A bill for an act

relating to health care reform; increasing affordability and continuity of care for state health care programs; modifying health care provisions; providing subsidies for employee share of employer-subsidized insurance in certain cases; establishing the Health Care Transformation Commission; creating an affordability standard; implementing a statewide health improvement program; requiring an evaluation of mandated health benefits; requiring a payment system to encourage provider innovation; requiring studies and reports; appropriating money; amending Minnesota Statutes 2006, sections 256B.057, subdivision 8; 256B.69, by adding a subdivision; 256L.05, by adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivision 3; 256L.15, by adding a subdivision; Minnesota Statutes 2007 Supplement, sections 256.01, subdivision 2b; 256B.056, subdivision 10; 256L.03, subdivisions 3, 5; 256L.04, subdivisions 1, 7; 256L.05, subdivision 3a; 256L.07, subdivision 1; 256L.15, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 145; 256B; proposing coding for new law as Minnesota Statutes, chapter 62U; repealing Minnesota Statutes 2006, section 256L.15, subdivision 3.

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

ARTICLE 1
HEALTH CARE HOMES

Section 1. Minnesota Statutes 2007 Supplement, 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 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. 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-managed care, subpart E-external quality review. 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.

(b) Effective July 1, 2009, or upon federal approval, whichever is later, the commissioner shall 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 have met personal health goals established with the patients' primary care providers to manage a chronic disease or condition, including but not limited to diabetes, high blood pressure, and coronary artery disease. The commissioner shall collaborate with the commissioner of health and with community-based organizations that conduct chronic disease consumer education programs targeted at labor, business, faith-based, and health care constituencies to avoid duplication of efforts.

Sec. 2. **[256B.0431] ENROLLEE REQUIREMENTS RELATED TO HEALTH CARE HOMES.**

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

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

Subd. 3. **Education and outreach.** Beginning January 1, 2009, the commissioner shall provide patient education and outreach to state health care program enrollees and applicants related to the importance of choosing a primary care clinic or medical group

and a health care home. Education and outreach must be targeted to underserved or special populations. The commissioner shall also develop and implement an outreach program to enroll eligible persons in state health care programs, by providing a per enrollee bonus to licensed producers under chapter 60K and nonprofit health care or social service organizations who provide assistance in enrolling applicants.

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

Sec. 3. **[256B.0751] HEALTH CARE HOMES; DEFINITIONS; ESTABLISHMENT.**

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

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

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

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

Subd. 2. **Establishment of health care homes.** The commissioners shall establish health care homes for state health care program enrollees who have complex or chronic health conditions. In establishing health care homes, the commissioners shall consider and, when appropriate, incorporate features of the medical home model developed for the provider-directed care coordination program authorized under section 256B.0625, subdivision 51. The commissioner shall study the feasibility of expanding health care homes to all enrollees and report to the legislature by January 1, 2011.

Subd. 3. **Certification.** By July 1, 2009, the commissioners shall begin certification of individual clinicians, who participate as providers in state health care programs and meet the requirements of section 256B.0752, as health care homes. Clinicians may enter into collaborative agreements with other clinicians to develop the components of a health care home. Clinician certification as a health care home is voluntary. Clinicians certified as health care homes shall renew their certification annually, in order to maintain their status as health care homes. The commissioner may waive some requirements in order to certify providers and clinicians with health care home models in existence on March 1, 2008, that serve special patient populations of diverse race, language, or ethnicity.

Sec. 4. **[256B.0752] HEALTH CARE HOME REQUIREMENTS.**

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

Subd. 2. **Patient-provider relationship; care teams.** Each patient of a health care home shall have an ongoing, long-term relationship with a provider trained as a personal clinician to provide first contact, continuous, and comprehensive care for all of a patient's health care needs. Appropriate specialists and other health care professionals who do not practice in a traditional primary care field, and advanced practice registered nurses, shall be allowed to serve as personal clinicians, if they provide care according to this section.

Subd. 3. **Care coordination.** The personal clinician, in coordination with other health care providers, is responsible for providing for all the patient's health care needs or for arranging appropriate care with other qualified professionals. Health care must be coordinated across all provider types, all care locations, and the greater community. This requirement applies to care for all stages of life, including preventive care, acute care, chronic care, and end-of-life care. Care coordination must include ongoing planning to prepare for patient transitions across different types of care and provider types. The care team shall also coordinate with those providing for the social service needs of the individual, if this is necessary to ensure a successful health outcome. Care coordination must be provided in a manner appropriate to the patient's race, ethnicity, and language.

