the age of 19 shall not vary by age in the exchange;
43.25 and
43.26 (2) premiums for children under the age of 19 must be excluded from rating factors
43.27 requirements under section 62A.65, subdivision 3, paragraph (b).
43.28 Subd. 7. **Individual participation and eligibility.** Individuals are eligible to
43.29 purchase health plans directly through the exchange or through an employer Section
43.30 125 Plan under section 62A.68. Nothing in this section requires guaranteed issue of
43.31 individual market health plans offered through the exchange. Individuals are eligible to
43.32 purchase individual market health plans through the exchange by meeting one or more
43.33 of the following qualifications:
43.34 (1) the individual is a Minnesota resident, meaning the individual is physically
43.35 residing on a permanent basis in a place that is the person's principal residence and from
43.36 which the person is absent only for temporary purposes;

44.1 (2) the individual is a student attending an institution outside of Minnesota and
44.2 maintains Minnesota residency;
44.3 (3) the individual is not a Minnesota resident but is employed by an employer
44.4 physically located within the state and the individual's employer does not offer a group
44.5 health insurance plan as defined in section 62A.10, but does offer a Section 125 Plan
44.6 through the exchange under section 62A.68;
44.7 (4) the individual is not a Minnesota resident but is self-employed and the
44.8 individual's principal place of business is in the state; or
44.9 (5) the individual is a dependent, as defined in section 62L.02, of another individual
44.10 who is eligible to participate in the exchange.
44.11 Subd. 8. **Continuation of coverage.** Enrollment in a health plan may be canceled
44.12 for nonpayment of premiums, fraud, or changes in eligibility for MinnesotaCare under
44.13 chapter 256L. Enrollment in an individual market health plan may not be canceled or
44.14 renewed because of any change in employer or employment status, marital status, health
44.15 status, age, residence, or any other change that does not affect eligibility as defined
44.16 in this section.
44.17 Subd. 9. **Responsibilities of the exchange.** The exchange shall serve as the sole
44.18 entity for enrollment and collection and transfer of premium payments for health plans
44.19 offered through the exchange. The exchange shall be responsible for the following
44.20 functions:
44.21 (1) publicize the exchange, including but not limited to its functions, eligibility
44.22 rules, and enrollment procedures;
44.23 (2) provide assistance to employers to set up an employer Section 125 Plan under
44.24 section 62A.68;
44.25 (3) create a system to allow individuals to compare and enroll in health plans offered
44.26 through the exchange;
44.27 (4) create a system to collect and transmit to the applicable plans all premium
44.28 payments or contributions made by or on behalf of individuals, including developing
44.29 mechanisms to receive and process automatic payroll deductions for individuals enrolled
44.30 in employer Section 125 Plans;
44.31 (5) refer individuals interested in MinnesotaCare under chapter 256L to the
44.32 Department of Human Services to determine eligibility;
44.33 (6) establish a mechanism with the Department of Human Services to transfer
44.34 premiums and subsidies for MinnesotaCare to qualify for federal matching payments;
44.35 (7) collect and assess information for eligibility for premium incentives under
44.36 chapter 256L;

