

This Document can be made available  
in alternative formats upon request

State of Minnesota  
**HOUSE OF REPRESENTATIVES**

EIGHTY-FIFTH  
SESSION

**HOUSE FILE No. 3391**

February 25, 2008

Authored by Huntley; Thissen; Loeffler; Bunn; Murphy, E., and others

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

1.1 A bill for an act  
1.2 relating to public health; increasing affordability and continuity of care for state  
1.3 health care programs; modifying health care provisions; establishing a public  
1.4 health access fund; increasing the tobacco impact fees; providing subsidies for  
1.5 employee share of employer-subsidized insurance; establishing the Minnesota  
1.6 Health Insurance Exchange; requiring certain employers to offer Section 125  
1.7 Plan; creating an affordability standard; requiring mandated reports; authorizing  
1.8 rulemaking; appropriating money; amending Minnesota Statutes 2006, sections  
1.9 16A.725, subdivision 1; 62A.65, subdivision 3; 62E.141; 62L.12, subdivisions  
1.10 2, 4; 256.01, by adding a subdivision; 256.9658, subdivisions 3, 9; 256B.061;  
1.11 256B.69, by adding a subdivision; 256D.03, by adding a subdivision; 256L.05,  
1.12 by adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivision 3;  
1.13 256L.15, by adding a subdivision; Minnesota Statutes 2007 Supplement, sections  
1.14 13.46, subdivision 2; 256B.056, subdivision 10; 256L.03, subdivisions 3, 5;  
1.15 256L.04, subdivisions 1, 7; 256L.05, subdivision 3a; 256L.07, subdivision 1;  
1.16 256L.15, subdivision 2; proposing coding for new law in Minnesota Statutes,  
1.17 chapters 16A; 145; 256B; proposing coding for new law as Minnesota Statutes,  
1.18 chapter 62U; repealing Minnesota Statutes 2006, section 256L.15, subdivision 3.

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

**ARTICLE 1**

**PUBLIC HEALTH**

1.22 Section 1. Minnesota Statutes 2006, section 16A.725, subdivision 1, is amended to  
1.23 read:

1.24 Subdivision 1. **Health impact fund.** There is created in the state treasury a health  
1.25 impact fund to which must be credited ~~all~~ revenue from the health impact fee as identified  
1.26 under section 256.9658, subdivision 9, clause (1), and any floor stocks fee enacted into law.

1.27 **Sec. 2. [16A.726] PUBLIC HEALTH ACCESS FUND.**

2.1 Subdivision 1. **Public health access fund.** There is created in the state treasury a  
2.2 public health access fund to which revenue from the health impact fee must be credited  
2.3 as identified under section 256.9658, subdivision 9, clause (2), and any floor stocks fee  
2.4 enacted into law. The fund is a direct appropriated special revenue fund. Notwithstanding  
2.5 section 11A.20, all investment income and all investment losses attributable to the  
2.6 investment of the public health access fund not currently needed shall be credited to the  
2.7 public health access fund.

2.8 Subd. 2. **Fund reimbursements.** Notwithstanding any law to the contrary, money  
2.9 in the public health access fund shall be appropriated only for public health initiatives.

2.10 **Sec. 3. [145.986] STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

2.11 Subdivision 1. **Goals.** The initial goals of the public health access fund are to reduce  
2.12 the percent of Minnesotans who are obese or overweight to less than half by the year  
2.13 2020 and to reduce tobacco smoking by 2 percent annually starting in 2011. By 2011,  
2.14 and considering available funding, the commissioner of health, in consultation with the  
2.15 State Community Health Advisory Committee established in section 145A.10, subdivision  
2.16 10, and other stakeholders, may make recommendations as to future goals related to  
2.17 alcohol use and illegal drug use.

2.18 Subd. 2. **Grants to local communities.** Beginning January 1, 2009, the  
2.19 commissioner of health must provide grants to community health boards to convene,  
2.20 coordinate, and lead locally developed programs targeted at achieving measurable health  
2.21 improvement goals. Funding to each community health board will be distributed based on  
2.22 a per capita formula, with a base allocation of \$50,000 to each community health board  
2.23 that receives funding. By January 15, 2011, the commissioner of health must recommend  
2.24 whether additional funding should be distributed to community health boards based on  
2.25 health disparities demonstrated in the populations served.

2.26 Subd. 3. **Outcomes.** (a) The commissioner of health must set performance measures  
2.27 and annually review the progress of local communities in improving the performance  
2.28 measures. The commissioner may provide technical assistance and corrective action plans  
2.29 to ensure that local communities are making sufficient progress.

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

2.33 Subd. 4. **Media campaign.** The commissioner of health must conduct a statewide  
2.34 marketing campaign using public media to reinforce local efforts at addressing health  
2.35 improvement goals. The commissioner must develop the statewide campaigns and

3.1 determine the timing of these campaigns in consultation with local public health  
 3.2 representatives.

3.3 Sec. 4. **APPROPRIATIONS.**

3.4 (a) \$..... is appropriated from the public health access fund in fiscal year 2009,  
 3.5 depending on availability of funds, to the commissioner of health to establish and  
 3.6 implement the statewide health improvement program under section 145.986. Subject to  
 3.7 the availability of funding, beginning January 1, 2009, the commissioner of health shall  
 3.8 make grants to community health boards to implement local public health programs.

3.9 (b) \$..... is appropriated from the public health access fund in fiscal year 2009,  
 3.10 depending on availability of funds, to the commissioner of health for a statewide public  
 3.11 health media campaign. Subject to the availability of funding, the funds shall be made  
 3.12 available to the commissioner of health beginning January 1, 2009.

3.13 Sec. 5. Minnesota Statutes 2006, section 256.9658, subdivision 3, is amended to read:

3.14 Subd. 3. **Fee imposed.** (a) A fee is imposed upon the sale of cigarettes in this  
 3.15 state, upon having cigarettes in possession in this state with intent to sell, upon any  
 3.16 person engaged in business as a distributor, and upon the use or storage by consumers  
 3.17 of cigarettes. The fee is imposed at the following rates:

3.18 (1) on cigarettes weighing not more than three pounds per thousand, ~~37.5~~ 50 mills  
 3.19 on each cigarette; and

3.20 (2) on cigarettes weighing more than three pounds per thousand, ~~75~~ 100 mills on  
 3.21 each cigarette.

3.22 (b) A fee is imposed upon all tobacco products in this state and upon any person  
 3.23 engaged in business as a distributor in an amount equal to the liability for tax under  
 3.24 section 297F.05, subdivision 3, or on a consumer of tobacco products equal to the tax  
 3.25 under section 297F.05, subdivision 4. Liability for the fee is in addition to the tax under  
 3.26 section 297F.05, subdivision 3 or 4.

3.27 **EFFECTIVE DATE.** This section is effective for sales and purchases made after  
 3.28 June 30, 2008.

3.29 Sec. 6. Minnesota Statutes 2006, section 256.9658, subdivision 9, is amended to read:

3.30 Subd. 9. **Deposit of revenues.** The commissioner of revenue shall deposit the  
 3.31 revenues from the fee under this section in the state treasury and credit them ~~to the health~~  
 3.32 ~~impact fund~~ as follows:

4.1 (1) an amount equal to 75 percent of the revenues received under subdivision 3 to  
4.2 the health impact fund established under section 16A.725; and

4.3 (2) an amount equal to 25 percent of the revenues received under subdivision 3 to  
4.4 the public health access fund established under section 16A.726.

4.5 **Sec. 7. NEW TOBACCO RATES.**

4.6 The commissioner of revenue must determine the change to the weighted average  
4.7 retail price in Minnesota Statutes, section 297F.25, as a result of this act and publish the  
4.8 new rates by June 1, 2008, effective for sales after June 30, 2008.

4.9 **ARTICLE 2**

4.10 **HEALTH CARE HOMES**

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

4.13 Subdivision 1. **Selection of primary care clinic.** Beginning January 1, 2009, the  
4.14 commissioner shall require state health care program enrollees eligible for services  
4.15 under the fee-for-service system to select a primary care clinic or medical group, within  
4.16 two months of enrollment. Beginning July 1, 2009, the commissioner shall encourage  
4.17 enrollees who have a complex or chronic condition to select a primary care clinic or  
4.18 medical group at which clinicians have been certified as health care homes under section  
4.19 256B.0751, subdivision 3. The commissioner and county social service agencies shall  
4.20 provide enrollees with lists of primary care clinics, medical groups, and clinicians certified  
4.21 as health care homes, and shall establish a toll-free number to provide enrollees with  
4.22 assistance in choosing a clinic, medical group, or health care home.

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

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

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

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

5.6 Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0754,  
5.7 the definitions in this subdivision apply.

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

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

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

5.13 Subd. 2. **Establishment of health care homes.** The commissioners shall establish  
5.14 health care homes for all state health care program enrollees, beginning first with  
5.15 enrollees who have, or are at risk of developing, complex or chronic health conditions. In  
5.16 establishing health care homes, the commissioners shall consider, and when appropriate  
5.17 incorporate, features of the medical home model developed for the provider-directed care  
5.18 coordination program authorized under section 256B.0625, subdivision 51.

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

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

5.27 Subdivision 1. **Requirement.** In order to be certified as a health care home, a  
5.28 clinician shall meet the criteria specified in this section.

5.29 Subd. 2. **Patient-provider relationship; care teams.** (a) Each patient of a health  
5.30 care home shall have an ongoing, long-term relationship with a primary care provider  
5.31 trained as a personal clinician to provide first contact, continuous, and comprehensive  
5.32 care for all of a patient's health care needs. Appropriate specialists and other health care  
5.33 professionals who do not practice in a traditional primary care field, and advanced practice

6.1 registered nurses, shall be allowed to serve as personal clinicians, if they provide care  
6.2 according to this section.

6.3 (b) Care must be provided using an interdisciplinary team of individuals who  
6.4 collectively take responsibility for the ongoing care of patients, and who practice to the  
6.5 full extent of the individual's license. The interdisciplinary team shall include two patient  
6.6 or parent partners as team members.

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

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

6.18 (b) Health care homes must encourage the patient, and when authorized and  
6.19 appropriate, the family, to actively participate in decision making and in health care home  
6.20 quality improvement initiatives, as a full member of the primary care team. Health care  
6.21 homes must consider patients and families as partners in decision making, and must  
6.22 provide access to a patient-directed, decision-making process, including appropriate  
6.23 decision aids, when available.

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

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

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

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

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

7.1 Subd. 6. **Comprehensive health assessment.** Health care homes must complete  
7.2 a comprehensive health assessment for each enrollee determined, by the initial health  
7.3 assessment required under section 256B.0431, subdivision 2, to have, or be at risk of  
7.4 developing, a complex or chronic health condition. Health care homes must develop and  
7.5 implement a comprehensive care plan to manage complex or chronic conditions based  
7.6 upon the comprehensive health assessment and other information. The comprehensive  
7.7 care plans must meet criteria specified by the commissioners.