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

(b) Health care homes must encourage the patient, and when authorized and appropriate, the family, to actively participate in decision making as a full member of the primary care team. Health care homes must consider patients and families as partners in decision making, and must provide access to a patient-directed, decision-making process, including appropriate decision aids, when available.

(c) Care delivery must be facilitated by the use of health information technology and through systematic patient follow-up using internal clinic patient registries, according to minimum standards specified by the commissioners.

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

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

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

(g) Providers certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

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

Subd. 6. **Comprehensive care plan.** Health care homes must develop, maintain, and ensure the implementation of a comprehensive care plan for each enrollee who has a complex or chronic condition, based upon health history, tests, assessments, and other information. The comprehensive care plan must meet the criteria specified by the commissioners. The comprehensive care plan must be culturally appropriate.

Subd. 7. **Care coordinators.** Health care homes must employ care coordinators to manage the care provided to patients with complex or chronic conditions. Care coordinators must be trained to provide services that are appropriate for the race, ethnicity, and language of the patient. Care coordination includes:

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

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

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

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

(5) collecting data on process and outcome measures;

(6) overseeing the development, maintenance, and implementation of care plans; and

(7) meeting other criteria as specified by the commissioner.

Subd. 8. **Health care home collaborative.** Health care homes must participate in the health care home collaborative defined in section 256B.0754, subdivision 4, as required by the commissioners for certification.

Sec. 5. **[256B.0753] CARE COORDINATION FEE.**

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

(b) Payment of the care coordination fee is contingent on the health care home meeting the certification standards for health care homes. The care coordination fee is in addition to reimbursement received by a health care home under the medical assistance fee-for-service payment system for health care services.

Subd. 2. **Amount of fee.** The care coordination fee must be determined by the commissioner in contracts with health care homes, and must vary by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination, such as those with very complex health care needs or several chronic conditions and those who face racial, ethnic, or language barriers.

Subd. 3. **Cost neutrality.** If initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner, the commissioner shall reallocate costs within the health care system.

EFFECTIVE DATE. Subdivisions 1 and 2 are effective July 1, 2009, or upon federal approval, whichever is later.

Sec. 6. **[256B.0754] DUTIES OF THE COMMISSIONERS.**

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

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

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

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

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

Subd. 2. **Monitoring and evaluation.** The commissioners shall ensure the collection from health care homes of data necessary to monitor implementation of the health care home model, measure and evaluate quality of care and outcomes, measure and evaluate patient experience, and determine cost savings from implementation of the health care home model. The commissioners shall collect and evaluate this data directly, but may contract with an appropriate private sector entity for technical assistance.

The commissioners shall provide health care homes with practice profiles measuring utilization, cost, and quality. Quality measures must include measures of disparities in treatment, health status, and outcomes based on race, ethnicity, or language.

Subd. 3. **Care Coordination Advisory Committee.** By July 1, 2008, the commissioners shall establish a Care Coordination Advisory Committee to assist the Departments of Human Services and Health in administering the health care home model, developing the criteria and standards required under subdivision 1, collecting data, and measuring and evaluating health outcomes and cost savings. The commissioners may satisfy this requirement by continuing the advisory committee established for the provider-directed care coordination program. If newly established, the committee must include representatives of: primary care and specialist physicians, advanced practice registered nurses, patients and their families including minority ethnic groups, health plans, providers serving low-income and culturally diverse populations, organizations with expertise in care coordination models, and other relevant entities. If newly established, membership terms and compensation and removal of members are governed by section 15.059. The committee does not expire.

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

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

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

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

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

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

Subd. 6. **Report on standards; annual reports.** (a) By November 15, 2008, the commissioners must report drafts of certification standards, care complexity thresholds, and other criteria, procedures, and payment amounts necessary to implement subdivision 1 to the chairs and lead minority members of the legislative committees with jurisdiction

over health care policy and finance. These standards, thresholds, criteria, procedures, and payment amount are not subject to chapter 14, and section 14.386 does not apply.