45.1 (8) upon request, issue certificates of previous coverage according to the provisions
45.2 of HIPAA and as referenced in section 62Q.181 to all such individuals who cease to be
45.3 covered by a participating health plan through the exchange;
45.4 (9) establish procedures to account for all funds received and disbursed by the
45.5 exchange for individual participants of the exchange; and
45.6 (10) make available to the public, at the end of each calendar year, a report of an
45.7 independent audit of the exchange's accounts.
45.8 Subd. 10. **Powers of the exchange.** The exchange shall have the power to:
45.9 (1) contract with insurance producers licensed in accident and health insurance
45.10 under chapter 60K and vendors to perform one or more of the functions specified in
45.11 subdivision 10;
45.12 (2) contract with employers to act as the plan administrator for participating
45.13 employer Section 125 Plans and to undertake the obligations required by federal law
45.14 of a plan administrator;
45.15 (3) establish and assess fees on health plan premiums of health plans purchased
45.16 through the exchange to fund the cost of administering the exchange;
45.17 (4) seek and directly receive grant funding from government agencies or private
45.18 philanthropic organizations to defray the costs of operating the exchange;
45.19 (5) establish and administer rules and procedures governing the operations of the
45.20 exchange;
45.21 (6) establish one or more service centers within Minnesota;
45.22 (7) sue or be sued or otherwise take any necessary or proper legal action;
45.23 (8) establish bank accounts and borrow money; and
45.24 (9) enter into agreements with the commissioners of commerce, health, human
45.25 services, revenue, employment and economic development, and other state agencies as
45.26 necessary for the exchange to implement the provisions of this section.
45.27 Subd. 11. **Dispute resolution.** The exchange shall establish procedures for
45.28 resolving disputes with respect to the eligibility of an individual to participate in the
45.29 exchange. The exchange does not have the authority or responsibility to intervene in or
45.30 resolve disputes between an individual and a health plan or health insurer. The exchange
45.31 shall refer complaints from individuals participating in the exchange to the commissioner
45.32 of human services to be resolved according to sections 62Q.68 to 62Q.73.
45.33 Subd. 12. **Governance.** The exchange shall be governed by a board of directors
45.34 with 11 members. The board shall convene on or before July 1, 2007, after the initial board
45.35 members have been selected. The initial board membership consists of the following:
45.36 (1) the commissioner of commerce;

46.1 (2) the commissioner of human services;

46.2 (3) the commissioner of health;

46.3 (4) four members appointed by a joint committee of the Minnesota senate and the
46.4 Minnesota house of representatives to serve three-year terms; and

46.5 (5) four members appointed by the governor to serve three-year terms.

46.6 Subd. 13. **Subsequent board membership.** Ongoing membership of the exchange
46.7 consists of the following effective July 1, 2010:

46.8 (1) the commissioner of commerce;

46.9 (2) the commissioner of human services;

46.10 (3) the commissioner of health;

46.11 (4) four members appointed by the governor with the approval of a joint committee
46.12 of the senate and house of representatives to serve two- or three-year terms. Appointed
46.13 members may serve more than one term; and

46.14 (5) four members elected by the membership of the exchange of which two are
46.15 elected to serve a two-year term and two are elected to serve a three-year term. Elected
46.16 members may serve more than one term.

46.17 Subd. 14. **Operations of the board.** Officers of the board of directors are elected by
46.18 members of the board and serve one-year terms. Six members of the board constitutes a
46.19 quorum, and the affirmative vote of six members of the board is necessary and sufficient
46.20 for any action taken by the board. Board members serve without pay, but are reimbursed
46.21 for actual expenses incurred in the performance of their duties.

46.22 Subd. 15. **Operations of the exchange.** The board of directors shall appoint an
46.23 exchange director who shall:

46.24 (1) be a full-time employee of the exchange;

46.25 (2) administer all of the activities and contracts of the exchange; and

46.26 (3) hire and supervise the staff of the exchange.

46.27 Subd. 16. **Insurance producers.** When a producer licensed in accident and health
46.28 insurance under chapter 60K enrolls an eligible individual in the exchange, the health plan
46.29 chosen by an individual may pay the producer a commission.

46.30 Subd. 17. **Implementation.** Health plan coverage through the exchange begins on
46.31 January 1, 2009. The exchange must be operational to assist employers and individuals
46.32 by September 1, 2008, and be prepared for enrollment by December 1, 2008. Enrollees
46.33 of individual market health plans, MinnesotaCare, and the Minnesota Comprehensive
46.34 Health Association as of December 2, 2008, are automatically enrolled in the exchange
46.35 on January 1, 2009, in the same health plan and at the same premium they were enrolled
46.36 in as of December 2, 2008, subject to the provisions of this section. As of January 1,

47.1 2009, all enrollees of individual market health plans, MinnesotaCare, and the Minnesota
47.2 Comprehensive Health Association shall make premium payments to the exchange.
47.3 Subd. 18. **Study of insurer issue requirements.** In consultation with
47.4 the commissioners of commerce and health, the exchange shall study and make
47.5 recommendations on rating requirements and risk adjustment mechanisms that could
47.6 be implemented to facilitate increased enrollment in the exchange by employers and
47.7 employees through employer Section 125 Plans. The exchange shall report study findings
47.8 and recommendations to the chairs of house and senate committees having jurisdiction
47.9 over commerce and health by January 15, 2011.