7.8 Subd. 7. **Care coordinators.** Health care homes must employ care coordinators to  
7.9 manage the care provided to patients with complex or chronic conditions specified by the  
7.10 commissioners. Care coordinators may be social workers, nurses, or other clinicians. Care  
7.11 coordinators are responsible for:

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

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

7.15 (3) helping patients coordinate their care or access needed services, including  
7.16 preventative care;

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

7.19 (5) collecting data on process and outcome measures.

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

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

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

7.30 Subd. 2. **Amount of fee.** The care coordination fee must not exceed an average  
7.31 of \$50 per person per month. The care coordination fee must be determined by the  
7.32 commissioner, and must vary by thresholds of care complexity, with the highest fees being  
7.33 paid for care provided to individuals requiring the most intensive care coordination, such  
7.34 as those with very complex health care needs or several chronic conditions.

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

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

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

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

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

8.13 (d) By January 1, 2009, the commissioners shall establish criteria and data collection  
8.14 procedures for evaluating health care homes.

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

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

8.27 Subd. 3. **Care Coordination Advisory Committee.** By July 1, 2008, the  
8.28 commissioners shall establish a Care Coordination Advisory Committee to assist the  
8.29 Departments of Human Services and Health in administering the health care home model,  
8.30 developing the criteria and standards required under subdivision 1, collecting data,  
8.31 and measuring and evaluating health outcomes and cost savings. The commissioners  
8.32 may satisfy this requirement by continuing the advisory committee established for the  
8.33 provider-directed care coordination program. If newly established, the committee must  
8.34 include representatives of: primary care and specialist physicians, advanced practice

9.1 registered nurses, patients and their families, health plans, the Institute for Clinical  
9.2 Systems Improvement, Minnesota Community Measurement, and other relevant entities.

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

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

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

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

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

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

9.18 Subd. 6. **Annual reports.** The commissioners shall report annually to the  
9.19 legislature on the implementation and administration of the health care home model for  
9.20 state health care program enrollees in both the fee-for-service and managed care sectors,  
9.21 beginning December 15, 2009, and each December 15 thereafter. The report must include  
9.22 information on the number of state health care program enrollees in health care homes, the  
9.23 number and characteristics of enrollees with complex or chronic conditions, the number  
9.24 and geographic distribution of health care home providers, the performance and quality of  
9.25 care of health care homes, measures of preventative care, costs related to implementation  
9.26 and payment of care coordination fees, health care home payment arrangements for  
9.27 managed care plans, and estimates of savings from implementation of the health care  
9.28 home model for both the fee-for-service and managed care sectors relative to the health  
9.29 care spending baseline calculated under section 620.07.

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

9.32 Subd. 29. **Health care home model.** (a) The commissioner shall require managed  
9.33 care plans, as a condition of contract, to adopt by July 1, 2009, a health care home model  
9.34 for providing care to state health care program enrollees. The health care home model  
9.35 must meet the criteria specified in this section and section 256B.0752. The commissioner,

10.1 in consultation with the commissioner of health, may waive or modify criteria for managed  
10.2 care plans if the commissioners of health and human services determine that performance  
10.3 and quality standards would still be met.

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

10.11 (c) Savings from the use of health care homes must be split among the state,  
10.12 providers, and managed care plan. The state must retain one-half of the savings, the plan  
10.13 may retain up to one-fourth of the savings, and at least one-fourth of the savings must be  
10.14 passed on to providers in the form of higher payment rates.

10.15 (d) Beginning July 1, 2009, the commissioner shall provide a performance  
10.16 incentive for expenses related to the operation of health care homes that would reimburse  
10.17 up-front costs related to implementation of health care homes after a one-year lag. The  
10.18 commissioners of health and human services shall establish quality and performance  
10.19 standards for health care homes, and beginning July 1, 2009, these standards shall be  
10.20 subject to the capitation rate withhold under subdivision 5a, paragraph (c).

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

10.25 (f) Beginning July 1, 2009, the commissioner shall require managed care plans to  
10.26 complete a comprehensive health assessment for each enrollee determined, by the initial  
10.27 health assessment required under section 256B.0431, subdivision 2, to have, or be at  
10.28 risk of developing, a complex or chronic health condition. The commissioner shall pay  
10.29 managed care plans a one-time health assessment fee for each enrollee who completes  
10.30 a comprehensive health assessment. Comprehensive health assessments must meet the  
10.31 criteria established for health care homes under section 256B.0752, subdivision 6.

10.32 (g) Beginning July 1, 2009, the commissioner shall implement financial  
10.33 arrangements for managed care plans to ensure that plans require each enrollee to choose a  
10.34 provider to serve as a health care home.

11.1       Sec. 7. **[256B.766] PRIMARY CARE PHYSICIANS REIMBURSEMENT RATE**  
11.2 **INCREASE.**

11.3           (a) Effective for physician services rendered on or after January 1, 2009, the  
11.4 commissioner shall increase reimbursements to primary care physicians deemed by the  
11.5 commissioner to meet the requirements in paragraph (b). Reimbursement may be increased  
11.6 by not more than 50 percent above the reimbursement rate that would otherwise be paid to  
11.7 the primary care provider. Payments to health plan companies shall be adjusted to reflect  
11.8 increased reimbursement to primary care physicians as approved by the commissioner.

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

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

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

11.22       Sec. 8. **APPROPRIATION; PRIMARY CARE EDUCATION INITIATIVES.**

11.23           (a) \$..... is appropriated for the fiscal year ending June 30, 2009, from the health  
11.24 care access fund to the Board of Regents of the University of Minnesota, to expand  
11.25 initiatives under Minnesota Statutes, sections 137.38 to 137.40, to increase the number of  
11.26 graduates of residency programs who practice primary care.

11.27           (b) \$..... is appropriated for the fiscal year ending June 30, 2009, from the health  
11.28 care access fund to the Mayo Medical Foundation for medical school initiatives to increase  
11.29 the number of graduates of residency programs who practice primary care.

11.30           (c) \$..... is appropriated for the fiscal year ending June 30, 2009, from the health  
11.31 care access fund to the Office of Higher Education to provide grants to schools of nursing  
11.32 in Minnesota to increase the number of graduates of advanced practice registered nurse  
11.33 programs.

12.1 (d) \$..... is appropriated for the fiscal year ending June 30, 2009, from the health  
 12.2 care access fund to the Board of Regents of the University of Minnesota, to address faculty  
 12.3 shortages in primary care medicine.

12.4 (e) \$..... is appropriated for the fiscal year ending June 30, 2009, from the health  
 12.5 care access fund to the Mayo Medical Foundation, to address faculty shortages in primary  
 12.6 care medicine.

12.7 (f) \$..... is appropriated for the fiscal year ending June 30, 2009, from the health  
 12.8 care access fund to the Office of Higher Education to provide grants to schools of nursing  
 12.9 in Minnesota to address faculty shortages.

### 12.10 **ARTICLE 3**

#### 12.11 **INCREASING ACCESS; CONTINUITY OF CARE**

12.12 Section 1. Minnesota Statutes 2006, section 256.01, is amended by adding a  
 12.13 subdivision to read:

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

12.17 (b) By July 1, 2009, the commissioner shall improve coordination between state  
 12.18 health care programs and social service programs including but not limited to WIC, free  
 12.19 and reduced school lunch programs, and food stamps, and shall develop and use automated  
 12.20 systems to identify persons served by social service programs who may be eligible for, but  
 12.21 are not enrolled in, a state health care program. The system must also permit enrollees to  
 12.22 renew state health care program enrollment through these social services programs. By  
 12.23 January 15, 2009, the commissioner shall, as necessary, identify and recommend to the  
 12.24 legislature statutory changes to state health care and social service programs necessary to  
 12.25 improve coordination and automation of outreach and enrollment efforts.

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

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

13.1 **EFFECTIVE DATE.** Paragraphs (a) and (d) are effective July 1, 2008. Paragraphs  
 13.2 (b) and (c) are effective January 1, 2009.

13.3 Sec. 2. Minnesota Statutes 2007 Supplement, section 256B.056, subdivision 10,  
 13.4 is amended to read:

13.5 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who  
 13.6 are applying for the continuation of medical assistance coverage following the end of the  
 13.7 60-day postpartum period to update their income and asset information and to submit  
 13.8 any required income or asset verification.

13.9 (b) The commissioner shall determine the eligibility of private-sector health care  
 13.10 coverage for infants less than one year of age eligible under section 256B.055, subdivision  
 13.11 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage  
 13.12 if this is determined to be cost-effective.

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

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

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

13.26 **EFFECTIVE DATE.** The amendment to paragraph (c) is effective January 1, 2009.  
 13.27 The amendment to paragraph (d) is effective January 1, 2010, or upon federal approval,  
 13.28 whichever is later. The commissioner of human services shall notify the revisor of statutes  
 13.29 when federal approval is obtained.

13.30 Sec. 3. Minnesota Statutes 2006, section 256B.061, is amended to read:

13.31 **256B.061 ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS;**  
 13.32 **DELAYED VERIFICATION.**

14.1 (a) If any individual has been determined to be eligible for medical assistance, it  
14.2 will be made available for care and services included under the plan and furnished in or  
14.3 after the third month before the month in which the individual made application for such  
14.4 assistance, if such individual was, or upon application would have been, eligible for  
14.5 medical assistance at the time the care and services were furnished. The commissioner  
14.6 may limit, restrict, or suspend the eligibility of an individual for up to one year upon  
14.7 that individual's conviction of a criminal offense related to application for or receipt of  
14.8 medical assistance benefits.

14.9 (b) On the basis of information provided on the completed application, an applicant  
14.10 who meets the following criteria must be determined eligible beginning in the month  
14.11 of application:

14.12 (1) gross income is less than 90 percent of the applicable income standard;

14.13 (2) total liquid assets are less than 90 percent of the asset limit;

14.14 (3) does not reside in a long-term care facility; and

14.15 (4) meets all other eligibility requirements, including compliance at the time of  
14.16 application with citizenship or nationality documentation requirements under section  
14.17 256B.06, subdivision 4.

14.18 The applicant shall provide all required verifications within 60 days' notice of the  
14.19 eligibility determination or eligibility shall be terminated. Applicants who are terminated  
14.20 for failure to provide all required verifications are not eligible to apply for coverage using  
14.21 the delayed verification procedures specified in this paragraph for 12 months.

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

14.23 Sec. 4. Minnesota Statutes 2006, section 256D.03, is amended by adding a subdivision  
14.24 to read:

14.25 Subd. 7a. **Additional duties of the commissioner.** In administering the general  
14.26 assistance medical care program, the commissioner shall: (1) apply the delayed verification  
14.27 procedure specified in section 256B.061, paragraph (b), to general assistance medical care  
14.28 applicants; and (2) provide general assistance medical care enrollees who fail to submit  
14.29 renewal forms and related documentation necessary to verify continued eligibility with an  
14.30 additional month of eligibility beyond the end of the current eligibility period.