(b) The commissioners shall report annually to the legislature on the implementation and administration of the health care home model for state health care program enrollees in the fee-for-service, managed care, and county-based purchasing sectors, beginning December 15, 2009, and each December 15 thereafter. The report must include: (1) information on the number of state health care program enrollees in health care homes; (2) the number and characteristics of enrollees with complex or chronic conditions, broken down by income, race, ethnicity, and language whenever possible; (3) the number and geographic distribution of health care home providers; (4) the performance and quality of care of health care homes; (5) measures of preventative care; (6) costs related to implementation and payment of care coordination fees; (7) health care home payment arrangements; (8) the estimated impact on health disparities; and (9) estimates of savings from implementation of the health care home model for the fee-for-service, managed care, and county-based purchasing sectors relative to the health care spending baseline calculated under section 62U.07.

Sec. 7. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 29. **Health care home model.** (a) The commissioner shall require demonstration providers, as a condition of contract, to adopt by July 1, 2009, a health care home model for providing care to state health care program enrollees. The health care home model must meet the criteria specified in this section and section 256B.0752. The commissioner, in consultation with the commissioner of health, may waive or modify criteria for demonstration providers if the commissioners of health and human services determine that performance and quality standards would still be met.

(b) The commissioner, as a condition of contract, shall require demonstration providers, as part of their implementation of the health care home model, to pay providers a care coordination fee. The care coordination fee must meet the requirements of section 256B.0753. Demonstration providers shall fund the care coordination fee through savings that result from implementation of the health care home model and, if necessary, through reductions in administrative costs and reallocation of other payment rates within its network. The commissioner shall not adjust current or future capitation rates for costs related to payment of the care coordination fee.

(c) The commissioners of health and human services shall require demonstration providers to: (1) collect from health care homes the data necessary to monitor

implementation of the health care home model, measure and evaluate quality of care and outcomes, measure and evaluate patient experience, and determine cost savings from implementation of the health care home model; and (2) submit this data to the commissioners. The commissioners of health and human services shall provide demonstration providers and health care homes with practice profiles measuring utilization, cost, and quality. Before establishing or amending general standards for data collection under this paragraph, the commissioners must report the draft standards to the chairs and lead minority members of the legislative committees with jurisdiction over health care policy and finance. Standards for data collection are not subject to chapter 14 and section 14.386 does not apply.

(d) The commissioner shall study the feasibility and method of calculating savings from the use of health care homes, as required in section 256B.0754, subdivision 6, paragraph (b). The study must consider the methodology for distribution of savings. Under the methodology, the state must retain one-half of the savings, the demonstration providers may retain up to one-fourth of the savings, and at least one-fourth of the savings must be passed on to health care providers in the form of higher payment rates.

(e) Demonstration providers must encourage state health care program enrollees to complete an initial health assessment within three months from the time of enrollment, in order to identify individuals with complex or chronic health conditions, and to identify preventative health care needs.

(f) Beginning July 1, 2009, the commissioner shall require demonstration providers to require health care homes to develop, maintain, and ensure the implementation of a comprehensive care plan, as defined in section 256B.0752, subdivision 6.

(g) Beginning July 1, 2009, the commissioner shall implement financial arrangements for demonstration providers to ensure that plans encourage each enrollee who has a complex or chronic condition to choose a certified primary care clinic or medical group to serve as a health care home.

Sec. 8. **PAYMENT OF CARE COORDINATION FEE UNDER STATE MANAGED CARE PROGRAMS.**

The commissioner of human services shall study the feasibility of paying the care coordination fee required under Minnesota Statutes, section 256B.69, subdivision 29, paragraph (b), directly to health care providers under contract with demonstration providers to serve state health care program enrollees, and shall present recommendations to the legislature by December 15, 2008.

Sec. 9. **WORKFORCE SHORTAGE STUDY.**

To address health care workforce shortages, the Health Care Transformation Commission, in consultation with health licensing boards and professional associations, shall study changes necessary in health professional licensure and regulation to ensure full utilization of advanced practice registered nurses and other licensed health care professionals in the health care home and primary delivery system. The Health Care Transformation Commission shall make recommendations to the legislature by January 15, 2009.

Sec. 10. **HEALTH CARE ACCESS FUND TRANSFER.**

On July 1, 2008, the commissioner of finance shall transfer $1,390,000 from the health care access fund to the general fund.

ARTICLE 2
INCREASING ACCESS; CONTINUITY OF CARE

Section 1. Minnesota Statutes 2007 Supplement, 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. 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. The amendment to paragraph (c) is effective January 1, 2009.

Sec. 2. Minnesota Statutes 2006, 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, 2010, or upon federal approval, whichever is later.