47.10 Sec. 3. **[62A.68] SECTION 125 PLANS.**
47.11 Subdivision 1. **Definitions.** The following terms have the meanings given unless
47.12 otherwise provided in text.
47.13 (a) "Current employee" means an employee currently on an employer's payroll other
47.14 than a retiree or disabled former employee.
47.15 (b) "Employer" means a person, firm, corporation, partnership, association, business
47.16 trust, or other entity employing one or more persons, including a political subdivision of
47.17 the state, filing payroll tax information on such employed person or persons.
47.18 (c) "Section 125 Plan" means a Premium Only Plan under section 125 of the Internal
47.19 Revenue Code.
47.20 (d) "Exchange" means the Minnesota Health Insurance Exchange under section
47.21 62A.67.
47.22 (e) "Exchange director" means the appointed director under section 62A.67,
47.23 subdivision 16.
47.24 Subd. 2. **Section 125 Plan requirement.** Effective January 1, 2009, all employers
47.25 with 11 or more current employees shall offer a Section 125 Plan through the exchange
47.26 to allow their employees to pay for health insurance premiums with pretax dollars. The
47.27 following employers are exempt from the Section 125 Plan requirement:
47.28 (1) employers that offer a group health insurance plan as defined in 62A.10;
47.29 (2) employers that offer group health insurance through a self-insured plan as
47.30 defined in section 62E.02; and
47.31 (3) employers with fewer than 11 current employees, except that employers under
47.32 this clause may voluntarily offer a Section 125 Plan.
47.33 Subd. 3. **Tracking compliance.** By July 1, 2008, the exchange, in consultation with
47.34 the commissioners of commerce, health, employment and economic development, and

48.1 revenue shall establish a method for tracking employer compliance with the Section 125
48.2 Plan requirement.

48.3 Subd. 4. **Employer requirements.** Employers that are required to offer or choose
48.4 to offer a Section 125 Plan through the exchange shall enter into an annual binding
48.5 agreement with the exchange, which includes the terms in paragraphs (a) to (h).

48.6 (a) The employer shall designate the exchange director to be the plan's administrator
48.7 for the employer's plan and the exchange director agrees to undertake the obligations
48.8 required of a plan administrator under federal law.

48.9 (b) Only the coverage and benefits offered by participating insurers in the exchange
48.10 constitutes the coverage and benefits of the participating employer plan.

48.11 (c) Any individual eligible to participate in the exchange may elect coverage under
48.12 any participating health plan for which they are eligible, and neither the employer nor
48.13 the exchange shall limit choice of coverage from among all the participating insurance
48.14 plans for which the individual is eligible.

48.15 (d) The employer shall deduct premium amounts on a pretax basis in an amount
48.16 not to exceed an employee's wages and make payments to the exchange as directed by
48.17 employees for health plans employees enroll in through the exchange.

48.18 (e) The employer shall not offer individuals eligible to participate in the exchange
48.19 any separate or competing group health plan under section 62A.10.

48.20 (f) The employer reserves the right to determine the terms and amounts of the
48.21 employer's contribution to the plan, if any.

48.22 (g) The employer shall make available to the exchange any of the employer's
48.23 documents, records, or information, including copies of the employer's federal and state
48.24 tax and wage reports that are necessary for the exchange to verify:

48.25 (1) that the employer is in compliance with the terms of its agreement with the
48.26 exchange governing the participating employer plan;

48.27 (2) that the participating employer plan is in compliance with applicable state and
48.28 federal laws, including those relating to nondiscrimination in coverage; and

48.29 (3) the eligibility of those individuals enrolled in the participating employer plan.

48.30 (h) The exchange shall not provide the participating employer plan with any
48.31 additional or different services or benefits not otherwise provided or offered to all other
48.32 participating employer plans.

48.33 Subd. 5. **Section 125 eligible health plans.** Individuals eligible to enroll in health
48.34 plans through an employer Section 125 Plan through the exchange may enroll in any
48.35 health plan offered through the exchange for which the individual is eligible including

49.1 individual market health plans, MinnesotaCare, and the Minnesota Comprehensive Health
49.2 Association.

