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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 1564

March 12, 2009
Authored by Huntley
The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight

A bill for an act

relating to health care reform; increasing affordability and eligibility for state health care programs; establishing the Minnesota Health Insurance Exchange; continuing payment reform; creating an affordability standard; establishing goals for universal coverage and a contingent individual responsibility mandate; amending Minnesota Statutes 2008, sections 13.46, subdivision 2; 62E.141; 62L.12, subdivisions 2, 4; 62U.04, subdivisions 3, 8; 62U.05; 62U.07, by adding a subdivision; 62U.08, subdivision 2; 256.01, by adding a subdivision; 256B.056, subdivision 10; 256B.057, subdivision 8; 256L.03, subdivisions 3, 5; 256L.04, subdivisions 1, 7; 256L.05, by adding a subdivision; 256L.07, subdivisions 1, 3; 256L.15, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 62U.

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

Section 1. Minnesota Statutes 2008, section 13.46, subdivision 2, is amended to read:

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

(1) according to section 13.05;

(2) according to court order;

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

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

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to

an individual or family across programs; evaluate the effectiveness of programs; assess parental contribution amounts; and investigate suspected fraud;

(6) to administer federal funds or programs;

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the participant:

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

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

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

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

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

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

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

(i) the member:

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

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

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

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

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

(19) the current address of a recipient of Minnesota family investment program, general assistance, general assistance medical care, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

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

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

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

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

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a local board of health as

defined in section 145A.02, subdivision 2, when the commissioner or local board of health has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

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

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

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

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

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

(30) according to section 256.01, subdivision 27, between the welfare system and the Minnesota Health Insurance Exchange under section 62U.11, in order to collect premiums from individuals in the medical assistance employed persons with disabilities program and the MinnesotaCare program under chapters 256B and 256L, and to administer the individual's and the individual's family's participation in the exchange.

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

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

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

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

Sec. 2. Minnesota Statutes 2008, section 62E.141, is amended to read:

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

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

Sec. 3. Minnesota Statutes 2008, section 62L.12, subdivision 2, is amended to read:

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

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

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

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

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

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to

substitute individual health plans for a group health plan nor as a result of any violation of subdivision 3 or 4.

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

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

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

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

(k) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to all employees or through the Minnesota Health Insurance Exchange under section 62U.11 to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. Except as provided in section 62U.07, subdivision 5, paragraph (b), the requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the premium and merely collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier or to the Minnesota Health Insurance Exchange under section 62U.11. Except for coverage under section 62A.65, subdivision 5, paragraph (b), or 62E.16, at the request of an employee, the health carrier or the Minnesota Health Insurance Exchange under section 62U.11 may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier or the Minnesota Health Insurance Exchange, as applicable, shall provide a

cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

The employer must provide a written and signed statement to the health carrier or the Minnesota Health Insurance Exchange, as applicable, stating that the employer is not contributing directly or indirectly to the employee's premiums. The Minnesota Health Insurance Exchange under section 62U.11 shall provide health carriers with enrolled employees of the employer a copy of the employer's statement. The health carrier may rely on the employer's statement and is not required to guarantee-issue individual health plans to the employer's ~~other current or future~~ employees, except as required under section 62U.07, subdivision 5, paragraph (b).

Sec. 4. Minnesota Statutes 2008, section 62L.12, subdivision 4, is amended to read:

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

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

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

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

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

Sec. 5. Minnesota Statutes 2008, section 62U.04, subdivision 3, is amended to read:

Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer grouping system for providers based on a combined measure that incorporates both provider risk-adjusted total cost of care and quality of care, and for specific conditions as determined by the commissioner. In developing this system, the commissioner shall consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. For purposes of the final establishment of the peer grouping system, the commissioner shall not contract

with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of the system.

(b) Beginning June 1, 2010, the commissioner shall disseminate information to providers on their cost of care, resource use, quality of care, and the results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. The provider shall have 21 days to review the data for accuracy.

(c) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports.

(d) Beginning September 1, 2010, the commissioner shall, no less than annually, publish information on providers' cost, quality, and the results of the peer grouping process. The results that are published must be on a risk-adjusted basis.