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

14.32 Sec. 5. Minnesota Statutes 2007 Supplement, section 256L.03, subdivision 3, is  
14.33 amended to read:

15.1 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include  
15.2 inpatient hospital services, including inpatient hospital mental health services and inpatient  
15.3 hospital and residential chemical dependency treatment, subject to those limitations  
15.4 necessary to coordinate the provision of these services with eligibility under the medical  
15.5 assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under  
15.6 section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and  
15.7 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or  
15.8 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not  
15.9 pregnant, is subject to an annual limit of ~~\$10,000~~ \$20,000.

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

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

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

15.19 **EFFECTIVE DATE.** This section is effective January 1, 2009, for enrollees for  
15.20 whom federal funding is not available, and is effective January 1, 2009, or upon federal  
15.21 approval, whichever is later, for enrollees for whom federal funding is available. The  
15.22 commissioner of human services shall notify the revisor of statutes when federal approval  
15.23 is obtained.

15.24 Sec. 6. Minnesota Statutes 2007 Supplement, section 256L.03, subdivision 5, is  
15.25 amended to read:

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

15.29 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,  
15.30 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and  
15.31 \$3,000 per family;

15.32 (2) \$3 per prescription for adult enrollees;

15.33 (3) \$25 for eyeglasses for adult enrollees;

15.34 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an  
15.35 episode of service which is required because of a recipient's symptoms, diagnosis, or

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

16.4 (5) \$6 for nonemergency visits to a hospital-based emergency room.

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

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

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

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

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

16.18 **EFFECTIVE DATE.** This section is effective January 1, 2009, for enrollees for  
 16.19 whom federal funding is not available, and is effective January 1, 2009, or upon federal  
 16.20 approval, whichever is later, for enrollees for whom federal funding is available. The  
 16.21 commissioner of human services shall notify the revisor of statutes when federal approval  
 16.22 is obtained.

16.23 Sec. 7. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 1, is  
 16.24 amended to read:

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

16.30 (b) Parents who enroll in the MinnesotaCare program must also enroll their children,  
 16.31 if the children are eligible. Children may be enrolled separately without enrollment by  
 16.32 parents. However, if one parent in the household enrolls, both parents must enroll, unless  
 16.33 other insurance is available. If one child from a family is enrolled, all children must  
 16.34 be enrolled, unless other insurance is available. If one spouse in a household enrolls,

17.1 the other spouse in the household must also enroll, unless other insurance is available.

17.2 Families cannot choose to enroll only certain uninsured members.

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

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

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

17.11 **EFFECTIVE DATE.** This section is effective January 1, 2009, or upon federal  
17.12 approval, whichever is later. The commissioner of human services shall notify the revisor  
17.13 of statutes when federal approval is obtained.

17.14 Sec. 8. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 7, is  
17.15 amended to read:

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

17.19 Effective ~~July~~ January 1, 2009, the definition of eligible persons includes all individuals  
17.20 and households with no children who have gross family incomes that are equal to or less  
17.21 than ~~215~~ 300 percent of the federal poverty guidelines.

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

17.23 Sec. 9. Minnesota Statutes 2007 Supplement, section 256L.05, subdivision 3a, is  
17.24 amended to read:

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

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

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

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

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

18.12 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal  
18.13 approval, whichever is later. The commissioner of human services shall notify the revisor  
18.14 of statutes when federal approval is obtained.

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

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

18.27 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal  
18.28 approval, whichever is later. The commissioner of human services shall notify the revisor  
18.29 of statutes when federal approval is obtained.

18.30 Sec. 11. Minnesota Statutes 2006, section 256L.06, subdivision 3, is amended to read:

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

19.1 (b) The commissioner shall develop and implement procedures to: (1) require  
 19.2 enrollees to report changes in income; (2) adjust sliding scale premium payments, based  
 19.3 upon both increases and decreases in enrollee income, at the time the change in income  
 19.4 is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required  
 19.5 premiums. Failure to pay includes payment with a dishonored check, a returned automatic  
 19.6 bank withdrawal, or a refused credit card or debit card payment. The commissioner may  
 19.7 demand a guaranteed form of payment, including a cashier's check or a money order, as  
 19.8 the only means to replace a dishonored, returned, or refused payment.

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

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

19.29 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal  
 19.30 approval, whichever is later. The commissioner of human services shall notify the revisor  
 19.31 of statutes when federal approval is obtained.

19.32 Sec. 12. Minnesota Statutes 2007 Supplement, section 256L.07, subdivision 1, is  
 19.33 amended to read:

19.34 Subdivision 1. **General requirements.** (a) Children enrolled in the original  
 19.35 children's health plan as of September 30, 1992, children who enrolled in the

20.1 MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,  
 20.2 article 4, section 17, and children who have family gross incomes that are equal to or  
 20.3 less than 150 percent of the federal poverty guidelines are eligible without meeting  
 20.4 the requirements of subdivision 2 ~~and the four-month requirement in subdivision 3~~, as  
 20.5 long as they maintain continuous coverage in the MinnesotaCare program or medical  
 20.6 assistance. Children who apply for MinnesotaCare on or after the implementation date  
 20.7 of the employer-subsidized health coverage program as described in Laws 1998, chapter  
 20.8 407, article 5, section 45, who have family gross incomes that are equal to or less than 150  
 20.9 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to  
 20.10 be eligible for MinnesotaCare.

20.11 Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose  
 20.12 income increases above ~~275~~ 300 percent of the federal poverty guidelines, are no longer  
 20.13 eligible for the program and shall be disenrolled by the commissioner. Beginning January  
 20.14 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7,  
 20.15 whose income increases above 200 percent of the federal poverty guidelines or ~~215~~ 300  
 20.16 percent of the federal poverty guidelines on or after ~~July~~ January 1, 2009, are no longer  
 20.17 eligible for the program and shall be disenrolled by the commissioner. For persons  
 20.18 disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of  
 20.19 the calendar month following the month in which the commissioner determines that the  
 20.20 income of a family or individual exceeds program income limits.

20.21 (b) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare  
 20.22 if ten percent of their gross individual or gross family income as defined in section  
 20.23 256L.01, subdivision 4, is less than the annual premium for a policy with a \$500  
 20.24 deductible available through the Minnesota Comprehensive Health Association. Children  
 20.25 who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month  
 20.26 notice period from the date that ineligibility is determined before disenrollment. The  
 20.27 premium for children remaining eligible under this clause shall be the maximum premium  
 20.28 determined under section 256L.15, subdivision 2, paragraph (b).

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

20.32 **EFFECTIVE DATE.** This section is effective January 1, 2009, or upon federal  
 20.33 approval, whichever is later, except that the amendment to paragraph (a) related to the  
 20.34 four-month requirement is effective January 1, 2010, or upon federal approval, whichever  
 20.35 is later. The commissioner of human services shall notify the revisor of statutes when  
 20.36 federal approval is obtained.

21.1 Sec. 13. Minnesota Statutes 2006, section 256L.07, subdivision 3, is amended to read:

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

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

21.8 (i) basic hospital insurance;

21.9 (ii) medical-surgical insurance;

21.10 (iii) prescription drug coverage;

21.11 (iv) dental coverage; or

21.12 (v) vision coverage;

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

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

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

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

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

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

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

22.1 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal  
22.2 approval, whichever is later. The commissioner of human services shall notify the revisor  
22.3 of statutes when federal approval is obtained.

22.4 Sec. 14. Minnesota Statutes 2007 Supplement, section 256L.15, subdivision 2, is  
22.5 amended to read:

22.6 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The  
22.7 commissioner shall establish a sliding fee scale to determine the percentage of monthly  
22.8 gross individual or family income that households at different income levels must pay  
22.9 to obtain coverage through the MinnesotaCare program. The sliding fee scale must be  
22.10 based on the enrollee's monthly gross individual or family income. The sliding fee scale  
22.11 must contain separate tables based on enrollment of one, two, or three or more persons.  
22.12 Until December 31, 2008, the sliding fee scale begins with a premium of 1.5 percent of  
22.13 monthly gross individual or family income for individuals or families with incomes below  
22.14 the limits for the medical assistance program for families and children in effect on January  
22.15 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8,  
22.16 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps  
22.17 ranging from the medical assistance income limit for families and children in effect on  
22.18 January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family  
22.19 size, up to a family size of five. The sliding fee scale for a family of five must be used  
22.20 for families of more than five. The sliding fee scale and percentages are not subject to  
22.21 the provisions of chapter 14. If a family or individual reports increased income after  
22.22 enrollment, premiums shall be adjusted at the time the change in income is reported.

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

22.33 (c) Beginning January 1, 2009, MinnesotaCare enrollees shall pay premiums  
22.34 according to the affordability scale established in section 62U.08 with the exception that

23.1 children in families with income at or below 150 percent of the federal poverty guidelines  
 23.2 shall pay a monthly premium of \$4.

23.3 **EFFECTIVE DATE.** This section is effective January 1, 2009, or upon federal  
 23.4 approval, whichever is later. The commissioner of human services shall notify the revisor  
 23.5 of statutes when federal approval is obtained.

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

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

23.12 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal  
 23.13 approval, whichever is later. The commissioner of human services shall notify the revisor  
 23.14 of statutes when federal approval is obtained.

23.15 Sec. 16. **INSURANCE COVERAGE FOR LONG-TERM CARE WORKERS.**

23.16 (a) By December 15, 2008, the commissioner of human services shall study and  
 23.17 report to the legislature with recommendations for a rate increase to long-term care  
 23.18 employers dedicated to the purchase of employee health insurance in the private market.  
 23.19 The commissioner shall collect necessary actuarial data, employment data, current  
 23.20 coverage data, and other needed information.

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

23.23 (1) the coverage provided to state employees;

23.24 (2) the coverage provided to MinnesotaCare enrollees; and

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

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

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

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

24.1 (2) provides long-term care services.

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

24.4 (d) The recommendations must include measures to:

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

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

24.9 **Sec. 17. REPEALER.**

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

24.11 **EFFECTIVE DATE.** This section is effective January 1, 2009, or upon federal  
24.12 approval of the amendments to section 14, whichever is later. The commissioner of human  
24.13 services shall notify the revisor of statutes when federal approval is obtained.

## 24.14 **ARTICLE 4**

### 24.15 **INSURANCE REFORM**

24.16 Section 1. **UNIFORM OUTCOME MEASURES WORKING GROUP.**

24.17 (a) The commissioner of health, or the commissioner's designee, shall create,  
24.18 convene, and chair an informal working group to attempt to arrive at a standardized,  
24.19 limited set of measures by which to measure performance of health care providers for  
24.20 use in establishing statewide health improvement goals and in measuring progress on  
24.21 these goals. The group shall focus first on the most common areas of data collection  
24.22 for pay-for-performance systems.