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

49.4 **62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.**

49.5 No employee of an employer that offers a group health plan, under which the
49.6 employee is eligible for coverage, is eligible to enroll, or continue to be enrolled, in
49.7 the comprehensive health association, except for enrollment or continued enrollment
49.8 necessary to cover conditions that are subject to an unexpired preexisting condition
49.9 limitation, preexisting condition exclusion, or exclusionary rider under the employer's
49.10 health plan. This section does not apply to persons enrolled in the Comprehensive Health
49.11 Association as of June 30, 1993. With respect to persons eligible to enroll in the health
49.12 plan of an employer that has more than 29 current employees, as defined in section
49.13 62L.02, this section does not apply to persons enrolled in the Comprehensive Health
49.14 Association as of December 31, 1994.

49.15 Sec. 5. Minnesota Statutes 2006, section 62L.12, subdivision 2, is amended to read:

49.16 Subd. 2. **Exceptions.** (a) A health carrier may sell, issue, or renew individual
49.17 conversion policies to eligible employees otherwise eligible for conversion coverage under
49.18 section 62D.104 as a result of leaving a health maintenance organization's service area.

49.19 (b) A health carrier may sell, issue, or renew individual conversion policies to
49.20 eligible employees otherwise eligible for conversion coverage as a result of the expiration
49.21 of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21,
49.22 62C.142, 62D.101, and 62D.105.

49.23 (c) A health carrier may sell, issue, or renew conversion policies under section
49.24 62E.16 to eligible employees.

49.25 (d) A health carrier may sell, issue, or renew individual continuation policies to
49.26 eligible employees as required.

49.27 (e) A health carrier may sell, issue, or renew individual health plans if the coverage
49.28 is appropriate due to an unexpired preexisting condition limitation or exclusion applicable
49.29 to the person under the employer's group health plan or due to the person's need for health
49.30 care services not covered under the employer's group health plan.

49.31 (f) A health carrier may sell, issue, or renew an individual health plan, if the
49.32 individual has elected to buy the individual health plan not as part of a general plan to
49.33 substitute individual health plans for a group health plan nor as a result of any violation of
49.34 subdivision 3 or 4.

50.1 (g) Nothing in this subdivision relieves a health carrier of any obligation to provide
50.2 continuation or conversion coverage otherwise required under federal or state law.
50.3 (h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage
50.4 issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or
50.5 contracts that supplement Medicare issued by health maintenance organizations, or those
50.6 contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social
50.7 Security Act, United States Code, title 42, section 1395 et seq., as amended.
50.8 (i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual
50.9 health plans necessary to comply with a court order.
50.10 (j) A health carrier may offer, issue, sell, or renew an individual health plan to
50.11 persons eligible for an employer group health plan, if the individual health plan is a high
50.12 deductible health plan for use in connection with an existing health savings account, in
50.13 compliance with the Internal Revenue Code, section 223. In that situation, the same or
50.14 a different health carrier may offer, issue, sell, or renew a group health plan to cover
50.15 the other eligible employees in the group.
50.16 (k) A health carrier may offer, sell, issue, or renew an individual health plan to one
50.17 or more employees of a small employer if the individual health plan is marketed directly to
50.18 all employees of the small employer and the small employer does not contribute directly
50.19 or indirectly to the premiums or facilitate the administration of the individual health plan.
50.20 The requirement to market an individual health plan to all employees does not require the
50.21 health carrier to offer or issue an individual health plan to any employee. For purposes
50.22 of this paragraph, an employer is not contributing to the premiums or facilitating the
50.23 administration of the individual health plan if the employer does not contribute to the
50.24 premium and merely collects the premiums from an employee's wages or salary through
50.25 payroll deductions and submits payment for the premiums of one or more employees in a
50.26 lump sum to the health carrier. Except for coverage under section 62A.65, subdivision 5,
50.27 paragraph (b), or 62E.16, at the request of an employee, the health carrier may bill the
50.28 employer for the premiums payable by the employee, provided that the employer is not
50.29 liable for payment except from payroll deductions for that purpose. If an employer is
50.30 submitting payments under this paragraph, the health carrier shall provide a cancellation
50.31 notice directly to the primary insured at least ten days prior to termination of coverage for
50.32 nonpayment of premium. Individual coverage under this paragraph may be offered only
50.33 if the small employer has not provided coverage under section 62L.03 to the employees
50.34 within the past 12 months.
50.35 The employer must provide a written and signed statement to the health carrier that
50.36 the employer is not contributing directly or indirectly to the employee's premiums. The

51.1 health carrier may rely on the employer's statement and is not required to guarantee-issue
51.2 individual health plans to the employer's other current or future employees.

