A bill for an act

relating to health; instituting health care reform; establishing the Minnesota Health Insurance Exchange; requiring certain employers to offer Section 125 Plans; instituting health care payment system reform; making a goal and commitment of the state to achieve universal health care by the year 2010; implementing a patient incentive health program; requiring community benefit reports; implementing provider-directed care coordination services; creating pilots to cover the uninsured; creating payment reform pilots; requiring a study to consolidate health care systems; modifying health information; supporting interoperable health record systems; providing uniform claim standards; creating task forces; requiring reports; amending Minnesota Statutes 2006, sections 62A.65, subdivision 3; 62E.141; 62J.04, subdivision 3; 62J.495; 62J.692, subdivision 4; 62J.81, subdivision 1; 62J.82; 62L.02, subdivision 11; 62L.12, subdivision 2; 62Q.165, subdivisions 1, 2; 62Q.80, subdivisions 3, 4, 13, 14; 144.698, subdivision 1; 144.699, by adding a subdivision; 256.01, subdivision 2b; 256B.0625, by adding a subdivision; 256L.01, subdivision 4; proposing coding for new law in Minnesota Statutes, chapters 62A; 62J; repealing Minnesota Statutes 2006, section 62J.052, subdivision 1.

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

ARTICLE 1

HEALTH INSURANCE EXCHANGE; SECTION 125 PLANS

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

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

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience,

and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age for adults aged 19 and above of up to plus or minus 50 percent of the index rate. Premium rates for children under the age of 19 may not vary based on age, regardless of whether the child is covered as a dependent or as a primary insured.

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 2. **[62A.67] 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 a not-for-profit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.

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

(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 insurers subject to the jurisdiction of the Department of Commerce;

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

(3) either commissioner's designated representative.

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

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

(e) "Individual market health plans," unless otherwise specified, means individual market health plans defined in section 62A.011.

(f) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125 of the Internal Revenue Code that allows employees to pay for health insurance premiums with pretax dollars.

Subd. 4. **Insurer and health plan participation.** All health plans as defined in section 62A.011, subdivision 3, issued or renewed in the individual market shall participate in the exchange. No health plans in the individual market may be issued or renewed outside of the exchange. Group health plans as defined in section 62A.10 shall not be offered through the exchange. Health plans offered through the Minnesota Comprehensive Health Association as defined in section 62E.10 are offered through the exchange to eligible enrollees as determined by the Minnesota Comprehensive Health Association. Health plans offered through MinnesotaCare under chapter 256L are offered through the exchange to eligible enrollees as determined by the commissioner of human services.

Subd. 5. **Approval of health plans.** No health plan may be offered through the exchange unless the commissioner has first certified that:

(1) the insurer seeking to offer the health plan is licensed to issue health insurance in the state; and

(2) the health plan meets the requirements of this section, and the health plan and the insurer are in compliance with all other applicable health insurance laws.

Subd. 6. **Individual market health plans.** Individual market health plans offered through the exchange continue to be regulated by the commissioner as specified in chapters 62A, 62C, 62D, 62E, 62Q, and 72A, and must include the following provisions that apply to all health plans issued or renewed through the exchange:

(1) premiums for children under the age of 19 shall not vary by age in the exchange; and

(2) premiums for children under the age of 19 must be excluded from rating factors under section 62A.65, subdivision 3, paragraph (b).

Subd. 7. **Individual participation and eligibility.** Individuals are eligible to purchase health plans directly through the exchange or through an employer Section 125 Plan under section 62A.68. Nothing in this section requires guaranteed issue of individual market health plans offered through the exchange. 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 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 62A.68;

(4) the individual is not a Minnesota resident but is self-employed and the individual's principal place of business is in the state; or

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

Subd. 8. **Continuation of coverage.** Enrollment in a health plan may be canceled for nonpayment of premiums, fraud, or changes in eligibility for MinnesotaCare under chapter 256L. Enrollment in an individual market health plan may not be canceled or nonrenewed because of any change in employer or employment status, marital status, health status, age, residence, or any other change that does not affect eligibility as defined in this section.