24.23 (b) The working group must be known as the Uniform Outcome Measures Working  
24.24 Group. The commissioner shall determine its members and the number of members.  
24.25 The working group must include representatives of health care providers, health care  
24.26 purchasers, health insurers, public health agencies, and consumers.

24.27 (c) The working group shall attempt to arrive at uniform definitions, measures, and  
24.28 forms for submission of data, to the greatest extent possible.

24.29 (d) The working group shall seek to reduce the administrative burden on health  
24.30 care providers and health care purchasers.

24.31 (e) The working group shall invite and use the expertise of existing organizations  
24.32 experienced in health care quality measurement.

24.33 (f) The working group shall encourage participation by the public.

25.1 (g) The commissioner of health shall encourage use of the working group  
 25.2 recommendations.

25.3 (h) By December 15, 2008, the commissioner of health shall provide to the  
 25.4 legislature a written report under Minnesota Statutes, section 3.195, summarizing the  
 25.5 work of the working group.

25.6 (i) The working group terminates on June 30, 2009, unless the commissioner of  
 25.7 health determines that the group's continued existence would be beneficial.

25.8 **Sec. 2. COMMUNITY BENEFIT STANDARDS AND REPORTING;**  
 25.9 **NONPROFIT HEALTH PLAN COMPANIES; RECOMMENDATIONS.**

25.10 (a) By December 15, 2008, the commissioner of health shall recommend to the  
 25.11 legislature community benefit standards to be required by law of nonprofit health plan  
 25.12 companies doing business in the state.

25.13 (b) The recommendations must include a procedure by which each nonprofit health  
 25.14 plan company would periodically report to the state and to the public regarding the  
 25.15 company's compliance with the requirements.

25.16 (c) The commissioner shall recommend a fair and effective enforcement and  
 25.17 remediation mechanism.

25.18 **Sec. 3. ANALYSIS OF PROPOSED INSURANCE MARKET REFORMS.**

25.19 The Legislative Commission on Health Care Access shall review available  
 25.20 information and analysis, and, by December 15, 2008, report to the legislature under  
 25.21 Minnesota Statutes, section 3.195, with recommendations regarding:

25.22 (1) the effects and possible desirability of increasing the definition of "small  
 25.23 employer" for purposes of the state's small employer health insurance market, in order to  
 25.24 expand that market to include some employers that have more than 50 employees;

25.25 (2) the effects and possible desirability of restricting or prohibiting the use of health  
 25.26 status and related factors in health insurance premium determination in the individual  
 25.27 and small employer markets, and what lifestyle choices such as smoking should be  
 25.28 considered; and

25.29 (3) the effects and possible desirability of merging the individual and small employer  
 25.30 markets if the state implements the following:

25.31 (i) an individual responsibility requirement, requiring all Minnesota residents to  
 25.32 have at least a specified level of health coverage; and

25.33 (ii) guaranteed issue in the individual market.

**ARTICLE 5****HEALTH INSURANCE PURCHASING AND AFFORDABILITY**

26.1

26.2

26.3 Section 1. Minnesota Statutes 2007 Supplement, section 13.46, subdivision 2, is  
26.4 amended to read:

26.5 Subd. 2. **General.** (a) Unless the data is summary data or a statute specifically  
26.6 provides a different classification, data on individuals collected, maintained, used, or  
26.7 disseminated by the welfare system is private data on individuals, and shall not be  
26.8 disclosed except:

26.9 (1) according to section 13.05;

26.10 (2) according to court order;

26.11 (3) according to a statute specifically authorizing access to the private data;

26.12 (4) to an agent of the welfare system, including a law enforcement person, attorney,  
26.13 or investigator acting for it in the investigation or prosecution of a criminal or civil  
26.14 proceeding relating to the administration of a program;

26.15 (5) to personnel of the welfare system who require the data to verify an individual's  
26.16 identity; determine eligibility, amount of assistance, and the need to provide services to  
26.17 an individual or family across programs; evaluate the effectiveness of programs; assess  
26.18 parental contribution amounts; and investigate suspected fraud;

26.19 (6) to administer federal funds or programs;

26.20 (7) between personnel of the welfare system working in the same program;

26.21 (8) to the Department of Revenue to assess parental contribution amounts for  
26.22 purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit  
26.23 programs and to identify individuals who may benefit from these programs. The following  
26.24 information may be disclosed under this paragraph: an individual's and their dependent's  
26.25 names, dates of birth, Social Security numbers, income, addresses, and other data as  
26.26 required, upon request by the Department of Revenue. Disclosures by the commissioner  
26.27 of revenue to the commissioner of human services for the purposes described in this clause  
26.28 are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include,  
26.29 but are not limited to, the dependent care credit under section 290.067, the Minnesota  
26.30 working family credit under section 290.0671, the property tax refund and rental credit  
26.31 under section 290A.04, and the Minnesota education credit under section 290.0674;

26.32 (9) between the Department of Human Services, the Department of Employment  
26.33 and Economic Development, and when applicable, the Department of Education, for  
26.34 the following purposes:

27.1 (i) to monitor the eligibility of the data subject for unemployment benefits, for any  
27.2 employment or training program administered, supervised, or certified by that agency;

27.3 (ii) to administer any rehabilitation program or child care assistance program,  
27.4 whether alone or in conjunction with the welfare system;

27.5 (iii) to monitor and evaluate the Minnesota family investment program or the child  
27.6 care assistance program by exchanging data on recipients and former recipients of food  
27.7 support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance  
27.8 under chapter 119B, or medical programs under chapter 256B, 256D, or 256L; and

27.9 (iv) to analyze public assistance employment services and program utilization,  
27.10 cost, effectiveness, and outcomes as implemented under the authority established in Title  
27.11 II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of  
27.12 1999. Health records governed by sections 144.291 to 144.298 and "protected health  
27.13 information" as defined in Code of Federal Regulations, title 45, section 160.103, and  
27.14 governed by Code of Federal Regulations, title 45, parts 160-164, including health care  
27.15 claims utilization information, must not be exchanged under this clause;

27.16 (10) to appropriate parties in connection with an emergency if knowledge of  
27.17 the information is necessary to protect the health or safety of the individual or other  
27.18 individuals or persons;

27.19 (11) data maintained by residential programs as defined in section 245A.02 may  
27.20 be disclosed to the protection and advocacy system established in this state according  
27.21 to Part C of Public Law 98-527 to protect the legal and human rights of persons with  
27.22 developmental disabilities or other related conditions who live in residential facilities for  
27.23 these persons if the protection and advocacy system receives a complaint by or on behalf  
27.24 of that person and the person does not have a legal guardian or the state or a designee of  
27.25 the state is the legal guardian of the person;

27.26 (12) to the county medical examiner or the county coroner for identifying or locating  
27.27 relatives or friends of a deceased person;

27.28 (13) data on a child support obligor who makes payments to the public agency  
27.29 may be disclosed to the Minnesota Office of Higher Education to the extent necessary to  
27.30 determine eligibility under section 136A.121, subdivision 2, clause (5);

27.31 (14) participant Social Security numbers and names collected by the telephone  
27.32 assistance program may be disclosed to the Department of Revenue to conduct an  
27.33 electronic data match with the property tax refund database to determine eligibility under  
27.34 section 237.70, subdivision 4a;

28.1 (15) the current address of a Minnesota family investment program participant  
28.2 may be disclosed to law enforcement officers who provide the name of the participant  
28.3 and notify the agency that:

28.4 (i) the participant:

28.5 (A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after  
28.6 conviction, for a crime or attempt to commit a crime that is a felony under the laws of the  
28.7 jurisdiction from which the individual is fleeing; or

28.8 (B) is violating a condition of probation or parole imposed under state or federal law;

28.9 (ii) the location or apprehension of the felon is within the law enforcement officer's  
28.10 official duties; and

28.11 (iii) the request is made in writing and in the proper exercise of those duties;

28.12 (16) the current address of a recipient of general assistance or general assistance  
28.13 medical care may be disclosed to probation officers and corrections agents who are  
28.14 supervising the recipient and to law enforcement officers who are investigating the  
28.15 recipient in connection with a felony level offense;

28.16 (17) information obtained from food support applicant or recipient households may  
28.17 be disclosed to local, state, or federal law enforcement officials, upon their written request,  
28.18 for the purpose of investigating an alleged violation of the Food Stamp Act, according  
28.19 to Code of Federal Regulations, title 7, section 272.1(c);

28.20 (18) the address, Social Security number, and, if available, photograph of any  
28.21 member of a household receiving food support shall be made available, on request, to a  
28.22 local, state, or federal law enforcement officer if the officer furnishes the agency with the  
28.23 name of the member and notifies the agency that:

28.24 (i) the member:

28.25 (A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a  
28.26 crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

28.27 (B) is violating a condition of probation or parole imposed under state or federal  
28.28 law; or

28.29 (C) has information that is necessary for the officer to conduct an official duty related  
28.30 to conduct described in subitem (A) or (B);

28.31 (ii) locating or apprehending the member is within the officer's official duties; and

28.32 (iii) the request is made in writing and in the proper exercise of the officer's official  
28.33 duty;

28.34 (19) the current address of a recipient of Minnesota family investment program,  
28.35 general assistance, general assistance medical care, or food support may be disclosed to  
28.36 law enforcement officers who, in writing, provide the name of the recipient and notify the

29.1 agency that the recipient is a person required to register under section 243.166, but is not  
29.2 residing at the address at which the recipient is registered under section 243.166;

29.3 (20) certain information regarding child support obligors who are in arrears may be  
29.4 made public according to section 518A.74;

29.5 (21) data on child support payments made by a child support obligor and data on  
29.6 the distribution of those payments excluding identifying information on obligees may be  
29.7 disclosed to all obligees to whom the obligor owes support, and data on the enforcement  
29.8 actions undertaken by the public authority, the status of those actions, and data on the  
29.9 income of the obligor or obligee may be disclosed to the other party;

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

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

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

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

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

29.30 (27) to monitor and evaluate the Minnesota family investment program by  
29.31 exchanging data between the Departments of Human Services and Education, on  
29.32 recipients and former recipients of food support, cash assistance under chapter 256, 256D,  
29.33 256J, or 256K, child care assistance under chapter 119B, or medical programs under  
29.34 chapter 256B, 256D, or 256L;

29.35 (28) to evaluate child support program performance and to identify and prevent  
29.36 fraud in the child support program by exchanging data between the Department of Human

30.1 Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a)  
 30.2 and (b), without regard to the limitation of use in paragraph (c), Department of Health,  
 30.3 Department of Employment and Economic Development, and other state agencies as is  
 30.4 reasonably necessary to perform these functions; ~~or~~

30.5 (29) counties operating child care assistance programs under chapter 119B may  
 30.6 disseminate data on program participants, applicants, and providers to the commissioner  
 30.7 of education; or

30.8 (30) according to section 256.01, subdivision 27, between the welfare system and the  
 30.9 Minnesota Health Insurance Exchange under section 62U.02, in order to collect premiums  
 30.10 from individuals in the medical assistance employed persons with disabilities program  
 30.11 and the MinnesotaCare program under chapters 256B and 256L and to administer the  
 30.12 individual's and the individual's families' participation in the Exchange.