Sec. 3. Minnesota Statutes 2007 Supplement, 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, 2009, for single adults and households with no children enrolled under section 256L.07, subdivision 4, and is effective July 1, 2009, 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. 4. Minnesota Statutes 2007 Supplement, 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, 2009, for single adults and households with no children enrolled under section 256L.04, subdivision 7, and is effective July 1, 2009, 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. 5. Minnesota Statutes 2007 Supplement, 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 $50,000.~~

~~(c)~~ 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, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** 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. 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 ~~215~~ 300 percent of the federal poverty guidelines.

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

Sec. 7. Minnesota Statutes 2007 Supplement, section 256L.05, subdivision 3a, is amended to read:

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

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. 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. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

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

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

EFFECTIVE DATE. This section is effective January 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. 8. Minnesota Statutes 2006, 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 cancelled. Applicants who are denied or cancelled for

failure to provide all required verifications are not eligible for coverage using the delayed verification procedures specified in this subdivision for 12 months.

EFFECTIVE DATE. This section is effective January 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. 9. Minnesota Statutes 2006, section 256L.06, subdivision 3, is amended to read:

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

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

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

(d) Nonpayment of the premium will result in disenrollment from the plan effective ~~for~~ the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. ~~Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ The commissioner shall waive premiums for coverage provided under this paragraph to persons disenrolled for nonpayment who reapply under section 256L.05, subdivision 3b. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good

cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

EFFECTIVE DATE. This section is effective January 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. 10. Minnesota Statutes 2007 Supplement, 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 ~~215~~ 300 percent of the federal poverty guidelines on or after ~~July~~ January 1, 2009, 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 $50,000 for the 12-month period of eligibility.~~

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later, except that the amendment to paragraph (a) related to the four-month requirement is effective January 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. 11. Minnesota Statutes 2006, 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.

~~(c) 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, 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. 12. Minnesota Statutes 2007 Supplement, section 256L.15, subdivision 2, is amended to read:

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

(b) ~~Families~~ Children whose gross income is above ~~275~~ 300 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare

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

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the affordability scale established in section 62U.08 with the exception that children in families with income at or below 150 percent of the federal poverty guidelines shall pay a monthly premium of $4.

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

Sec. 13. Minnesota Statutes 2006, 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, 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. 14. **INSURANCE COVERAGE FOR LONG-TERM CARE WORKERS.**

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

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

(1) the coverage provided to state employees;

(2) the coverage provided to MinnesotaCare enrollees; and

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

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

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

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

(2) provides long-term care services.

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

(d) The recommendations must include measures to:

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

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

Sec. 15. **REPEALER.**

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

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval of the amendments to section 11, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 16. **APPROPRIATION.**

$804,000 is appropriated from the health care access fund to the commissioner of human services for fiscal year 2009, to study insurance coverage for long-term care workers under section 14.

ARTICLE 3
INSURANCE REFORM

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

(a) The Health Care Transformation Commission, established under Minnesota Statutes, section 62U.04, shall establish an informal working group to create a standardized limited set of measures by which to measure performance of health care

providers for use in establishing statewide health improvement goals and in measuring progress on these goals. The group shall focus first on the most common areas of data collection for pay-for-performance systems.

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

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

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

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

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

(g) The commission shall encourage use of the working group recommendations.

(h) By December 15, 2008, the commission shall provide to the legislature a written report under Minnesota Statutes, section 3.195, summarizing the work of the working group. The report must include recommendations for: (1) a standardized set of health care provider performance measures to be enacted by the legislature; and (2) a payment methodology to reduce capitation rates paid by the commissioner of human services under Minnesota Statutes, section 256B.69, to demonstration providers that use provider performance measures other than those included in the standardized set under clause (1).

(i) The working group expires on June 30, 2009, unless the commission determines that the group's continued existence would be beneficial.

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

(a) By December 15, 2008, the commissioner of health shall recommend to the legislature community benefit standards to be required by law of nonprofit health plan companies doing business in the state. The expectations of the community benefits provided and reported should be related to the statutory expectations in Minnesota Statutes, sections 62C.01 and 62D.01, and thus focus on advocating public health, improving the art and science of medical care, and addressing the need for financial assistance to access ongoing coverage, and not related to general philanthropic endeavors. The commissioner shall seek public input regarding the range of options to be explored and the accountability measures.