51.3 (l) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual
51.4 health plans through the Minnesota Health Insurance Exchange under section 62A.67
51.5 or 62A.68.

51.6 Sec. 6. Minnesota Statutes 2006, section 256L.02, subdivision 3, is amended to read:

51.7 Subd. 3. **Financial management.** (a) The commissioner shall manage spending
51.8 for the MinnesotaCare program in a manner that maintains a minimum reserve. As
51.9 part of each state revenue and expenditure forecast, the commissioner must make an
51.10 assessment of the expected expenditures for the covered services for the remainder of the
51.11 current biennium and for the following biennium. The estimated expenditure, including
51.12 the reserve, shall be compared to an estimate of the revenues that will be available in
51.13 the health care access fund. Based on this comparison, and after consulting with the
51.14 chairs of the house Ways and Means Committee and the senate Finance Committee,
51.15 and the Legislative Commission on Health Care Access, the commissioner shall, as
51.16 necessary, make the adjustments specified in paragraph (b) to ensure that expenditures
51.17 remain within the limits of available revenues for the remainder of the current biennium
51.18 and for the following biennium. The commissioner shall not hire additional staff using
51.19 appropriations from the health care access fund until the commissioner of finance makes
51.20 a determination that the adjustments implemented under paragraph (b) are sufficient to
51.21 allow MinnesotaCare expenditures to remain within the limits of available revenues for
51.22 the remainder of the current biennium and for the following biennium.

51.23 (b) The adjustments the commissioner shall use must be implemented in this order:
51.24 first, stop enrollment of single adults and households without children; second, upon 45
51.25 days' notice, stop coverage of single adults and households without children already
51.26 enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium
51.27 subsidy amounts by ten percent for families with gross annual income above 200 percent
51.28 of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium
51.29 subsidy amounts by ten percent for families with gross annual income at or below 200
51.30 percent; and fifth, require applicants to be uninsured for at least six months prior to
51.31 eligibility in the MinnesotaCare program. If these measures are insufficient to limit the
51.32 expenditures to the estimated amount of revenue, the commissioner shall further limit
51.33 enrollment or decrease premium subsidies.

(c) The commissioner shall work in cooperation with the Minnesota Health Insurance Exchange under section 62A.67 to make adjustments under paragraph (b) as required under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 7. Minnesota Statutes 2006, section 256L.02, is amended by adding a subdivision to read:

Subd. 5. **Enrollment responsibilities.** According to section 256L.05, subdivision 6, effective January 1, 2009, the Minnesota Health Insurance Exchange under section 62A.67 shall assume responsibility for enrolling eligible applicants and enrollees in a health plan for MinnesotaCare coverage. The commissioner shall maintain responsibility for determining eligibility for MinnesotaCare.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 8. Minnesota Statutes 2006, section 256L.02, is amended by adding a subdivision to read:

Subd. 6. **Exchange of data.** An entity that is part of the welfare system as defined in section 13.46, subdivision 1, paragraph (c), and the Minnesota Health Insurance Exchange under section 62A.67 may exchange private data about individuals without the individual's consent in order to enroll and collect premiums from individuals in the MinnesotaCare program under chapter 256L and to administer the individual's and the individual's family's participation in the program. This subdivision only applies if the entity that is part of the welfare system and the Minnesota Health Insurance Exchange have entered into an agreement that complies with the requirements in Code of Federal Regulations, title 45, section 164.314.

Sec. 9. Minnesota Statutes 2006, section 256L.05, subdivision 5, is amended to read:

Subd. 5. **Availability of private insurance.** (a) The commissioner~~, in consultation with the commissioners of health and commerce,~~ shall provide information regarding the availability of private health insurance coverage and the ~~possibility of disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided~~

53.1 Minnesota Health Insurance Exchange under section 62A.67 upon initial enrollment
53.2 and annually thereafter. ~~The commissioner shall also include information regarding the~~
53.3 ~~availability of private health insurance coverage in~~

53.4 (b) The notice of ineligibility provided to persons subject to disenrollment under
53.5 section 256L.07, subdivision 1, paragraphs (b) and (c), must include information about
53.6 assistance with identifying and selecting private health insurance coverage provided by
53.7 the Minnesota Health Insurance Exchange under section 62A.67.