30.13 (b) Information on persons who have been treated for drug or alcohol abuse may  
 30.14 only be disclosed according to the requirements of Code of Federal Regulations, title  
 30.15 42, sections 2.1 to 2.67.

30.16 (c) Data provided to law enforcement agencies under paragraph (a), clause (15),  
 30.17 (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected  
 30.18 nonpublic while the investigation is active. The data are private after the investigation  
 30.19 becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

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

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

30.24 Sec. 2. Minnesota Statutes 2006, section 62A.65, subdivision 3, is amended to read:

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

30.28 (a) Except for policies issued under section 62U.03, subdivision 5, paragraph (b),  
 30.29 premium rates must be no more than 25 percent above and no more than 25 percent below  
 30.30 the index rate charged to individuals for the same or similar coverage, adjusted pro  
 30.31 rata for rating periods of less than one year. The premium variations permitted by this  
 30.32 paragraph must be based only upon health status, claims experience, and occupation. For  
 30.33 purposes of this paragraph, health status includes refraining from tobacco use or other  
 30.34 actuarially valid lifestyle factors associated with good health, provided that the lifestyle  
 30.35 factor and its effect upon premium rates have been determined by the commissioner to

31.1 be actuarially valid and have been approved by the commissioner. Variations permitted  
31.2 under this paragraph must not be based upon age or applied differently at different ages.  
31.3 This paragraph does not prohibit use of a constant percentage adjustment for factors  
31.4 permitted to be used under this paragraph.

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

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

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

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

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

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

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

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

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

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

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

31.35 (h) The rates must not be approved, unless the commissioner has determined that the  
31.36 rates are reasonable. In determining reasonableness, the commissioner shall consider the

32.1 growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar  
 32.2 year or years that the proposed premium rate would be in effect, actuarially valid changes  
 32.3 in risks associated with the enrollee populations, and actuarially valid changes as a result  
 32.4 of statutory changes in Laws 1992, chapter 549.

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

32.17 Sec. 3. Minnesota Statutes 2006, section 62E.141, is amended to read:

32.18 **62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.**

32.19 No employee of an employer that offers a group health plan, under which the  
 32.20 employee is eligible for coverage, is eligible to enroll, or continue to be enrolled, in  
 32.21 the comprehensive health association, except for enrollment or continued enrollment  
 32.22 necessary to cover conditions that are subject to an unexpired preexisting condition  
 32.23 limitation, preexisting condition exclusion, or exclusionary rider under the employer's  
 32.24 health plan. This section does not apply to persons enrolled in the Comprehensive Health  
 32.25 Association as of June 30, 1993. With respect to persons eligible to enroll in the health  
 32.26 plan of an employer that has more than 29 current employees, as defined in section  
 32.27 62L.02, this section does not apply to persons enrolled in the Comprehensive Health  
 32.28 Association as of December 31, 1994.

32.29 Sec. 4. Minnesota Statutes 2006, section 62L.12, subdivision 2, is amended to read:

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

32.33 (b) A health carrier may sell, issue, or renew individual conversion policies to  
 32.34 eligible employees otherwise eligible for conversion coverage as a result of the expiration

33.1 of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21,  
33.2 62C.142, 62D.101, and 62D.105.

33.3 (c) A health carrier may sell, issue, or renew conversion policies under section  
33.4 62E.16 to eligible employees.

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

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

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

33.15 (g) Nothing in this subdivision relieves a health carrier of any obligation to provide  
33.16 continuation or conversion coverage otherwise required under federal or state law.

33.17 (h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage  
33.18 issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or  
33.19 contracts that supplement Medicare issued by health maintenance organizations, or those  
33.20 contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social  
33.21 Security Act, United States Code, title 42, section 1395 et seq., as amended.

33.22 (i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual  
33.23 health plans necessary to comply with a court order.

33.24 (j) A health carrier may offer, issue, sell, or renew an individual health plan to  
33.25 persons eligible for an employer group health plan, if the individual health plan is a high  
33.26 deductible health plan for use in connection with an existing health savings account, in  
33.27 compliance with the Internal Revenue Code, section 223. In that situation, the same or  
33.28 a different health carrier may offer, issue, sell, or renew a group health plan to cover  
33.29 the other eligible employees in the group.

33.30 (k) A health carrier may offer, sell, issue, or renew an individual health plan to one  
33.31 or more employees of a small employer if the individual health plan is marketed directly to  
33.32 employees or through the Minnesota Health Insurance Exchange under section 62U.02 to  
33.33 all employees of the small employer and the small employer does not contribute directly  
33.34 or indirectly to the premiums or facilitate the administration of the individual health plan.  
33.35 Except as provided in section 62U.03, subdivision 5, paragraph (b), the requirement to  
33.36 market an individual health plan to all employees does not require the health carrier to

34.1 offer or issue an individual health plan to any employee. For purposes of this paragraph,  
34.2 an employer is not contributing to the premiums or facilitating the administration of the  
34.3 individual health plan if the employer does not contribute to the premium and merely  
34.4 collects the premiums from an employee's wages or salary through payroll deductions  
34.5 and submits payment for the premiums of one or more employees in a lump sum to the  
34.6 health carrier or to the Minnesota Health Insurance Exchange under section 62U.02.  
34.7 Except for coverage under section 62A.65, subdivision 5, paragraph (b), or 62E.16, at the  
34.8 request of an employee, the health carrier or the Minnesota Health Insurance Exchange  
34.9 under section 62U.02 may bill the employer for the premiums payable by the employee,  
34.10 provided that the employer is not liable for payment except from payroll deductions for  
34.11 that purpose. If an employer is submitting payments under this paragraph, the health  
34.12 carrier or the Minnesota Health Insurance Exchange, as applicable, shall provide a  
34.13 cancellation notice directly to the primary insured at least ten days prior to termination  
34.14 of coverage for nonpayment of premium. Individual coverage under this paragraph may  
34.15 be offered only if the small employer has not provided coverage under section 62L.03 to  
34.16 the employees within the past 12 months.

34.17 The employer must provide a written and signed statement to the health carrier or  
34.18 the Minnesota Health Insurance Exchange, as applicable, stating that the employer is not  
34.19 contributing directly or indirectly to the employee's premiums. The Minnesota Health  
34.20 Insurance Exchange under section 62U.02 shall provide all health carriers with enrolled  
34.21 employees of the employer with a copy of the employer's statement. The health carrier  
34.22 may rely on the employer's statement and is not required to guarantee-issue individual  
34.23 health plans to the employer's ~~other current or future~~ employees.

34.24 Sec. 5. Minnesota Statutes 2006, section 62L.12, subdivision 4, is amended to read:

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

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

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

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

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

35.3 Sec. 6. **[62U.01] DEFINITIONS.**

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

35.6 Subd. 2. **Board.** "Board" means the Health Benefit and Design Board established  
35.7 in section 62U.04.

35.8 Subd. 3. **Clinically effective.** "Clinically effective" means that the use of a  
35.9 particular health technology improves patient clinical status, as measured by medical  
35.10 condition, survival rates, and other variables, and that the use of the particular technology  
35.11 demonstrates a clinical advantage over alternative technologies.

35.12 Subd. 4. **Cost effective.** "Cost effective" means that the economic costs of using  
35.13 a particular service, device, or health technology to achieve improvement in a patient's  
35.14 health outcome are justified given the comparison to both the economic costs and the  
35.15 improvement in patient health outcome resulting from the use of an alternative service,  
35.16 device, or technology, or from not providing the service, device, or technology.

35.17 Subd. 5. **Exchange.** "Exchange" means the Minnesota Health Insurance Exchange  
35.18 established in section 62U.02.

35.19 Subd. 6. **Health plan.** "Health plan" means a health plan as defined in section  
35.20 62A.011.

35.21 Subd. 7. **Health plan company.** "Health plan company" has the meaning provided  
35.22 in section 62Q.01, subdivision 4.

35.23 Subd. 8. **Health technology.** "Health technology" means medical and surgical  
35.24 devices and procedures, medical equipment, and diagnostic tests.

35.25 Subd. 9. **Section 125 Plan.** "Section 125 Plan" means a cafeteria or premium-only  
35.26 plan under section 125 of the Internal Revenue Code that allows employees to pay for  
35.27 health insurance premiums with pretax dollars.

35.28 Subd. 10. **Third-party administrators.** "Third-party administrators" means a  
35.29 vendor of risk-management services or an entity administering a self-insurance or health  
35.30 insurance plan under section 60A.23.

35.31 Sec. 7. **[62U.02] MINNESOTA HEALTH INSURANCE EXCHANGE.**

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

36.1            Subd. 2. **Creation; tax exemption.** The Minnesota Health Insurance Exchange  
36.2 is created for the limited purpose of providing individuals with greater access, choice,  
36.3 portability, and affordability of health insurance products. The Minnesota Health  
36.4 Insurance Exchange is created as an unincorporated association and shall promptly  
36.5 incorporate as a nonprofit corporation under chapter 317A and apply for qualification  
36.6 under section 501(c) of the Internal Revenue Code.

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

36.9            (a) "Board" means the Board of Directors of the Minnesota Health Insurance  
36.10 Exchange under subdivision 13.

36.11            (b) "Commissioner" means:

36.12            (1) the commissioner of commerce for health plan companies subject to the  
36.13 jurisdiction of the Department of Commerce;

36.14            (2) the commissioner of health for health plan companies subject to the jurisdiction  
36.15 of the Department of Health; or

36.16            (3) either commissioner's designated representative.

36.17            (c) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

36.18            (d) "Individual market health plan" means a health plan as defined in section  
36.19 62A.011.

36.20            (e) "Small employer" means a small employer as defined in section 62L.02,  
36.21 subdivision 26.

36.22            (f) "Small employer health benefit plan" means a health benefit plan as defined in  
36.23 section 62L.02, subdivision 15.

36.24            Subd. 4. **Health plan company and health plan participation and availability.**

36.25            (a) Only individual market health plans and small employer health benefit plans offered by  
36.26 a health plan company licensed to issue health plans in Minnesota must be made available  
36.27 for purchase through the Exchange.