Sec. 6. Minnesota Statutes 2008, section 62U.04, subdivision 8, is amended to read:

Subd. 8. **Provider innovation to reduce health care costs and improve quality.** (a) Nothing in this section shall prohibit group purchasers and health care providers, upon mutual agreement, from entering into arrangements that establish package prices for a comprehensive set of services or separately for the cost of care for specific health conditions in addition to the ~~baskets of care established in~~ package prices established under section 62U.05, in order to give providers the flexibility to innovate on ways to reduce health care costs while improving overall quality of care and health outcomes.

(b) The commissioner of health may convene working groups of private sector payers and health care providers to discuss and develop new strategies for reforming health care payment systems to promote innovative care delivery that reduces health care costs and improves quality.

Sec. 7. Minnesota Statutes 2008, section 62U.05, is amended to read:

62U.05 PROVIDER PRICING FOR BASKETS OF CARE AND TOTAL COST OF CARE.

Subdivision 1. **Establishment of definitions.** (a) By July 1, 2009, the commissioner of health shall establish uniform definitions for baskets of care beginning with a minimum of seven baskets of care. In selecting health conditions for which baskets of care should be defined, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression. In selecting health conditions, the commissioner shall also

consider the prevalence of the health conditions, the cost of treating the health conditions, and the potential for innovations to reduce cost and improve quality.

(b) The commissioner shall convene one or more work groups to assist in establishing these definitions. Each work group shall include members appointed by statewide associations representing relevant health care providers and health plan companies, and organizations that work to improve health care quality in Minnesota.

(c) To the extent possible, the baskets of care and the total cost of care as specified under paragraph (d) must incorporate a patient-directed, decision-making support model.

(d) By July 1, 2010, the commissioner shall establish uniform definitions for the total cost of providing all necessary services to a patient, and shall develop a standard method and format for providers to use for submitting package prices for the total cost of care. This method shall be published in the State Register and must be made available to all providers.

Subd. 2. **Package prices.** (a) Beginning January 1, 2010, health care providers may establish package prices for the baskets of care defined under subdivision 1. By January 1, 2011, health care providers may establish package prices for the total cost of care defined under subdivision 1.

(b) Beginning January 1, 2010, no health care provider or group of providers that has established a package price for a basket of care under this section, and beginning January 1, 2011, no health care provider or group of providers that has established a package price for the total cost of care under this section shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser. This paragraph applies only to health care services provided to Minnesota residents or to non-Minnesota residents who obtain health insurance through a Minnesota employer. This paragraph does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile insurance. This paragraph does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

Subd. 3. **Quality measurements for baskets of care.** (a) The commissioner shall establish quality measurements for the defined baskets of care by December 31, 2009. The commissioner shall establish quality measures for the total cost of care by December 31, 2010. The commissioner may contract with an organization that works to improve health

care quality to make recommendations about the use of existing measures or establishing new measures where no measures currently exist.

(b) Beginning July 1, 2010, the commissioner or the commissioner's designee shall publish comparative price and quality information on the baskets of care in a manner that is easily accessible and understandable to the public, as this information becomes available. Beginning July 1, 2011, the commissioner or the commissioner's designee shall publish comparative price and quality information on total cost of care in a manner that is easily accessible and understandable to the public, as this information becomes available.

Sec. 8. Minnesota Statutes 2008, section 62U.07, is amended by adding a subdivision to read:

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

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

Sec. 9. Minnesota Statutes 2008, section 62U.08, subdivision 2, is amended to read:

Subd. 2. **Duties.** (a) By October 15, 2009, the work group shall develop and submit to the commissioner an initial essential benefit set and design that includes coverage for a broad range of services, is based on scientific evidence that services are clinically effective and cost-effective, and provides lower enrollee cost sharing for services that have been determined to be cost-effective. The benefit set must include necessary evidence-based health care services, procedures, diagnostic tests, and technologies that are scientifically proven to be both clinically effective and cost-effective. In developing its recommendations, the work group may consult with the Institute for Clinical Systems Improvement (ICSI) to assemble existing scientifically based practice standards.

(b) The benefit set and design must be used as a minimum requirement for health plans offered through the Minnesota Health Insurance Exchange established under section 62U.11. The benefit set and design must include a limited number of maximum cost-sharing variations based upon deductibles and maximum out-of-pocket costs. There must be no maximum lifetime benefit.

(c) The commissioner shall review the benefit set and design on an ongoing periodic basis and shall adjust the benefit set and design as necessary, to ensure that the benefit set and design continues to be safe, effective, and scientifically based.