Subd. 9. **Responsibilities of the exchange.** The exchange shall serve as the sole entity for enrollment and collection and transfer of premium payments for health plans sold to individuals through the exchange. The exchange shall be responsible for the following functions:

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

(2) provide assistance to employers to establish Section 125 Plans under section 62A.68;

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

(4) create a system to allow individuals to compare and enroll in health plans offered through the exchange;

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

(6) refer individuals interested in MinnesotaCare under chapter 256L to the Department of Human Services to determine eligibility;

(7) establish a mechanism with the Department of Human Services to transfer premiums and subsidies for MinnesotaCare to qualify for federal matching payments;

(8) upon request, issue certificates of previous coverage according to the provisions of HIPAA and as referenced in section 62Q.181 to all such individuals who cease to be covered by a participating health plan through the exchange;

(9) establish procedures to account for all funds received and disbursed by the exchange for individual participants of the exchange; and

(10) make available to the public, at the end of each calendar year, a report of an independent audit of the exchange's accounts. The exchange shall not accept premium payments for individual market health plans from an employer Section 125 Plan if the employer offers a group health plan as defined in section 62A.10 or if the employer is a self-insurer as defined in section 62E.02.

Subd. 10. **Powers of the 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 specified in subdivision 10;

(2) contract with employers to collect premiums through a Section 125 Plan for eligible individuals who purchase an individual market health plan through the exchange;

(3) establish and assess fees on health plan premiums of health plans purchased through the exchange to fund the cost of administering the exchange;

(4) seek and directly receive grant funding from government agencies or private philanthropic organizations 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 does not have the authority or responsibility to intervene in or resolve disputes between an individual and a health plan or health insurer. The exchange shall refer complaints from individuals participating in the exchange 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, 2007, 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;

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

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

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

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

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

Subd. 14. **Operations of the board.** Officers of the board of directors are elected by members of the board and serve one-year terms. Six members of the board constitutes 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.

Subd. 15. **Operations of the 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. **Insurance producers.** When a producer licensed in accident and health insurance under chapter 60K enrolls an eligible individual in the exchange, the health plan chosen by an individual may pay the producer a commission.

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

Sec. 3. **[62A.68] SECTION 125 PLANS.**

Subdivision 1. **Definitions.** The following terms have the meanings given unless otherwise provided in text:

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

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

(c) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125 of the Internal Revenue Code that allows employees to purchase health insurance with pretax dollars.

(d) "Exchange" means the Minnesota Health Insurance Exchange under section 62A.67.

(e) "Exchange director" means the appointed director under section 62A.67, subdivision 16.

Subd. 2. **Section 125 Plan requirement.** (a) Effective January 1, 2009, all employers with 11 or more current employees shall establish a Section 125 Plan to allow their employees to purchase individual market health plan coverage with pretax dollars. The following employers are exempt from the Section 125 Plan requirement:

(1) employers that offer a group health insurance plan as defined in 62A.10;

(2) employers that are self-insurers as defined in section 62E.02; and

(3) employers with fewer than 11 current employees, except that employers under this clause may voluntarily offer a Section 125 Plan.

(b) Employers that offer a Section 125 Plan may enter into an agreement with the exchange to administer the employer's Section 125 Plan.

Subd. 3. **Tracking compliance.** By July 1, 2008, the exchange, in consultation with the commissioners of commerce, health, employment and economic development, and revenue shall establish a method for tracking employer compliance with the Section 125 Plan requirement.

Subd. 4. **Employer requirements.** Employers that are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase an individual market health plan for themselves and their dependents through the exchange;

(2) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the exchange; and

(3) provide notice to employees that individual market health plans purchased through the exchange are not employer-sponsored.

Subd. 5. **Section 125 eligible health plans.** Individuals who are eligible to use an employer Section 125 Plan to pay for health insurance coverage purchased through the exchange may enroll in any health plan offered through the exchange for which the individual is eligible including individual market health plans, MinnesotaCare, and the Minnesota Comprehensive Health Association.

Sec. 4. Minnesota Statutes 2006, 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 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 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. 5. Minnesota Statutes 2006, 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 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. 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. Except for coverage under section 62A.65, subdivision 5, paragraph (b), or 62E.16, at the request of an employee, the health carrier 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 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 that the employer is not contributing directly or indirectly to the employee's premiums. 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.

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

ARTICLE 2
HEALTH CARE PAYMENT REFORM

Section 1. Minnesota Statutes 2006, section 62J.04, subdivision 3, is amended to read:

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

(1) establish statewide and regional cost containment goals for total health care spending under this section ~~and~~, collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals, and annually report to the legislature on whether the goals were achieved and, if not, what action should be taken to ensure that goals are achieved in the future;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti,

Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

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

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

(5) undertake health planning responsibilities;

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

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

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

(9) make the cost containment goal data available to the public in a consumer-oriented manner.