36.28            (b) Each health plan made available by a health plan company through the Exchange  
36.29 must meet the minimum benefit and design requirements provided under section 62U.04,  
36.30 subdivision 5.

36.31            (c) Any health plan company that issues health plans in the individual or small  
36.32 employer market must offer through the Exchange at least one health plan that meets  
36.33 the benefits set and design established by the Health Benefits and Design Board under  
36.34 section 62U.04.

37.1 (d) Health plans offered through the Minnesota Comprehensive Health Association  
37.2 as defined in section 62E.10 must be available for sale through the Exchange as determined  
37.3 by the Minnesota Comprehensive Health Association.

37.4 (e) Health plans offered through the MinnesotaCare program must be available  
37.5 through the Exchange, as determined by the commissioner of human services, to  
37.6 individuals and families who meet the eligibility requirements for MinnesotaCare and  
37.7 who pay premiums through an employer Section 125 Plan.

37.8 (f) Nothing in this section restricts the sale of individual market health plans and  
37.9 small employer health benefit plans outside the Exchange. The requirements applicable  
37.10 to issuance, renewal, cancelation, and pricing of coverage are the same for health plans  
37.11 purchased inside and outside the Exchange, except as described under section 62U.03,  
37.12 subdivision 5, paragraph (b).

37.13 Subd. 5. **Ranking of health plans.** The Exchange shall create an Internet-based  
37.14 system for ranking individual market health plans and small employer health benefit  
37.15 plans. The ranking system shall consider variation across plans in factors, including, but  
37.16 not limited to, premiums, deductibles, co-payment and coinsurance requirements, annual  
37.17 out-of-pocket maximum payments, and lifetime benefit limits, and the system shall rank  
37.18 plans based on priorities specified by the user.

37.19 Subd. 6. **Individual participation and eligibility.** Individuals are eligible to  
37.20 purchase health plans directly through the Exchange or through an employer Section  
37.21 125 Plan under section 62U.03. Nothing in this section requires guaranteed issue of  
37.22 individual market health plans offered through the Exchange except as provided under  
37.23 section 62U.03, subdivision 5, paragraph (b). Individuals are eligible to purchase  
37.24 individual market health plans through the Exchange by meeting one or more of the  
37.25 following qualifications:

37.26 (1) the individual is a Minnesota resident, meaning the individual is physically  
37.27 residing on a permanent basis in a place that is the person's principal residence and from  
37.28 which the person is absent only for temporary purposes;

37.29 (2) the individual is a student attending an institution outside of Minnesota and  
37.30 maintains Minnesota residency;

37.31 (3) the individual is not a Minnesota resident but is employed by an employer  
37.32 physically located within the state and the individual's employer is required to offer a  
37.33 Section 125 Plan under section 62U.03; or

37.34 (4) the individual is a dependent as defined in section 62L.02, of another individual  
37.35 who is eligible to participate in the Exchange.

38.1 Subd. 7. **Small employer participation and eligibility.** Small employers, as  
38.2 defined in section 62L.02, may purchase health plans through the Exchange.

38.3 Subd. 8. **Responsibilities of the Exchange.** The Exchange may serve as a  
38.4 coordinating entity for enrollment and collection and transfer of premium payments for  
38.5 health plans sold to individuals through the Exchange. The Exchange must be responsible  
38.6 for the following functions:

38.7 (1) publicize the Exchange, including but not limited to its functions, eligibility  
38.8 rules, and enrollment procedures;

38.9 (2) provide assistance to employers to establish Section 125 Plans under section  
38.10 62U.03;

38.11 (3) provide education and assistance to employers to help them understand the  
38.12 requirements of Section 125 Plans and compliance with applicable regulations;

38.13 (4) create a system to allow individuals to compare and enroll in health plans  
38.14 offered through the Exchange, including a system of comparative rating of health plans  
38.15 and benefits set;

38.16 (5) create a system to collect and transmit to the applicable plans all premium  
38.17 payments made by individuals, including developing mechanisms to receive and process  
38.18 automatic payroll deductions for individuals who purchase coverage through employer  
38.19 Section 125 Plans;

38.20 (6) for participating employers, bill the employer for the premiums payable by the  
38.21 employer for a small employer health benefit plan;

38.22 (7) for individuals purchasing individual market health plans through a Section 125  
38.23 Plan, bill the individual's employer for premiums payable by the employee, provided that  
38.24 the employer is not liable for payment except from payroll deductions for that purpose;

38.25 (8) provide information on public insurance programs to individuals who may  
38.26 qualify for these programs, and provide application assistance, if needed on applying  
38.27 for these programs;

38.28 (9) establish a mechanism with the Department of Human Services to transfer  
38.29 premiums paid by Minnesota health care program enrollees from Section 125 Plans;

38.30 (10) establish procedures to account for all funds received and disbursed by the  
38.31 Exchange; and

38.32 (11) make available to the public, within 90 days from the end of each fiscal year, a  
38.33 report of an independent audit of the Exchange's accounts.

38.34 Subd. 9. **State not liable.** The state of Minnesota is not liable for the actions of  
38.35 the Exchange.

38.36 Subd. 10. **Powers of the Exchange.** The Exchange shall have the power to:

39.1 (1) contract with insurance producers licensed in accident and health insurance  
 39.2 under chapter 60K and vendors to perform one or more of the functions specified in  
 39.3 subdivision 8;

39.4 (2) contract with employers to collect premiums for small employer health benefit  
 39.5 plans and for individual market health plans purchased through a Section 125 Plan;

39.6 (3) establish and assess fees on health plan premiums of small employer health  
 39.7 benefit plans and individual market health plans to fund the cost of administering the  
 39.8 Exchange;

39.9 (4) seek and directly receive grant funding from government agencies or private  
 39.10 philanthropic organizations to defray the costs of operating the Exchange;

39.11 (5) establish and administer rules and procedures governing the operations of the  
 39.12 Exchange;

39.13 (6) establish one or more service centers within Minnesota;

39.14 (7) sue or be sued or otherwise take any necessary or proper legal action;

39.15 (8) establish bank accounts and borrow money; and

39.16 (9) enter into agreements with the commissioners of commerce, health, human  
 39.17 services, revenue, employment and economic development, and other state agencies as  
 39.18 necessary for the Exchange to implement the provisions of this section.

39.19 Subd. 11. **Dispute resolution.** The Exchange shall establish procedures for  
 39.20 resolving disputes with respect to the eligibility of an individual to participate in the  
 39.21 Exchange. The Exchange shall not have the authority or responsibility to intervene in or  
 39.22 resolve disputes between an individual and a health plan or health plan company. The  
 39.23 Exchange shall refer complaints from individuals participating in the Exchange to the  
 39.24 commissioner to be resolved according to sections 62Q.68 to 62Q.73.

39.25 Subd. 12. **Governance.** The Exchange shall be governed by a board of directors  
 39.26 with 11 members. The board shall convene on or before July 1, 2008, after the initial board  
 39.27 members have been selected. The initial board membership consists of the following:

39.28 (1) the commissioner of commerce;

39.29 (2) the commissioner of human services;

39.30 (3) the commissioner of health; and

39.31 (4) eight members with knowledge and experience related to health insurance  
 39.32 and health insurance markets, appointed to serve three-year terms as follows: two  
 39.33 members appointed by the Subcommittee on Committees of the Committee on Rules and  
 39.34 Administration of the senate; two members appointed by the speaker of the house of  
 39.35 representatives; and four members appointed by the governor.

40.1 Subd. 13. **Subsequent board membership.** (a) Effective July 1, 2011, ongoing  
40.2 membership of the Exchange consists of the following:

40.3 (1) the commissioner of commerce;

40.4 (2) the commissioner of human services;

40.5 (3) the commissioner of health;

40.6 (4) two members appointed as follows: one member appointed by the Subcommittee  
40.7 on Committees of the Committee on Rules and Administration of the senate; and one  
40.8 member appointed by the speaker of the house of representatives to serve two-year  
40.9 terms; and

40.10 (5) four members elected by the membership of the Exchange of which two are  
40.11 elected to serve a two-year term and two are elected to serve a three-year term.

40.12 (b) Elected members may serve more than one term. At least one of the elected  
40.13 members must represent a small employer, and at least one member must be a person who  
40.14 purchases an individual market health plan through the Exchange.

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

40.20 Subd. 15. **Operations of the Exchange.** The board of directors shall appoint an  
40.21 Exchange director who shall:

40.22 (1) be a full-time employee of the Exchange;

40.23 (2) administer all of the activities and contracts of the Exchange; and

40.24 (3) hire and supervise the staff of the Exchange.

40.25 Subd. 16. **Insurance producers.** An individual has the right to choose any  
40.26 insurance producer licensed in accident and health insurance under chapter 60K to assist  
40.27 them in purchasing an individual market health plan through the Exchange. When a  
40.28 producer licensed in accident and health insurance under chapter 60K enrolls an eligible  
40.29 individual in the Exchange, the health plan company chosen by the individual may pay the  
40.30 producer a commission.

40.31 Subd. 17. **Implementation.** Health plan coverage through the Exchange begins on  
40.32 July 1, 2009. The Exchange must be operational to assist employers and individuals by  
40.33 January 1, 2009, and be prepared for enrollment by June 1, 2009.

40.34 **EFFECTIVE DATE.** This section is effective the day following final enactment.

40.35 Sec. 8. **[62U.03] SECTION 125 PLANS.**

41.1 Subdivision 1. **Definitions.** The following terms have the meanings given them.

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

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

41.7 (c) "Exchange" means the Minnesota Health Insurance Exchange in section 62U.02.

41.8 (d) "Exchange director" means the appointed director under section 62U.02,  
41.9 subdivision 15.

41.10 Subd. 2. **Section 125 Plan requirement.** (a) Effective January 1, 2010, each  
41.11 employer that has three or more current employees shall establish a Section 125 Plan to  
41.12 either allow its employees to purchase individual market health plan coverage or allow  
41.13 its employees to pay the employees share of premiums for employer-based health plan  
41.14 coverage with pretax dollars. Nothing in this section requires an employer to offer or  
41.15 purchase group health insurance coverage for its employees. An employer that has no  
41.16 employees who are eligible to participate in a Section 125 Plan is exempt from this  
41.17 requirement.

41.18 (b) An employer that offers a Section 125 Plan may enter into an agreement with the  
41.19 Exchange to administer the employer's Section 125 Plan.

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

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

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

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

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

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

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

42.3 Subd. 5. **Health plan company requirements.** (a) Individuals who are eligible  
42.4 to use an employer Section 125 Plan may use it to pay for an individual market health  
42.5 plan for which the individual is eligible and purchase it through the Exchange, including  
42.6 an individual market health plan, MinnesotaCare, and the Minnesota Comprehensive  
42.7 Health Association.