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

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

ARTICLE 4
HEALTH INSURANCE PURCHASING AND AFFORDABILITY

Section 1. **[62U.01] DEFINITIONS.**

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

Subd. 2. **Advisory committee.** "Advisory committee" means the Health Benefit Set and Design Advisory Committee established in section 62U.055.

Subd. 3. **Clinically effective.** "Clinically effective" means that the use of a particular health technology or service improves or prevents a decline in patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology or service demonstrates a clinical or outcome advantage over alternative technologies or services.

Subd. 4. **Commission.** "Commission" means the Health Care Transformation Commission established in section 62U.04.

Subd. 5. **Cost-effective.** "Cost-effective" means that the economic costs of using a particular service, device, or health technology to achieve improvement or prevent a decline in a patient's health outcome are justified given the comparison to both the economic costs and the improvement in patient health outcome resulting from the use of an alternative service, device, or technology, or from not providing the service, device, or technology.

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

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

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

Subd. 9. **State health care program.** "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

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

Sec. 2. **[62U.04] HEALTH CARE TRANSFORMATION COMMISSION.**

Subdivision 1. **Creation.** The Health Care Transformation Commission is created for the purpose of coordinating the health care transformation activities within Minnesota.

Subd. 2. **Members.** (a) The Health Care Transformation Commission shall consist of ten members who are appointed as follows:

(1) three nonlegislators appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate;

(2) three nonlegislators appointed by the speaker of the house of representatives; and

(3) four members appointed by the governor, two of whom shall be state commissioners from the agencies listed in section 15.01.

(b) The appointed members who are not commissioners must have expertise in health care financing, health care delivery, health care quality improvement, health economics, actuarial science, business operations, health disparities, culturally competent care, social services funded through medical assistance and property tax resources, or be an informed consumer representative.

(c) If a member is no longer able or eligible to perform the required duties, a new member shall be appointed by the entity that appointed the outgoing member.

Subd. 3. **Operations of the commission.** (a) The commission shall convene on or before July 1, 2008, following the initial appointment of the members.

(b) The commission shall elect a chair among its members.

(c) The commission members shall not be compensated for commission activities except for actual expenses incurred in the performance of their duties. Expenses shall be compensated according to section 15.0575.

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

Subd. 5. **Responsibilities of the commission.** The Health Care Transformation Commission shall:

(1) collect data from providers on health care prices and quality, including measures of process, outcomes, and patient satisfaction, and publish comparative price and quality information in a manner that is easily understandable and accessible to consumers;

(2) develop a design and implementation plan for health care payment system reform as required under sections 62U.11 and 62U.12;

(3) establish a uniform definition and methodology for calculating the relative utilization and health care costs for providers in treating patients, including but not limited to patients with coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, depression, and other chronic conditions. The methodology must include risk adjustment mechanisms that address at least the following factors:

(i) the health status of the individual in the year the individual enters the provider's care;

(ii) a worsening of the patient's health condition that was not reasonably preventable by action that the provider could have taken;

(iii) socioeconomic and cultural factors that bear directly on the cost of care; and

(iv) the percentage of individuals served by the provider or care system whose care is paid for by public health insurance programs;

(4) provide education, technical assistance, and materials necessary for providers to participate in the restructured payment system;

(5) implement and administer the payment system reform;

(6) make recommendations to the governor and legislature as to additional actions that are needed in order to successfully achieve health care transformation in Minnesota;

(7) consult and coordinate with the commissioners of health and human services, health care providers, health plan companies, organizations that work to improve health care quality in Minnesota, consumers, and employers;

(8) establish a Uniform Outcome Measures Working Group and make recommendations on community benefit standards, as required under article 3, section 2;

(9) establish uniform definitions for packages of services used to provide care to patients, including but not limited to patients with coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, depression, and other chronic conditions, for the purpose of establishing package pricing; and

(10) carry out other duties assigned in this chapter and this article.

Subd. 6. **Powers of the commission.** The commission shall have the power to:

(1) advise the commissioner of human services on federal policy changes desirable for furthering transformation of Minnesota's health care system. The commissioner shall also consult with the legislature on any federal changes; and

(2) contract with other organizations to carry out all or part of its responsibilities.

Subd. 7. **Standard benefit set and design.** (a) Based on the recommendations submitted by the Health Benefit Set and Design Advisory Committee, the commission shall establish a standard benefit set and design by July 1, 2009.

(b) The standard health benefit set and design must meet the requirements described in section 62U.055.

(c) Prior to establishing the standard benefit set and design, the commission shall convene public hearings throughout the state.