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

Sec. 2. Minnesota Statutes 2006, section 62J.81, subdivision 1, is amended to read:

Subdivision 1. **Required disclosure of estimated payment.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, provide that consumer with a good faith estimate of the ~~reimbursement~~ allowable payment the provider ~~expects to receive~~

~~from the health plan company in which the consumer is enrolled~~ has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. Health plan companies must allow contracted providers, or their designee, to release this information. ~~A good faith estimate must also be made available at the request of a consumer who is not enrolled in a health plan company.~~ If a consumer has no applicable public or private coverage, the health care provider must give the consumer a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee or the enrollee's designee, provide that enrollee with a good faith estimate of the ~~reimbursement~~ allowable amount the health plan company ~~would expect to pay to~~ has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. ~~If requested by the enrollee, the health plan company shall also provide to the enrollee a good faith estimate of the enrollee's out-of-pocket cost for the health care service.~~ An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the ~~reimbursement~~ allowable amount or enrollee's out-of-pocket cost.

EFFECTIVE DATE. This section is effective August 1, 2007.

Sec. 3. Minnesota Statutes 2006, section 62Q.165, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 4. Minnesota Statutes 2006, section 62Q.165, subdivision 2, is amended to read:

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

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

Sec. 5. Minnesota Statutes 2006, section 62Q.80, subdivision 3, is amended to read:

Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care coverage program, a community-based health initiative shall submit to the commissioner of health for approval the community-based health care coverage program developed by the initiative. ~~The commissioner shall only approve a program that has been awarded a community access program grant from the United States Department of Health and Human Services.~~ The commissioner shall ensure that the program meets the federal grant requirements and any requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community-based health initiative in establishing premium rates for the community-based health care coverage program.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Sec. 6. Minnesota Statutes 2006, section 62Q.80, subdivision 4, is amended to read:

Subd. 4. **Establishment.** ~~(a)~~ The initiative shall establish and operate upon approval by the commissioner of health a community-based health care coverage program. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost-sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

~~(b) The payments collected under paragraph (a), clause (2), may be used to capture available federal funds.~~

Sec. 7. Minnesota Statutes 2006, section 62Q.80, subdivision 13, is amended to read:

Subd. 13. **Report.** (a) The initiative shall submit quarterly status reports to the commissioner of health on January 15, April 15, July 15, and October 15 of each year, with the first report due January 15, ~~2007~~ 2008. The status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the commissioner of health or commerce or the legislature.

(b) The initiative shall contract with an independent entity to conduct an evaluation of the program to be submitted to the commissioners of health and commerce and the legislature by January 15, ~~2009~~ 2010. The evaluation shall include:

(1) an analysis of the health outcomes established by the initiative and the performance measurements to determine whether the outcomes are being achieved;

(2) an analysis of the financial status of the program, including the claims to premiums loss ratio and utilization and cost experience;

(3) the demographics of the enrollees, including their age, gender, family income, and the number of dependents;

(4) the number of employers and employees who have been denied access to the program and the basis for the denial;

(5) specific analysis on enrollees who have aggregate medical claims totaling over $5,000 per year, including data on the enrollee's main diagnosis and whether all the medical claims were covered by the program;

(6) number of enrollees referred to state public assistance programs;

(7) a comparison of employer-subsidized health coverage provided in a comparable geographic area to the designated community-based geographic area served by the program, including, to the extent available:

(i) the difference in the number of employers with 50 or fewer employees offering employer-subsidized health coverage;

(ii) the difference in uncompensated care being provided in each area; and

(iii) a comparison of health care outcomes and measurements established by the initiative; and

(8) any other information requested by the commissioner of health or commerce.

Sec. 8. Minnesota Statutes 2006, section 62Q.80, subdivision 14, is amended to read:

Subd. 14. **Sunset.** This section expires December 31, ~~2011~~ 2012.

Sec. 9. Minnesota Statutes 2006, section 144.698, subdivision 1, is amended to read:

Subdivision 1. **Yearly reports.** (a) Each hospital and each outpatient surgical center, which has not filed the financial information required by this section with a voluntary, nonprofit reporting organization pursuant to section 144.702, shall file annually with the commissioner of health after the close of the fiscal year:

(1) a balance sheet detailing the assets, liabilities, and net worth of the hospital or outpatient surgical center;

(2) a detailed statement of income and expenses;

(3) a copy of its most recent cost report, if any, filed pursuant to requirements of Title XVIII of the United States Social Security Act;

(4) a copy of all changes to articles of incorporation or bylaws;

(5) information on services provided to benefit the community, including services provided at no cost or for a reduced fee to patients unable to pay, teaching and research activities, or other community or charitable activities;

(6) information required on the revenue and expense report form set in effect on July 1, 1989, or as amended by the commissioner in rule;

(7) information on changes in ownership or control; and

(8) other information required by the commissioner in rule.