53.8 **EFFECTIVE DATE.** This section is effective January 1, 2009.

53.9 Sec. 10. Minnesota Statutes 2006, section 256L.05, is amended by adding a subdivision
53.10 to read:

53.11 Subd. 6. **Minnesota Health Insurance Exchange.** The commissioner shall refer
53.12 all MinnesotaCare applicants and enrollees to the Minnesota Health Insurance Exchange
53.13 under section 62A.67. The Minnesota Health Insurance Exchange shall provide those
53.14 referred with assistance in selecting a managed care plan through which to receive
53.15 MinnesotaCare covered services and in analyzing health plans available through the
53.16 private market. MinnesotaCare applicants and enrollees shall effect enrollment in a
53.17 managed care plan or a private market health plan through the Minnesota Health Insurance
53.18 Exchange.

53.19 **EFFECTIVE DATE.** This section is effective January 1, 2009.

53.20 Sec. 11. Minnesota Statutes 2006, section 256L.12, subdivision 7, is amended to read:

53.21 Subd. 7. **Managed care plan vendor requirements.** The following requirements
53.22 apply to all counties or vendors who contract with the Department of Human Services to
53.23 serve MinnesotaCare recipients. Managed care plan contractors:

53.24 (1) shall authorize and arrange for the provision of the full range of services listed in
53.25 section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

53.26 (2) shall accept the prospective, per capita payment or other contractually defined
53.27 payment from the commissioner in return for the provision and coordination of covered
53.28 health care services for eligible individuals enrolled in the program;

53.29 (3) may contract with other health care and social service practitioners to provide
53.30 services to enrollees;

53.31 (4) shall provide for an enrollee grievance process as required by the commissioner
53.32 and set forth in the contract with the department;

53.33 (5) shall retain all revenue from enrollee co-payments;

54.1 (6) shall accept all eligible MinnesotaCare enrollees, without regard to health status
54.2 or previous utilization of health services;
54.3 (7) shall demonstrate capacity to accept financial risk according to requirements
54.4 specified in the contract with the department. A health maintenance organization licensed
54.5 under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required
54.6 to demonstrate financial risk capacity, beyond that which is required to comply with
54.7 chapters 62C and 62D; ~~and~~
54.8 (8) shall submit information as required by the commissioner, including data required
54.9 for assessing enrollee satisfaction, quality of care, cost, and utilization of services~~.~~; and
54.10 (9) shall participate in the Minnesota Health Insurance Exchange under section
54.11 62A.67 for the purpose of enrolling individuals under this chapter.

54.12 **EFFECTIVE DATE.** This section is effective January 1, 2009.

54.13 Sec. 12. Minnesota Statutes 2006, section 256L.15, subdivision 1a, is amended to read:
54.14 Subd. 1a. **Payment options.** (a) The commissioner may offer the following
54.15 payment options to an enrollee:
54.16 (1) payment by check;
54.17 (2) payment by credit card;
54.18 (3) payment by recurring automatic checking withdrawal;
54.19 (4) payment by onetime electronic transfer of funds;
54.20 (5) payment by wage withholding with the consent of the employer and the
54.21 employee; or
54.22 (6) payment by using state tax refund payments.
54.23 At application or reapplication, a MinnesotaCare applicant or enrollee may authorize
54.24 the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds
54.25 from the applicant's or enrollee's refund for the purposes of meeting all or part of the
54.26 applicant's or enrollee's MinnesotaCare premium obligation. The applicant or enrollee
54.27 may authorize the commissioner to apply for the state working family tax credit on behalf
54.28 of the applicant or enrollee. The setoff due under this subdivision shall not be subject to
54.29 the $10 fee under section 270A.07, subdivision 1.
54.30 (b) Effective January 1, 2009, the Minnesota Health Insurance Exchange under
54.31 section 62A.67 is responsible for collecting MinnesotaCare premiums.