Sec. 10. **[62U.11] MINNESOTA HEALTH INSURANCE EXCHANGE.**

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

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

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

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

(b) "Commissioner" means:

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

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

(3) either commissioner's designated representative.

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

(d) "Individual market health plan" means a health plan as defined in section 62A.011, that is designed for sale in the individual market and that may cover either an individual or an individual and the individual's dependents.

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

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

Subd. 4. **Health plan company and health plan participation and availability.** (a) Only individual market health plans and small employer health benefit plans offered by a health plan company licensed to issue health plans in Minnesota may be made available for purchase through the exchange.

(b) Each health plan made available by a health plan company through the exchange must meet the essential benefit set and design requirements provided under section 62U.08.

(c) Any health plan company that issues health plans in the individual or small employer market in this state must offer through the exchange at least one health plan that meets the benefit set and design established under section 62U.08.

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

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

(f) Nothing in this section restricts the sale of individual market health plans and small employer health benefit plans outside of the exchange. The requirements applicable to issuance, renewal, cancellation, and pricing of coverage are the same for health plans purchased inside and outside the exchange, except as described under section 62U.07, subdivision 5, paragraph (b).

Subd. 5. **Comparison of health plans.** The exchange shall help consumers understand and compare the standardized health plan options established under section 62U.08. Within each standardized plan grouping, the exchange shall provide easy ways for consumers to select among the offerings by comparing quality ratings, searching for a particular provider in its network, or by cost factors. This information must be made available via the Internet as well as by toll-free telephone assistance and written materials.

Subd. 6. **Individual participation and eligibility.** (a) Individuals are eligible to purchase health plans directly through the exchange or through an employer Section 125 Plan under section 62U.07.

(b) Nothing in this section requires guaranteed issue of individual market health plans offered through the exchange except as provided under section 62U.07, subdivision 5, paragraph (b).

(c) Individuals are eligible to purchase individual market health plans through the exchange by meeting one or more of the following qualifications:

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

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

(3) the individual is not a Minnesota resident but is employed by an employer physically located within the state and the individual's employer is required to offer a Section 125 Plan under section 62U.07; or

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

(d) A self-employed individual, including a partner of a partnership, a member of a limited liability company, or other owner of a business, who may not be eligible to participate in a Section 125 plan, may obtain coverage through the exchange either as an individual under paragraph (c) or as an employee covered under a small employer health benefit plan if permitted under chapter 62L.

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

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

(1) publicizing the exchange including, but not limited to, its functions, eligibility rules, and enrollment procedures;

(2) providing assistance to employers to establish Section 125 Plans under section 62U.07;

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

(4) creating a system to allow individuals to compare and enroll in health plans offered through the exchange, including a system of comparative rating of health plans and benefit sets;

(5) creating a system to collect and transmit to the applicable health plan companies all premium payments made by individuals and small employers, including developing mechanisms to receive and process automatic payroll deductions for individuals who purchase coverage through employer Section 125 Plans;

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

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

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

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

(10) establishing procedures to account for all funds received and disbursed by the exchange; and

(11) making available to the public, within 90 days after the end of each fiscal year, a report of an independent audit of the exchange's accounts.

Subd. 9. **State not liable.** The state is not liable for the actions of the exchange.

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

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

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

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

(4) seek and directly receive grant funding from government agencies or private philanthropic organizations, other than those connected with Minnesota-based nonprofit health providers or health plan companies, to defray the costs of operating the exchange;

(5) establish and administer rules and procedures governing the operations of the exchange;

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

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

(8) establish bank accounts and borrow money; and

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

Subd. 11. **Dispute resolution.** The exchange shall establish procedures for resolving disputes with respect to the eligibility of an individual to participate in the

exchange. The exchange shall not have the authority or responsibility to intervene in or resolve disputes between an individual and a health plan or health plan company. If the exchange receives complaints involving such disputes from individuals participating in the exchange, the exchange shall inform the individual about the right to make such complaints to the commissioner to be resolved according to sections 62Q.68 to 62Q.73.