(b) Beginning with hospital fiscal year 2009, each nonprofit hospital shall report on community benefits under paragraph (a), clause (5). "Community benefit" means the costs of community care, underpayment for services provided under state health care programs, research costs, community health services costs, financial and in-kind contributions, costs of community building activities, costs of community benefit operations, education, and the cost of operating subsidized services. The cost of bad debts and underpayment for Medicare services are not included in the calculation of community benefit.

Sec. 10. Minnesota Statutes 2006, section 144.699, is amended by adding a subdivision to read:

Subd. 5. **Annual reports on community benefit, community care amounts, and state program underfunding.** (a) For each hospital reporting health care cost information under section 144.698 or 144.702, the commissioner shall report annually on the hospital's community benefit, community care, and underpayment for state public health care programs.

(b) For purposes of this subdivision, "community benefits" has the definition given in section 144.698, paragraph (b).

(c) For purposes of this subdivision, "community care" means the costs for medical care for which a hospital has determined is charity care, as defined under Minnesota Rules, part 4650.0115, or for which the hospital determines after billing for the services that there is a demonstrated inability to pay. Any costs forgiven under a hospital's community care plan or under section 62J.83 may be counted in the hospital's calculation of community care. Bad debt expenses and discounted charges available to the uninsured shall not be included in the calculation of community care. The amount of community care is the value of costs incurred and not the charges made for services.

(d) For purposes of this subdivision, underpayment for services provided by state public health care programs is the difference between hospital costs and public program payments. The information shall be reported in terms of total dollars and as a percentage of total operating costs for each hospital.

Sec. 11. Minnesota Statutes 2006, section 256.01, subdivision 2b, is amended to read:

Subd. 2b. **Performance payments.** (a) The commissioner shall develop and implement a pay-for-performance system to provide performance payments to:

(1) eligible medical groups and clinics that demonstrate optimum care in serving individuals with chronic diseases who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L.;

(2) medical groups that implement effective medical home models of patient care that improve quality and reduce costs through effective primary and preventive care, care coordination, and management of chronic conditions; and

(3) eligible medical groups and clinics that evaluate medical provider usage patterns and provide feedback to individual medical providers on that provider's practice patterns relative to peer medical providers.

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

(c) The commissioner may receive any federal matching money that is made available through the medical assistance program for managed care oversight contracted through vendors including consumer surveys, studies, and external quality reviews as required by the Federal Balanced Budget Act of 1997, Code of Federal Regulations, title 42, part 438, subpart E. Any federal money received for managed care oversight is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received in either year of the biennium.

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

Sec. 12. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 49. **Provider-directed care coordination services.** The commissioner shall develop and implement a provider-directed care coordination program for medical assistance recipients who are not enrolled in the prepaid medical assistance program and who are receiving services on a fee-for-service basis. This program provides payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans; have a dedicated care coordinator; and have an adequate number of fee-for-service clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement.

Sec. 13. **HEALTH CARE PAYMENT SYSTEM REFORM.**

Subdivision 1. **Payment reform plan.** The commissioners of employee relations, human services, commerce, and health shall develop a plan for promoting and facilitating

changes in payment rates and methods for paying for health care services, drugs, devices, supplies, and equipment in order to:

(1) reward the provision of cost-effective primary and preventive care;

(2) reward the use of evidence-based care;

(3) discourage underutilization, overuse, and misuse;

(4) reward the use of the most cost-effective settings, drugs, devices, providers, and treatments; and

(5) encourage consumers to maintain good health and use the health care system appropriately.

In developing the plan, the commissioners shall analyze existing data to determine specific services and health conditions for which changes in payment rates and methods would lead to significant improvements in quality of care.

Subd. 2. **Report.** The commissioners shall submit a report to the legislature by December 15, 2007, describing the payment reform plan. The report must include proposed legislation for implementing those components of the plan requiring legislative action or appropriations of money.

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

Sec. 14. **COMMUNITY COLLABORATIVE PILOT PROJECTS TO COVER THE UNINSURED.**

Subdivision 1. **Community collaboratives.** The commissioner of human services shall provide grants to and authorization for up to three community collaboratives that satisfy the requirements in this section. To be eligible to receive a grant and authorization under this section, a community collaborative must include:

(1) one or more counties;

(2) one or more local hospitals;

(3) one or more local employers who collectively provide at least 300 jobs in the community;

(4) one or more health care clinics or physician groups; and

(5) a third-party payer, which may be a county-based purchasing plan operating under Minnesota Statutes, section 256B.692, a self-insured employer, or a health plan company as defined in Minnesota Statutes, section 62Q.01, subdivision 4.