54.32 **EFFECTIVE DATE.** This section is effective January 1, 2009.

Sec. 13. Minnesota Statutes 2006, section 256L.15, is amended by adding a subdivision to read:

Subd. 5. **Premium discount incentive.** Adults and families with children are eligible for a premium reduction of $3 per month for each child who met goals for preventive care or an adult who met goals for cardiac or diabetes care in the previous calendar year. The maximum premium reduction may not exceed $15 per month per family. The commissioner, in consultation with the Minnesota Health Insurance Exchange, shall establish specific goals for preventive care, including cardiac and diabetes care, that make an enrollee eligible for the premium reduction. The premium discount incentive is administered by the Minnesota Health Insurance Exchange under section 62A.67.

EFFECTIVE DATE. This section is effective January 1, 2009.

ARTICLE 3
HEALTH INFORMATION

Section 1. Minnesota Statutes 2006, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine consultations.** Medical assistance covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. ~~A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation.~~ Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate. The commissioner shall develop policies for coverage of and payment for additional telemedicine services including patient communications by e-mail, teleconferencing, telephone consultations, and other virtual visits or consultations.

Sec. 2. **STATEWIDE INFORMATION EXCHANGE.**

The Minnesota health care connection is authorized to build a statewide information exchange, help organizers of local and regional data exchange efforts, and ensure that Minnesota's data exchange projects are consistent with national technology platforms and networks.

56.1 Sec. 3. **PAY-FOR-USE PROGRAMS.**

56.2 The commissioner of human services shall adopt pay-for-use programs that offer
56.3 financial incentives to providers for the implementation and use of health care information
56.4 technology in clinical practice. To be eligible for payments under this section, the
56.5 information technology must meet national standards for interoperability, functionality,
56.6 and security and provide clinicians with data upon which to improve the quality and
56.7 safety of patient care.

56.8 Sec. 4. **APPROPRIATION.**

56.9 (a) $....... is appropriated from the health care access fund to the commissioner of
56.10 health for the fiscal year ending June 30, 2008, to provide grants under Minnesota Statutes,
56.11 section 144.3345, to health care providers in rural and underserved communities for
56.12 interoperable and transferable health information technologies.

56.13 (b) $....... for the fiscal year ending June 30, 2008, and $....... for the fiscal year
56.14 ending June 30, 2009, are appropriated from the general fund to the commissioner of
56.15 human services for electronic health information pay-for-use programs.

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62A.301 COVERAGE OF FULL-TIME STUDENTS.

If an insurer provides individual or group accident and health coverage for dependents after what otherwise would be the limiting age based on full-time student status the insurer must include in its definition of full-time student, any student who by reason of illness, injury, or physical or mental disability as documented by a physician is unable to carry what the educational institution considers a full-time course load so long as the student's course load is at least 60 percent of what otherwise is considered by the institution to be a full-time course load. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this provision.

For purposes of this section, "insurer" means an insurer providing accident and health insurance regulated under this chapter, a nonprofit health service plan corporation regulated under chapter 62C, a health maintenance organization regulated under chapter 62D, or a fraternal benefit society regulated under chapter 64B.

256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Subdivision 1. **Co-payments.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3 for eyeglasses;

(3) $6 for nonemergency visits to a hospital-based emergency room; and

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(b) Recipients of medical assistance are responsible for all co-payments in this subdivision.

Subd. 2. **Exceptions.** Co-payments shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; and

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

Subd. 3. **Collection.** The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $12 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in subdivision 4.

Subd. 4. **Uncollected debt.** If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and subject to an annual limitation of $10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay; outpatient hospital services; freestanding ambulatory surgical center services; chiropractic services; lab and diagnostic services; diabetic supplies and equipment; and prescription drugs; subject to the following co-payments:

(i) $50 co-pay per emergency room visit;

(ii) $3 co-pay per prescription drug; and

(iii) $5 co-pay per nonpreventive visit.

The services covered under this section may be provided by a physician, physician ancillary, chiropractor, psychologist, or licensed independent clinical social worker if the services are within the scope of practice of that health care professional.

For purposes of this section, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by any health care provider identified in this paragraph.

Enrollees are responsible for all co-payments in this section.

(b) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (c).

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