Subd. 8. **Reports.** Beginning January 15, 2010, and each January 15 thereafter, the commission shall submit an annual report to the governor and legislature on the following:

(1) the extent to which health care providers have reduced their costs and fees;

(2) the extent to which costs and cost growth are likely to be maintained or reduced in future years;

(3) the extent to which the quality of health care services has improved;

(4) the extent to which all Minnesotans have access to quality, affordable health care; and

(5) recommendations on additional actions that are needed in order to successfully achieve health care transformation in Minnesota.

Subd. 9. **Expiration.** The commission shall expire December 31, 2013.

Sec. 3. **[62U.055] STANDARD BENEFIT SET AND DESIGN.**

Subdivision 1. **Creation.** The Health Care Transformation Commission shall convene a health benefit set and design advisory committee to make recommendations to the legislature on a standard benefit set and design. The advisory committee shall consist of seven members. The members shall be appointed by the commission and must have expertise in benefit design and development, actuarial analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits.

Subd. 2. **Operations of the committee.** (a) The advisory committee shall convene on or before September 1, 2008, upon the appointment of the initial committee and must meet at least once a year, and at other times as necessary.

(b) The commission shall provide office space, equipment and supplies, and technical support to the committee.

(c) The committee shall be governed by section 15.059, except the committee shall not expire. Upon the expiration of the Health Care Transformation Commission, the Health Benefit Set and Design Advisory Committee shall continue to exist under the oversight of the commissioner of health.

Subd. 3. **Immunity of liability.** No member of the committee shall be held civilly liable for an act or omission by that member if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

Subd. 4. **Duties of the committee.** (a) By January 1, 2009, the committee shall develop and submit to the legislature a benefit set and design that provides individuals access to a broad range of health care services, including preventive health care, without incurring severe financial loss as a result of serious illness or injury. The benefit set must include necessary health care services, procedures, and diagnostic tests that are scientifically proven to be both clinically effective and cost effective. In establishing the benefit set, the committee may contract with the Institute for Clinical Systems Improvement (ICSI) to assemble existing scientifically based practice standards. The committee shall consider cultural, ethnic, and religious values and beliefs to ensure that the health care needs of all Minnesota residents will be addressed in the benefit set.

(b) The benefit set must identify and include preventive services, chronic care coordination services, and early diagnostic tests that, if included in the benefit set, with minimal or no cost-sharing requirements, would result in savings that are equal to or greater than the cost of providing the services.

(c) The benefit set must include evidence-based outpatient care for asthma, heart disease, diabetes, and depression with no cost-sharing requirements, or with minimal cost-sharing requirements that would not impose an economic barrier to accessing the care. The committee may consult with ICSI in identifying standards for care.

(d) The benefit design must be the only benefit plan eligible for premium subsidies under section 62U.09. In addition, each health plan company that issues coverage in the individual or small employer market in this state must offer at least one health plan that complies with the benefit design in each of these two markets in which it issues coverage. The benefit design must establish a limited number of maximum cost-sharing variations based upon deductibles and maximum out-of-pocket costs. There must be no maximum lifetime benefit.

Subd. 5. **Continued review.** The committee 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. 4. **[62U.06] 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 2009;

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

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

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

Subd. 2. **Measurement of percent insured.** The determination of the percent of Minnesota residents insured must be based on an annual survey of the Minnesota population younger than age 65 to be conducted or contracted for by the commissioner of health which 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 fail to achieve universal coverage, an individual responsibility requirement must have been proven to be necessary.

(b) If any one of the phase-in goals specified in subdivision 1 for fiscal year 2011 or later is not met, as determined by the commissioner of health, in spite of implementation of the increased affordability, cost containment, insurance reform, and voluntary efforts provided for under sections 62U.01 to 62U.09, 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.08 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. 5. **[62U.07] PROJECTED SPENDING.**

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

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

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

Subd. 2. **Actual spending.** By February 15 of each year, beginning February 15, 2010, the commissioner shall determine the actual private and public health care spending for the calendar year preceding the current calendar year and shall determine the difference between the projected spending as determined under subdivision 1 and the actual spending for that year. The actual spending must be certified by an independent actuarial consultant.

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

Sec. 6. **[62U.08] 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	**Percent 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%

Sec. 7. **[62U.09] EMPLOYEE SUBSIDIES FOR HEALTH COVERAGE.**

Subdivision 1. **Establishment of subsidy program.** The commissioner of human services shall establish a subsidy program for eligible employees and dependents to provide assistance in purchasing health coverage.