Subd. 2. **Pilot project requirements.** (a) Community collaborative pilot projects must:

(1) identify and enroll persons in the community who are uninsured, and who have, or are at risk of developing, one of the following chronic conditions: mental illness, diabetes, asthma, hypertension, or other chronic condition designated by the project;

(2) assist uninsured persons to obtain private-sector health insurance coverage if possible or to enroll in any public health care programs for which they are eligible. If the uninsured individual is unable to obtain health coverage, the community collaborative must enroll the individual in a local health care assistance program that provides specified services to prevent or effectively manage the chronic condition;

(3) include components to help uninsured persons retain employment or to become employable, if currently unemployed;

(4) ensure that each uninsured person enrolled in the program has a medical home responsible for providing, or arranging for, health care services and assisting in the effective management of the chronic condition;

(5) coordinate services between all providers and agencies serving an enrolled individual; and

(6) be coordinated with the state's Q-Care initiative and improve the use of evidence-based treatments and effective disease management programs in the broader community, beyond those individuals enrolled in the project.

(b) Projects established under this section are not insurance and are not subject to state-mandated benefit requirements or insurance regulations.

Subd. 3. **Criteria.** Proposals must be evaluated by actuarial, financial, and clinical experts based on the likelihood that the project would produce a positive return on investment for the community. In awarding grants, the commissioner of human services shall give preference to proposals that:

(1) have broad community support from local businesses, provider counties, and other public and private organizations;

(2) would provide services to uninsured persons who have, or are at risk of developing, multiple, co-occurring chronic conditions;

(3) integrate or coordinate resources from multiple sources, such as employer contributions, county funds, social service programs, and provider financial or in-kind support;

(4) provide continuity of treatment and services when uninsured individuals in the program become eligible for public or private health insurance or when insured individuals lose their coverage;

(5) demonstrate how administrative costs for health plan companies and providers can be reduced through greater simplification, coordination, consolidation, standardization, reducing billing errors, or other methods; and

(6) involve local contributions to the cost of the pilot projects.

Subd. 4. **Grants.** The commissioner of human services shall provide implementation grants of up to one-half of the community collaborative's costs for planning, administration, and evaluation. The commissioner shall also provide grants to community collaboratives to develop a fund to pay up to 50 percent of the cost of the services provided to uninsured individuals. The remaining costs must be paid for through other sources or by agreement of a health care provider to contribute the cost as charity care.

Subd. 5. **Evaluation.** The commissioner of human services shall evaluate the effectiveness of each community collaborative project awarded a grant, by comparing actual costs for serving the identified uninsured persons to the predicted costs that would have been incurred in the absence of early intervention and consistent treatment to manage the chronic condition, including the costs to medical assistance, MinnesotaCare, and general assistance medical care. The commissioner shall require community collaborative projects, as a condition of receipt of a grant award, to provide the commissioner with all information necessary for this evaluation.

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

Sec. 15. **HEALTH CARE PAYMENT REFORM PILOT PROJECTS.**

Subdivision 1. **Pilot projects.** (a) The commissioners of health, human services, and employee relations shall develop and administer payment reform pilot projects for state employees and persons enrolled in medical assistance, MinnesotaCare, or general assistance medical care, to the extent permitted by federal requirements. The purpose of the projects is to promote and facilitate changes in payment rates and methods for paying for health care services, drugs, devices, supplies, and equipment in order to:

(1) reward the provision of cost-effective primary and preventive care;

(2) reward the use of evidence-based care;

(3) reward coordination of care for patients with chronic conditions;

(4) discourage overuse and misuse;

(5) reward the use of the most cost-effective settings, drugs, devices, providers, and treatments;

(6) encourage consumers to maintain good health and use the health care system appropriately.

(b) The pilot projects must involve the use of designated care professionals or clinics to serve as a patient's medical home and be responsible for coordinating health care services across the continuum of care. The pilot projects must evaluate different payment reform models and must be coordinated with the Minnesota senior health options program and the Minnesota disability health options program. To the extent possible, the commissioners shall coordinate state purchasing activities with other public employers and with private purchasers, self-insured groups, and health plan companies to promote the use of pilot projects encompassing both public and private purchasers and markets.

Subd. 2. **Payment methods and incentives.** The commissioners shall modify existing payment methods and rates for those enrollees and health care providers participating in the pilot project in order to provide incentives for care management, team-based care, and practice redesign, and increase resources for primary care, chronic condition care, and care provided to complex patients. The commissioners may create financial incentives for patients to select a medical home under the pilot project by reducing, modifying, or eliminating deductibles and co-payments for certain services, or through other incentives. The commissioners may require patients to remain with their designated medical home for a specified period of time. Alternative payment methods may include complete or partial capitation, fee-for-service payments, or other payment methodologies. The payment methods may provide for the payment of bonuses to medical home providers or other providers, or to patients, for the achievement of performance goals. The payment methods may include allocating a portion of the payment that would otherwise be paid to health plans under state prepaid health care programs to the designated medical home for specified services.