Subd. 12. **Governance.** The exchange shall be governed by a board of directors with 11 members. The board shall convene on or before July 1, 2009, after the initial board members have been selected. The initial board membership consists of the following:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health; and

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

Subd. 13. **Subsequent board membership.** (a) Effective July 1, 2012, ongoing membership of the exchange consists of the following:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

(4) two members appointed as follows: one nonlegislator appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate and one nonlegislator appointed by the speaker of the house to serve two-year terms. These appointed members are eligible to be reappointed for one additional term; and

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

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

Subd. 14. **Operations of board.** Officers of the board of directors are elected by members of the board and serve one-year terms. Six members of the board constitute a quorum, and the affirmative vote of six members of the board is necessary and sufficient for any action taken by the board. Board members serve without pay, but are reimbursed for actual expenses incurred in the performance of their duties. Board meetings must be open to the public, except as specified in the bylaws of the exchange.

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

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

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

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

Subd. 16. **Investment of assets.** The exchange must certify to the State Board of Investment that a portion of the assets of the exchange, in the judgment of the exchange director, are not required for immediate use. Investment earnings on assets transferred to the State Board of Investment under this subdivision must be maintained in an account in the state treasury. Money in the account may be spent, as appropriated by law, for purposes related to assisting individuals in paying health insurance premiums and for making health insurance products more affordable.

Subd. 17. **Audit.** The legislative auditor must audit the exchange, as provided in sections 3.971 and 3.972.

Subd. 18. **Insurance producers.** An individual has the right to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist the individual in purchasing an individual market health plan through the exchange. When a producer licensed in accident and health insurance under chapter 60K enrolls an eligible individual in the exchange, the health plan company chosen by the individual may pay the producer a commission.

Subd. 19. **Implementation.** Health plan coverage through the exchange begins on July 1, 2010. The exchange must be operational to assist employers and individuals by January 1, 2010, and be prepared for enrollment by June 1, 2010.

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

Sec. 11. **[62U.12] GOALS FOR UNIVERSAL COVERAGE; CONTINGENT INDIVIDUAL RESPONSIBILITY REQUIREMENT.**

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

(1) 94 percent insured by end of fiscal year 2010;

(2) 96 percent insured by end of fiscal year 2012;

(3) 97 percent insured by end of fiscal year 2013; and

(4) 98 percent insured by end of fiscal year 2014 and thereafter.

Subd. 2. **Measurement of percentage insured.** The commissioner of health must determine what percentage of Minnesota residents are insured. The determination must be based on an annual survey of the Minnesota population younger than 65, to be conducted

or contracted for by the commissioner of health. The survey must include questions related to the type of insurance, amount of cost sharing, and potential barriers to public program enrollment.

Subd. 3. **Contingent individual responsibility requirement.** (a) If the increased affordability, cost containment, insurance reform, and voluntary efforts provided for under this act and Laws 2008, chapter 358, fail to achieve universal coverage, an individual responsibility requirement is deemed to be necessary.

(b) If any one of the phase-in goals in subdivision 1 for fiscal year 2012 or later is not met, as determined by the commissioner of health, an individual responsibility requirement requiring every Minnesota resident to obtain and maintain health coverage from a public or private sector source of the person's choice must become effective 12 months after the end of that fiscal year, provided that the commissioner certifies that health plans that meet the affordability standard under section 62U.13 are available to Minnesotans.

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

(d) An individual need not comply with the individual responsibility requirement if the individual objects to the requirement on the basis of a conscientiously held religious belief or bona fide religious practice. In the case of a minor child, this paragraph applies to the belief or practice of the child's parents. An individual may, but is not required to, apply to the commissioner of health for a written waiver of the requirement based upon this paragraph. The commissioner shall approve the waiver if the applicant provides satisfactory proof of eligibility for the waiver under this paragraph.

(e) An individual with gross household income that exceeds 400 percent of the federal poverty guidelines need not comply with the individual responsibility mandate if the commissioner certifies that a health plan is not available in the individual's geographic area for which the sum of premiums, deductibles, and other out-of-pocket costs paid for health coverage by the individual does not exceed ten percent of gross income.

Sec. 12. **[62U.13] AFFORDABILITY STANDARD.**

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

Subd. 2. **Affordability standard.** The following affordability standard is established for individuals and households with gross family incomes of 400 percent of the federal poverty guidelines or less.

AFFORDABILITY STANDARD

Federal Poverty Guideline Range	Percentage of Average Gross Monthly Income
0-33%	minimum
33-54%	1.1%
55-81%	1.2%
82-109%	1.6%
110-136%	2.4%
137-164%	2.9%
165-191%	3.9%
192-219%	4.6%
220-248%	5.4%
248-274%	6.0%
275-300%	6.0%
301-324%	6.5%
325-349%	7.2%
350-374%	7.8%
375-400%	8.0%

For purposes of this subdivision, "minimum" means a monthly premium of $4.