42.8 (b) Individuals who purchase an individual market health plan through a Section 125  
42.9 Plan may purchase coverage on a guaranteed issue basis during an annual open enrollment  
42.10 period that coincides with the open enrollment period for their employer's Section 125  
42.11 Plan or upon experiencing a qualifying event as defined in United States Code, title 43,  
42.12 section 4980B. Nothing in this section precludes a health plan company from issuing  
42.13 coverage with preexisting condition exclusions as allowed elsewhere in law. Health plans  
42.14 may not charge higher or lower premiums based on health status for individuals who  
42.15 purchase coverage on a guaranteed issue basis under this section, except for variations in  
42.16 premium that are allowable based on health behaviors such as tobacco use.

42.17 **Sec. 9. [62U.04] COST-EFFECTIVE BENEFITS SET AND DESIGN.**

42.18 Subdivision 1. **Creation.** There is created a Health Benefits and Design Board that  
42.19 consists of seven voting members and four ex officio nonvoting members.

42.20 Subd. 2. **Members.** (a) The voting membership of the board shall be appointed  
42.21 to serve three-year terms as follows: three members appointed by the governor; two  
42.22 members appointed by the Subcommittee on Committees of the Committee on Rules and  
42.23 Administration of the senate; and two members appointed by the speaker of the house  
42.24 of representatives.

42.25 (b) The nonvoting members shall be the commissioners of health, human services,  
42.26 commerce, and finance, or their designees.

42.27 (c) No voting members shall have a direct financial interest in the outcome of the  
42.28 board's proceeding other than as an individual consumer of health care services.

42.29 (d) The voting members shall have expertise in benefit design and development,  
42.30 actuarial analysis, or knowledge relating to the analysis of the cost impact of coverage of  
42.31 specified benefits.

42.32 Subd. 3. **Operations of the board.** (a) The board shall convene on or before  
42.33 September 1, 2008, upon the appointment of the initial board and shall meet at least once a  
42.34 year, and at other times at the call of the chair.

43.1 (b) The board may hire an executive director who shall serve in the unclassified  
43.2 service. The executive director may hire employees and consultants as authorized by the  
43.3 board and may prescribe their duties. The attorney general shall provide legal services to  
43.4 the board.

43.5 (c) The commissioner of health shall provide office space, equipment and supplies,  
43.6 and technical support to the board.

43.7 (d) The board shall be governed by section 15.0575, except the board shall not expire.

43.8 Subd. 4. **Immunity of liability.** No member of the board may be held civilly liable  
43.9 for an act or omission by that member if the act or omission was in good faith and within  
43.10 the scope of the member's responsibilities under this chapter.

43.11 Subd. 5. **Duties of the board.** (a) The board shall establish an initial cost-effective,  
43.12 evidence-based benefit set and design by January 15, 2009, that provides individuals  
43.13 access to a broad range of health care services, including preventive health care, without  
43.14 incurring severe financial loss as a result of serious illness or injury. The initial benefit set  
43.15 must include necessary evidence-based health care services, procedures, and diagnostic  
43.16 tests that are scientifically proven to be both clinically effective and cost effective. In  
43.17 establishing the initial benefit set, the board may contract with the Institute for Clinical  
43.18 Systems Improvement (ICSI) to assemble existing scientifically based practice standards.  
43.19 The board shall consider cultural, ethnic, and religious values and beliefs to ensure that the  
43.20 health care needs of all Minnesota residents are addressed in the benefit set.

43.21 (b) The benefit set must cover preventive services, immunizations, and  
43.22 early diagnostic tests, that are scientifically proven to be both clinically effective  
43.23 and cost-effective with no cost-sharing requirements. The benefit set must cover  
43.24 evidence-based outpatient care for chronic conditions, including but not limited to asthma,  
43.25 heart disease, diabetes, and depression with no cost-sharing requirements, or cost-sharing  
43.26 requirements that do not impose an economic barrier to access that care.

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

43.30 (d) Before finalizing the benefit set, the board shall convene public hearings  
43.31 throughout the state.

43.32 (e) The benefit set and design shall be used as a minimum requirement for health  
43.33 plans offered through the Exchange and be the only benefit plan eligible for premium  
43.34 subsidies under section 62U.09. The benefit design must establish a limited number of  
43.35 maximum cost-sharing variations based upon deductibles and maximum out-of-pocket  
43.36 costs. There shall be no maximum lifetime benefit.

44.1 Subd. 6. **Continued review.** The board shall review the benefit set on an ongoing  
 44.2 periodic basis and shall adjust the benefit set as necessary to ensure that the benefit design  
 44.3 continues to be safe, effective, and scientifically based.

44.4 Subd. 7. **Exemption from administrative procedures.** To carry out the purposes  
 44.5 of this section and section 62U.05, the board may adopt rules under chapter 14. The board  
 44.6 is exempt from rulemaking requirements to the extent rules are necessary to establish the  
 44.7 benefit set and design described in subdivision 5. The board may use the provisions of  
 44.8 section 14.386, paragraph (a), clauses (1) and (3). Rules adopted are exempt from section  
 44.9 14.386, paragraph (b).

44.10 **Sec. 10. [62U.05] HEALTH TECHNOLOGY ASSESSMENT.**

44.11 Subdivision 1. **Technology Advisory Committee.** (a) The Health Benefit Set and  
 44.12 Design Board shall convene an advisory committee to make recommendations to the  
 44.13 board regarding the inclusion of new and existing health technologies in the cost-effective  
 44.14 benefit set.

44.15 (b) The advisory committee must be made up of 11 members appointed by  
 44.16 the board's executive director, in consultation with the Institute for Clinical Systems  
 44.17 Improvement, the Health Services Advisory Council, and the University of Minnesota.  
 44.18 The members shall consist of:

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

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

44.22 (c) A member of the advisory committee shall not have a substantial financial  
 44.23 interest in a health technology company and shall not be employed by or under contract  
 44.24 with a health technology manufacturer during their term or for 18 months before their  
 44.25 appointment.

44.26 (d) The members shall be immune from civil liability for any official acts performed  
 44.27 in good faith as members of the committee.

44.28 (e) The advisory committee shall be governed under section 15.059, except that  
 44.29 the committee shall not expire.

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

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

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

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

45.2 Subd. 3. **Technology review.** (a) Upon the selection of a health technology for  
 45.3 review, the board shall contract for a systematic evidence-based assessment of the  
 45.4 technology's safety, efficacy, and cost effectiveness. The contract must be with an  
 45.5 evidence-based practice center designated by the federal Agency for Health Care Research  
 45.6 and Quality, or another appropriate entity as designated by the board.

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

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

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

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

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

45.21 Sec. 11. **[62U.06] GOALS FOR UNIVERSAL COVERAGE; CONTINGENT**  
 45.22 **INDIVIDUAL RESPONSIBILITY REQUIREMENT.**

45.23 Subdivision 1. **Phase-in goals.** The state's phase-in goals for progress toward  
 45.24 universal health coverage for Minnesota residents are:

45.25 (1) 94 percent insured by end of fiscal year 2009;

45.26 (2) 96 percent insured by end of fiscal year 2011;

45.27 (3) 97 percent insured by end of fiscal year 2012; and

45.28 (4) 98 percent insured by end of fiscal year 2013 and thereafter.

45.29 Subd. 2. **Measurement of percent insured.** The determination of the percent  
 45.30 of Minnesota residents insured must be based on an annual survey of the Minnesota  
 45.31 population younger than age 65 to be conducted or contracted for by the commissioner  
 45.32 of health which must include questions related to the type of insurance, amount of  
 45.33 cost-sharing, and potential barriers to public program enrollment.

45.34 Subd. 3. **Contingent individual responsibility requirement.** (a) If the increased  
 45.35 affordability, cost containment, insurance reform, and voluntary efforts provided for under

46.1 this section fail to achieve universal coverage, an individual responsibility requirement  
46.2 will have been proven to be necessary.

46.3 (b) If any one of the phase-in goals specified in subdivision 1 for fiscal year 2011 or  
46.4 later is not met, as determined by the commissioner of health, in spite of implementation  
46.5 of the increased affordability, cost containment, insurance reform, and voluntary efforts  
46.6 provided for under 62U.01 to 62U.09, an individual responsibility requirement, requiring  
46.7 every Minnesota resident to obtain and maintain health coverage from a public or private  
46.8 sector source of the person's choice, shall become effective 12 months after the end of  
46.9 that fiscal year.

46.10 (c) Failure to comply with the individual responsibility requirement is not a crime,  
46.11 but will subject the person to a financial penalty to be specified in law.

46.12 **Sec. 12. [62U.07] SAVINGS RECAPTURE ASSESSMENT.**

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

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

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

46.25 Subd. 2. **Actual spending.** (a) By February 15 of each year, beginning February 15,  
46.26 2010, the commissioner shall determine the actual private and public health care spending  
46.27 for the calendar year preceding the current calendar year and shall determine the difference  
46.28 between the projected spending as determined under subdivision 1 and the actual spending  
46.29 for that year. The actual spending must be certified by an independent actuarial consultant.  
46.30 If the actual spending is less than the projected spending, the commissioner shall  
46.31 determine an aggregate savings offset amount not to exceed 40 percent of the difference.

46.32 (b) Based on this calculation, the commissioner shall determine annually a savings  
46.33 offset amount to be paid by health plan companies and third-party administrators. The  
46.34 aggregate savings offset amount may not exceed 40 percent of the aggregate savings  
46.35 reflected in the difference between the actual spending and the projected spending.

47.1 Subd. 3. **Publication of spending.** By February 15 of each year, beginning February  
47.2 15, 2010, the commissioner shall publish in the State Register the projected spending  
47.3 baseline, including any adjustments, and the actual spending for the preceding year.

47.4 Subd. 4. **Savings offset assessments.** (a) Each health plan company and third-party  
47.5 administrator shall pay a savings offset assessment. The commissioner shall calculate the  
47.6 savings offset assessments as a percentage of paid claims as follows:

47.7 (1) for health plan companies, the savings offset assessment may not exceed four  
47.8 percent of annual paid health care claims on policies that insure residents of this state; and

47.9 (2) for third-party administrators, the savings offset assessment may not exceed four  
47.10 percent of annual paid claims for health care for residents of this state.

47.11 (b) A health plan company may not be required to pay a savings offset assessment  
47.12 on policies or contracts insuring federal employees.

47.13 (c) Savings offset assessments apply to claims paid for plan years beginning on  
47.14 or after January 1, 2010.

47.15 (d) Savings offset assessments must be made quarterly to the commissioner of  
47.16 revenue within 60 days of the close of each quarter, beginning April 15, 2010.

47.17 Subd. 5. **Deposit of assessments.** The commissioner of revenue shall deposit the  
47.18 revenue derived from the assessments into the health care access fund.