Subd. 3. **Requirements.** In order to be designated a medical home under the pilot project, health care professionals or clinics must demonstrate their ability to:

(1) be the patient's first point of contact by telephone or other means, 24 hours a day, seven days a week;

(2) provide or arrange for patients' comprehensive health care needs, including the ability to structure planned chronic disease visits and to manage chronic disease through the use of disease registries;

(3) coordinate patients' care when care must be provided outside the medical home;

(4) provide longitudinal care, not just episodic care, including meeting long-term and unique personal needs;

(5) utilize an electronic health record and incorporate a plan to develop and make available to patients that choose a medical home an electronic personal health record that

is prepopulated with the patient's data, consumer-directed, connected to the provider, 24-hour accessible, and owned and controlled by the patient;

(6) systematically improve quality of care using, among other inputs, patient feedback; and

(7) create a provider network that provides for increased reimbursement for a medical home in a cost-neutral manner.

Subd. 4. **Evaluation.** Pilot projects must be evaluated based on patient satisfaction, provider satisfaction, clinical process and outcome measures, program costs and savings, and economic impact on health care providers. Pilot projects must be evaluated based on the extent to which the medical home:

(1) coordinated health care services across the continuum of care and thereby reduced duplication of services and enhanced communication across providers;

(2) provided safe and high-quality care by increasing utilization of effective treatments, reduced use of ineffective treatments, reduced barriers to essential care and services, and eliminated barriers to access;

(3) reduced unnecessary hospitalizations and emergency room visits and increased use of cost-effective care and settings;

(4) encouraged long-term patient and provider relationships by shifting from episodic care to consistent, coordinated communication and care with a specified team of providers or individual providers;

(5) engaged and educated consumers by encouraging shared patient and provider responsibility and accountability for disease prevention, health promotion, chronic disease management, acute care, and overall well-being, encouraging informed medical decision-making, ensuring the availability of accurate medical information, and facilitated the transfer of accurate medical information;

(6) encouraged innovation in payment methodologies by using patient and provider incentives to coordinate care and utilize medical home services and fostering the expansion of a technology infrastructure that supports collaboration; and

(7) reduced overall health care costs as compared to conventional payment methods for similar patient populations.

Subd. 5. **Rulemaking.** The commissioners are exempt from administrative rulemaking under chapter 14 for purposes of developing, administering, contracting for, and evaluating pilot projects under this section. The commissioner shall publish a proposed request for proposals in the State Register and allow 30 days for comment before issuing the final request for proposals.

Subd. 6. **Regulatory and payment barriers.** The commissioners shall study state and federal statutory and regulatory barriers to the creation of medical homes and provide a report and recommendations to the legislature by December 15, 2007.

Sec. 16. **HEALTH CARE SYSTEM CONSOLIDATION.**

(a) The commissioner of health shall study the effect of health care provider and health plan company consolidation in the four metropolitan statistical areas in Minnesota on: health care costs, including provider payment rates; quality of care; and access to care. The commissioner shall separately consider hospitals, specialty groups, and primary care groups. The commissioner shall present findings and recommendations to the legislature by December 15, 2007.

(b) For purposes of this study, health carriers, provider networks, and other health care providers shall provide data on network participation, contracted payment rates, charges, costs, payments received, patient referrals, and other information requested by the commissioner, in the form and manner specified by the commissioner. Provider-level information on contracted payment rates and payments from health plans provided to the commissioner of health for the purposes of this study are (1) private data on individuals as defined in Minnesota Statutes, section 13.02, subdivision 12, and (2) nonpublic data as defined in Minnesota Statutes, section 13.02, subdivision 9. The commissioner may not collect patient-identified data for purposes of this study. Data collected for purposes of this study may not be used for any other purposes.

Sec. 17. **REPEALER.**

Minnesota Statutes 2006, section 62J.052, subdivision 1, is repealed effective August 1, 2007.

ARTICLE 3
HEALTH INSURANCE

Section 1. Minnesota Statutes 2006, section 62J.495, is amended to read:

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

Subdivision 1. ~~**Establishment; members; duties**~~ **Implementation.** By January 1, 2012, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the Health Information Technology and Infrastructure Advisory Committee, shall develop a statewide plan to meet this goal,

including uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, with a status report on the development of these standards submitted to the legislature by January 15, 2008.