Sec. 13. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision to read:

Subd. 29. **Exchange of data.** An entity that is part of the welfare system as defined in section 13.46, subdivision 1, paragraph (c), and the Minnesota Health Insurance Exchange under section 62U.11 may exchange private data about individuals without the individual's consent in order to collect premiums from individuals in the medical assistance employed persons with disabilities program and the MinnesotaCare program under chapters 256B and 256L. This subdivision only applies if the entity that is part of the welfare system and the Minnesota Health Insurance Exchange have entered into an agreement that complies with the requirements in Code of Federal Regulations, title 45, section 164.314.

Sec. 14. Minnesota Statutes 2008, section 256B.056, subdivision 10, is amended to read:

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

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

(c) The commissioner shall verify ~~assets and~~ income for all applicants, and for all recipients upon renewal. The commissioner shall verify liquid assets for applicants, and for recipients upon renewal, only if the applicant or recipient reports total countable assets within ten percent of the applicable asset limit. The commissioner may verify nonliquid assets, but is not required to do so. This paragraph does not apply to applicants or recipients applying for or receiving medical assistance payment of long-term care services, including services under section 256B.0915, 256B.092, or 256B.49.

(d) The commissioner shall designate locations where enrollees may submit renewal forms including, but not limited to, community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner.

EFFECTIVE DATE. Paragraph (c) is effective January 1, 2010.

Sec. 15. Minnesota Statutes 2008, section 256B.057, subdivision 8, is amended to read:

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable family income is above 275 percent of the federal poverty guidelines for the same size family but less than or equal to ~~280~~ 305 percent of the federal poverty guidelines for the same size family.

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval, whichever is later.

Sec. 16. Minnesota Statutes 2008, section 256L.03, subdivision 3, is amended to read:

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2010, for single adults and households with no children enrolled under section 256L.07, subdivision 4, and is effective July 1, 2010, or upon federal approval, whichever is later, for adults in families with children enrolled under section 256L.04, subdivision 1. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2008, section 256L.03, subdivision 5, is amended to read:

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

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

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

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

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

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

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009,

and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the ~~$10,000~~ $20,000 inpatient hospital benefit limit.

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

EFFECTIVE DATE. This section is effective January 1, 2010, for single adults and households with no children enrolled under section 256L.04, subdivision 7, and is effective July 1, 2010, or upon federal approval, whichever is later, for adults in families with children enrolled under section 256L.04, subdivision 1. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2008, section 256L.04, subdivision 1, is amended to read:

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

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

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

(d) ~~Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $57,500.~~

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

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

Sec. 19. Minnesota Statutes 2008, section 256L.04, subdivision 7, is amended to read:

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

(b) Effective July 1, 2009, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than ~~250~~ 300 percent of the federal poverty guidelines.

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

Sec. 20. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Delayed verification.** On the basis of information provided on the completed application, an applicant whose gross income is less than 90 percent of the applicable income standard and meets all other eligibility requirements, including compliance at the time of application with citizenship or nationality documentation requirements under section 256L.04, subdivision 10, must be determined eligible and enrolled upon payment of premiums according to subdivision 3. The applicant shall provide all required verifications within 60 days' notice of the eligibility determination, or eligibility shall be denied or canceled. Applicants who are denied or canceled for failure to provide all required verifications are not eligible for coverage using the delayed verification procedures in this subdivision for 12 months.

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2008, section 256L.07, subdivision 1, is amended to read:

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

the requirements of subdivision 2 ~~and the four-month requirement in subdivision 3~~, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above ~~275~~ 300 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or ~~250~~ 300 percent of the federal poverty guidelines on or after July 1, ~~2009~~ 2010, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

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

~~(c) Notwithstanding paragraphs (a) and (b), parents are not eligible for MinnesotaCare if gross household income exceeds $57,500 for the 12-month period of eligibility.~~

EFFECTIVE DATE. This section is effective July 1, 2010, or upon federal approval, whichever is later, except that the amendment to paragraph (a) related to the four-month requirement is effective January 1, 2011, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2008, section 256L.07, subdivision 3, is amended to read:

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

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 23. Minnesota Statutes 2008, section 256L.15, is amended by adding a subdivision to read:

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

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.