47.19 **Sec. 13. [62U.08] AFFORDABILITY STANDARD.**

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

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

47.27 **AFFORDABILITY STANDARD**

	<b><u>Federal Poverty</u></b> <b><u>Guideline Range</u></b>	<b><u>Percent of Average Gross</u></b> <b><u>Monthly Income</u></b>
47.28	<u>0-33%</u>	<u>minimum</u>
47.29	<u>33-54%</u>	<u>1.1%</u>
47.30	<u>55-81%</u>	<u>1.2%</u>
47.31	<u>82-109%</u>	<u>1.6%</u>
47.32	<u>110-136%</u>	<u>2.4%</u>
47.33	<u>137-164%</u>	<u>2.9%</u>
47.34	<u>165-191%</u>	<u>3.9%</u>

48.1	<u>192-219%</u>	<u>4.6%</u>
48.2	<u>220-248%</u>	<u>5.4%</u>
48.3	<u>248-274%</u>	<u>6.0%</u>
48.4	<u>275-300%</u>	<u>6.0%</u>

48.5 Subd. 3. Incomes greater than 300 percent but not exceeding 400 percent of the  
 48.6 federal poverty guidelines. For purposes of determining affordability, the affordability  
 48.7 standard for individuals and households with gross family incomes greater than 300  
 48.8 percent but not exceeding 400 percent of the federal poverty guidelines shall be based  
 48.9 on a continuation of the sliding scale specified in subdivision 2, with the percentage of  
 48.10 average gross monthly income rising proportionately at each income range, to a maximum  
 48.11 of 8.0 percent.

48.12 Sec. 14. [62U.09] EMPLOYEE SUBSIDIES FOR EMPLOYER-SUBSIDIZED  
 48.13 HEALTH COVERAGE.

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

48.18 Subd. 2. Eligible employees. In order to be eligible for a subsidy under this section,  
 48.19 an employee shall:

48.20 (1) be covered by employer-subsidized health coverage that meets the benefits  
 48.21 set and design established under section 62U.04 and is purchased through the Health  
 48.22 Insurance Exchange established under section 62U.02; and

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

48.25 (i) no access to employer-subsidized coverage under section 256L.07, subdivision  
 48.26 2; and

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

48.28 Subd. 3. Amount of subsidy. The subsidy must equal the amount the employee  
 48.29 is required to pay for health coverage, including premiums, deductibles, and other cost  
 48.30 sharing, minus an amount based on the affordability standard specified in section 62U.08.  
 48.31 The maximum subsidy must not exceed the amount of the subsidy that would have been  
 48.32 provided under the MinnesotaCare program, if the employee and any dependents were  
 48.33 eligible for that program.

48.34 Subd. 4. Payment of subsidy. The commissioner shall pay the subsidy amount  
 48.35 for an employee and any dependents to the Minnesota Health Insurance Exchange, and

49.1 this payment shall be credited toward the employee's share of premium. Any additional  
 49.2 amount paid by the commissioner to the Minnesota Health Insurance Exchange that  
 49.3 exceeds the employee's share of premium must be credited first toward the employee  
 49.4 deductible and then toward any employee cost-sharing obligation.

49.5 **EFFECTIVE DATE.** This section is effective July 1, 2010.

49.6 Sec. 15. **[62U.11] PAYMENT RESTRUCTURING; PAYMENTS BASED ON**  
 49.7 **QUALITY AND EFFICIENCY OF CARE.**

49.8 **Subdivision 1. Development.** The commissioners of human services and health  
 49.9 shall develop a payment system that links the level of payments to providers to the quality  
 49.10 and efficiency of care for voluntary implementation in the private sector beginning January  
 49.11 1, 2009. The payment system must incorporate payments to primary care physicians,  
 49.12 specialty care physicians, health care clinics, and hospitals, and other providers who  
 49.13 provide services included in the evidence-based benefit set and design developed under  
 49.14 section 62U.04.

49.15 **Subd. 2. Payment system criteria.** The payment system must meet the following  
 49.16 criteria:

49.17 (1) providers meeting specified targets, or who demonstrate a significant amount of  
 49.18 improvement over time, must be eligible for quality and efficiency-based payments that  
 49.19 are in addition to existing payment levels;

49.20 (2) priority must be placed on measures of health care outcomes, rather than process  
 49.21 measures, wherever possible;

49.22 (3) quality measures for primary care providers must focus on preventive services,  
 49.23 coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary  
 49.24 disease, depression, and other conditions or procedures for which, in the determination of  
 49.25 the commissioners, improved outcomes will lead to significant cost savings;

49.26 (4) quality measures for specialty care must be designated by the commissioners, and  
 49.27 initially based on quality indicators measured and reported publicly by specialty societies;

49.28 (5) hospital payments must be adjusted for quality and efficiency using existing  
 49.29 measures where available, which focus on health conditions or procedures for which,  
 49.30 in the determination of the commissioners, improved outcomes will lead to significant  
 49.31 cost savings; and

49.32 (6) other indicators of care quality and efficiency must be incorporated where  
 49.33 appropriate. These indicators may include care infrastructure, collection and reporting of  
 49.34 results, measures of efficiency for specific procedures, and measures of overall cost of  
 49.35 care for individuals.

50.1       Sec. 16. **[62U.12] PAYMENT RESTRUCTURING; CARE COORDINATION**  
50.2 **PAYMENTS FOR HEALTH CARE HOMES.**

50.3       Subdivision 1. **Development.** The commissioners of health and human services  
50.4 shall develop, for voluntary implementation in the private sector beginning July 1, 2009,  
50.5 a payment system that provides care coordination payments to health care providers.  
50.6 In order to be eligible for a care coordination payment, a health care provider must be  
50.7 certified as a health care home by the commissioners of human services and health based  
50.8 on the certification standards for health care homes established under section 256B.0754.

50.9       Subd. 2. **Care coordination fee.** (a) Under the payment system, health care homes  
50.10 must receive a per-person per-month care coordination fee for providing care coordination  
50.11 services and employing care coordinators, as specified in section 256B.0752, subdivisions  
50.12 3 and 7.

50.13       (b) The care coordination fee must not exceed an average of \$50 per person per  
50.14 month. The care coordination fee must be determined by the commissioners, and must  
50.15 vary by thresholds of care complexity, with the highest fees being paid for care provided  
50.16 to individuals requiring the most intensive care coordination, such as those with very  
50.17 complex health care needs or several chronic conditions.

50.18       (c) In setting care coordination fees, the commissioners shall consider the additional  
50.19 time and resources needed by patients with limited English-language skills, cultural  
50.20 differences, or other barriers to health care.

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

50.23       Subd. 3. **Quality/efficiency-based payments.** The quality/efficiency-based  
50.24 payments under section 62U.11 must also be included in the care coordination payment  
50.25 system. Providers whose quality or efficiency does not allow them to qualify for payments  
50.26 under section 62U.11 are not be eligible to receive care coordination fees.

50.27       Sec. 17. **[62U.13] COORDINATION WITH THE PRIVATE SECTOR.**

50.28       In developing the payment systems required under sections 62U.11 and 62U.12, the  
50.29 commissioners of human services and health shall consult and coordinate with health  
50.30 care providers, health plan companies, consumers, and employers and other payors.  
50.31 The commissioners shall publicize and promote the payment systems required under  
50.32 sections 62U.11 and 62U.12, and shall provide technical assistance to entities interested in  
50.33 adopting one or both of these payment systems.

51.1 Sec. 18. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision  
51.2 to read:

51.3 Subd. 27. **Exchange of data.** An entity that is part of the welfare system as defined  
51.4 in section 13.46, subdivision 1, paragraph (c), and the Minnesota Health Insurance  
51.5 Exchange under section 62U.02 may Exchange private data about individuals without  
51.6 the individual's consent in order to collect premiums from individuals in the medical  
51.7 assistance employed persons with disabilities program and the MinnesotaCare program  
51.8 under chapters 256B and 256L. This subdivision only applies if the entity that is part of  
51.9 the welfare system and the Minnesota Health Insurance Exchange have entered into an  
51.10 agreement that complies with the requirements in Code of Federal Regulations, title  
51.11 45, section 164.314.

51.12 Sec. 19. **AMENDMENTS TO CURRENT HEALTH BENEFIT SETS.**

51.13 The commissioners of health, commerce, and employee relations shall report to the  
51.14 legislature under Minnesota Statutes, section 3.195, on necessary changes to current  
51.15 mandated benefit sets to align these with the cost-effective benefit set developed by the  
51.16 Health Benefits and Design Board established in Minnesota Statutes, section 62U.04.

APPENDIX  
Article/Section location for 08-6170

ARTICLE 1

Page.Ln 1.20

PUBLIC HEALTH

Section 1. .... 1.22    Sec. 3. .... 2.10    Sec. 5. .... 3.13    Sec. 7. .... 4.5  
Sec. 2. .... 1.27    Sec. 4. .... 3.3    Sec. 6. .... 3.29

ARTICLE 2

Page.Ln 4.9

HEALTH CARE HOMES

Section 1. ....4.11    Sec. 3. .... 5.26    Sec. 5. .... 8.4    Sec. 7. ....11.1  
Sec. 2. .... 5.4    Sec. 4. .... 7.20    Sec. 6. .... 9.30    Sec. 8. ....11.22

ARTICLE 3

Page.Ln 12.10

INCREASING ACCESS; CONTINUITY OF CARE

Section 1. .... 12.12    Sec. 5. .... 14.32    Sec. 9. .... 17.23    Sec. 13. .... 21.1    Sec. 17. .... 24.9  
Sec. 2. .... 13.3    Sec. 6. .... 15.24    Sec. 10. .... 18.15    Sec. 14. .... 22.4  
Sec. 3. .... 13.30    Sec. 7. .... 16.23    Sec. 11. .... 18.30    Sec. 15. .... 23.6  
Sec. 4. .... 14.23    Sec. 8. .... 17.14    Sec. 12. .... 19.32    Sec. 16. .... 23.15

ARTICLE 4

Page.Ln 24.14

INSURANCE REFORM

Section 1. .... 24.16    Sec. 2. .... 25.8    Sec. 3. .... 25.18

ARTICLE 5

Page.Ln 26.1

HEALTH INSURANCE PURCHASING AND AFFORDABILITY

Section 1. .... 26.3    Sec. 5. .... 34.24    Sec. 9. .... 42.17    Sec. 13. .... 47.19    Sec. 17. .... 50.27  
Sec. 2. .... 30.24    Sec. 6. .... 35.3    Sec. 10. .... 44.10    Sec. 14. .... 48.12    Sec. 18. .... 51.1  
Sec. 3. .... 32.17    Sec. 7. .... 35.31    Sec. 11. .... 45.21    Sec. 15. .... 49.6    Sec. 19. .... 51.12  
Sec. 4. .... 32.29    Sec. 8. .... 40.35    Sec. 12. .... 46.12    Sec. 16. .... 50.1