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

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

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

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

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

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

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

Sec. 2. **[62J.496] ELECTRONIC HEALTH RECORD SYSTEM REVOLVING ACCOUNT AND LOAN PROGRAM.**

Subdivision 1. **Account establishment.** The commissioner of finance shall establish and implement a revolving account in the state government special revenue fund to provide loans to physicians or physician group practices to assist in financing the

installation or support of an interoperable health record system. The system must provide for the interoperable exchange of health care information between the applicant and, at a minimum, a hospital system, pharmacy, and a health care clinic or other physician group.

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

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

(2) a signed contract with a vendor;

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

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

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

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

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

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

(d) Repayments must be credited to the account.

Sec. 3. **[62J.536] UNIFORM ELECTRONIC TRANSACTIONS AND IMPLEMENTATION GUIDE STANDARDS.**

Subdivision 1. **Electronic claims and eligibility transactions required.** (a) Beginning January 15, 2009, all group purchasers must accept from health care providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all group purchasers must accept from health care providers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(b) Beginning January 15, 2009, all group purchasers must transmit to providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 1, 2009, all group purchasers must transmit to providers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(c) Beginning January 15, 2009, all health care providers must submit to group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all health care providers must submit to group purchasers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(d) Beginning January 15, 2009, all health care providers must accept from group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 15, 2009, all health care providers must accept from group purchasers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(e) Each of the transactions described in paragraphs (a) to (d) shall require the use of a single, uniform companion guide to the implementation guides described under Code of Federal Regulations, title 45, part 162. The companion guides will be developed pursuant to subdivision 2.

(f) Notwithstanding any other provisions in sections 62J.50 to 62J.61, all group purchasers and health care providers must exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines required under this subdivision. Group purchasers may not impose any fee on providers for the use of the transactions prescribed in this subdivision.

(g) Nothing in this subdivision shall prohibit group purchasers and health care providers from using a direct data entry, Web-based methodology for complying with the requirements of this subdivision. Any direct data entry method for conducting the transactions specified in this subdivision must be consistent with the data content component of the single, uniform companion guides required in paragraph (e) and the implementation guides described under Code of Federal Regulations, title 45, part 162.

Subd. 2. **Establishing uniform, standard companion guides.** (a) At least 12 months prior to the timelines required in subdivision 1, the commissioner of health shall promulgate rules pursuant to section 62J.61 establishing and requiring group purchasers

and health care providers to use the transactions and the uniform, standard companion guides required under subdivision 1, paragraph (e).

(b) The commissioner of health must consult with the Minnesota Administrative Uniformity Committee on the development of the single, uniform companion guides required under subdivision 1, paragraph (e), for each of the transactions in subdivision 1. The single uniform companion guides required under subdivision 1, paragraph (e), must specify uniform billing and coding standards. The commissioner of health shall base the companion guides required under subdivision 1, paragraph (e), billing and coding rules, and standards on the Medicare program, with modifications that the commissioner deems appropriate after consulting the Minnesota Administrative Uniformity Committee.

(c) No group purchaser or health care provider may add to or modify the single, uniform companion guides defined in subdivision 1, paragraph (e), through additional companion guides or other requirements.

(d) In promulgating the rules in paragraph (a), the commissioner shall not require data content that is not essential to accomplish the purpose of the transactions in subdivision 1.

Sec. 4. Minnesota Statutes 2006, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute 90 percent of available medical education funds to all qualifying applicants based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and

(2) a public program volume factor, which is determined by the total volume of public program ~~revenue received~~ charges submitted by each training site as a percentage of all public program ~~revenue received~~ charges submitted by all training sites in the fund pool.

In this formula, the education factor is weighted at 67 percent and the public program volume factor is weighted at 33 percent.

Public program ~~revenue~~ charges for the distribution formula ~~includes revenue from~~ include charges for medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care submitted for payment to this state and to contiguous states. Training sites that ~~receive~~ have no public program ~~revenue~~ charges are ineligible for funds available under this paragraph. Total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide

average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

(b) The commissioner shall annually distribute ten percent of total available medical education funds to all qualifying applicants based on the percentage received by each applicant under paragraph (a). These funds are to be used to offset clinical education costs at eligible clinical training sites based on criteria developed by the clinical medical education program. Applicants may choose to distribute funds allocated under this paragraph based on the distribution formula described in paragraph (a).

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraph (a) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

(e) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(f) The commissioner shall distribute by June 30 of each year an amount equal to the funds transferred under subdivision 10, plus five percent interest to the University of Minnesota Board of Regents for the instructional costs of health professional programs at the Academic Health Center and for interdisciplinary academic initiatives within the Academic Health Center.

(g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, paragraph (b), clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

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

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

Subdivision 1. **Required information.** The Minnesota Hospital Association shall develop a Web-based system, available to the public free of charge, for reporting ~~charge information~~ the following, for Minnesota residents~~;~~:

(1) hospital-specific performance on the measures of care developed under section 256B.072 for acute myocardial infarction, heart failure, and pneumonia;

(2) by January 1, 2009, hospital-specific performance on the public reporting measures for hospital-acquired infections as published by the National Quality Forum and collected by the Minnesota Hospital Association and Stratis Health in collaboration with infection control practitioners; and

(3) charge information, including, but not limited to, number of discharges, average length of stay, average charge, average charge per day, and median charge, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association.

Subd. 2. **Web site.** The Web site must provide information that compares hospital-specific data to hospital statewide data. The Web site must be ~~established by October 1, 2006, and must be~~ updated annually. The commissioner shall provide a link to this reporting information on the department's Web site.

Subd. 3. **Enforcement.** The commissioner shall provide a link to this information on the department's Web site. If a hospital does not provide this information to the Minnesota Hospital Association, the commissioner of health may require the hospital to do so in accordance with section 144.55, subdivision 6. ~~The commissioner shall provide a link to this information on the department's Web site.~~

Sec. 6. **[62J.84] HEALTH CARE TRANSFORMATION TASK FORCE.**

Subdivision 1. **Task force.** The governor shall convene a health care transformation task force to advise and assist the governor and the Minnesota legislature. The task force shall consist of:

(1) four legislators from the house of representatives, two appointed by the speaker of the house of representatives and two by the minority leader, and four legislators from the senate, two appointed by the majority leader and two by the minority leader;

(2) four representatives of the governor and state agencies appointed by the governor;

(3) at least four persons appointed by the governor who have demonstrated leadership in health care organizations, health improvement initiatives, health care trade or professional associations, or other collaborative health system improvement activities; and

(4) at least two persons appointed by the governor who have demonstrated leadership in employer and group purchaser activities related to health system improvement, at least one of which must be from a labor organization.

Subd. 2. **Public input.** The commissioner of health shall review available research, and conduct statewide, regional, and local surveys, focus groups, and other activities as needed to fill gaps in existing research, to determine Minnesotans' values, preferences, opinions, and perceptions related to health care and to the issues confronting the task force, and shall report the findings to the task force.

Subd. 3. **Inventory and assessment of existing activities; action plan.** The task force shall complete an inventory and assessment of all public and private organized activities, coalitions, and collaboratives working on tasks relating to health system improvement including, but not limited to, patient safety, quality measurement and reporting, evidence-based practice, adoption of health information technology, disease management and chronic care coordination, medical homes, access to health care, cultural competence, prevention and public health, consumer incentives, price and cost transparency, nonprofit organization community benefits, education, research, and health care workforce.

Subd. 4. **Action plan.** By December 15, 2007, the governor, with the advice and assistance of the task force, shall develop and present to the legislature a statewide action plan for transforming the health care system to improve affordability, quality, and access. The plan shall include draft legislation needed to implement the plan. The plan may consist of legislative actions, administrative actions of governmental entities, collaborative actions, and actions of individuals and individual organizations. Among other things, the action plan must include the following, with specific and measurable goals and deadlines for each:

(1) proposed actions that will slow the rate of increase in health care costs to a rate that does not exceed the increase in the Consumer Price Index for urban consumers for the preceding calendar year plus two percentage points, plus an additional percentage based on the added costs necessary to implement legislation enacted in 2007;

(2) actions that will increase the affordable health coverage options for uninsured and underinsured Minnesotans and other strategies that will ensure that all Minnesotans will have health coverage by January 2010;

(3) actions to improve the quality and safety of health care and reduce racial and ethnic disparities in access and quality;

(4) actions that will reduce the rate of preventable chronic illness through prevention and public health and wellness initiatives; and

(5) proposed changes to state health care purchasing and payment strategies used for state health care programs and state employees that will promote higher quality, lower cost health care through incentives that reward prevention and early intervention, use of cost-effective primary care, effective care coordination, and management of chronic disease;

(6) actions that will promote the appropriate and cost-effective investment in new facilities, technologies, and drugs;

(7) actions to reduce administrative costs; and

(8) the results of the inventory completed under subdivision 3 and recommendations for how these activities can be coordinated and improved.

Subd. 5. **Options for small employers.** The task force shall study and report back to the legislature by December 15, 2008, on options for serving small employers and their employees, and self-employed individuals.

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

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

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

Sec. 8. Minnesota Statutes 2006, section 256L.01, subdivision 4, is amended to read:

Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the six-month period of eligibility using the net profit or loss reported on the applicant's federal income tax form for the previous year and using the medical assistance families with children

methodology for determining allowable and nonallowable self-employment expenses and countable income.

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

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

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