Subd. 2. **Eligible employees and dependents; incomes not exceeding 300 percent of the federal poverty guidelines.** In order to be eligible for a subsidy under this section, an employee or dependent with a gross household income that does not exceed 300 percent of the federal poverty guidelines must:

(1) be covered by employer-subsidized health coverage, as defined in section 256L.07, subdivision 2, paragraph (c), that meets the benefits set and design requirements established under section 62U.04; and

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

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

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

Subd. 3. **Eligible employees and dependents; incomes greater than 300 percent but not exceeding 400 percent of the federal poverty guidelines.** In order to be eligible for a subsidy under this section, an employee or dependent with a gross household income that is greater than 300 percent but does not exceed 400 percent of the federal poverty guidelines must:

(1) be covered by health coverage that meets the benefits set and design requirements established under section 62U.04; and

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

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

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

(iii) gross household income under section 256L.04, subdivisions 1 and 7.

Subd. 4. **Amount of subsidy.** The subsidy must equal the amount the employee is required to pay for health coverage for the employee and any dependents, including premiums, deductibles, and other cost sharing, minus an amount based on the affordability standard specified in section 62U.08. The maximum subsidy must not exceed the amount of the subsidy that would have been provided under the MinnesotaCare program, if the employee and any dependents were eligible for that program.

Subd. 5. **Payment of subsidy.** The commissioner shall pay the subsidy amount for an employee and any dependents to the employee's health plan company, and this payment shall be credited toward the employee's share of premium. Any additional amount paid by the commissioner to the employee's health plan company that exceeds the employee's share of premium must be credited first toward the employee deductible and then toward any employee cost-sharing obligation.

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

Sec. 8. **[62U.11] PAYMENT RESTRUCTURING; PAYMENTS BASED ON QUALITY AND EFFICIENCY OF CARE.**

Subdivision 1. **Development.** By January 15, 2009, the Health Care Transformation Commission shall report to the legislature in the manner specified in section 3.195 on rules to implement a payment system that links the level of payments to providers to the quality and efficiency of care. The payment system must incorporate payments to primary care physicians, specialty care physicians, health care clinics, hospitals, and other providers who provide services included in the evidence-based benefit set and design developed under section 62U.04. Before January 1, 2010, the commission must adopt rules necessary to implement this payment system.

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

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

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

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

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

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

(6) to the greatest extent possible, the quality targets used in clause (1) must be adjusted for variation in patient population to reduce incentives for health care providers to locate outside of areas with high rates of poverty, a low patient base, or racial or cultural diversity;

(7) payment methods must adjust for racial, ethnic, or language factors that affect outcomes; and

(8) other indicators of care quality and efficiency must be incorporated where appropriate. These indicators may include care infrastructure, collection and reporting of results, disparities between racial and ethnic populations, and measures of overall cost of care for individuals.

Subd. 3. **Uniform measures required.** Once the payment system required by this section is established, health plan companies shall not require providers to use and report health plan company-specific quality and outcome measures. This shall not, however, limit the ability of the commissioner of human services to establish by contract and monitor, as part of its quality assurance obligations for state health care programs, outcome and performance measures for nonmedical services and health issues likely to occur in low-income populations or racial or cultural groups disproportionately represented in state health care program enrollment that would likely be underrepresented when using traditional measures that are based on longer-term enrollment.

Subd. 4. **Implementation.** (a) By January 1, 2010, the commissioner of human services shall implement this payment system for all state health care program enrollees served under fee-for-service, and shall require demonstration providers serving state health care program enrollees to implement this payment system by January 1, 2010, for all state health care program enrollees served under managed care and county-based purchasing.

(b) By January 1, 2010, the commissioner of employee relations shall implement this payment system for all participants in the State Employee Group Insurance Program.

(c) By January 1, 2010, all health plan companies shall implement this payment system for all participating providers.

Sec. 9. **[62U.12] PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS FOR HEALTH CARE HOMES.**

Subdivision 1. **Development.** The Health Care Transformation Commission, in cooperation with the commissioners of health and human services, shall develop a payment system that provides care coordination payments to health care providers. In order to be eligible for a care coordination payment, a health care provider must be certified as a health care home by the commissioners of human services and health based on the certification standards for health care homes established under section 256B.0754.

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

(b) The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination, such as those with very complex health care needs or several chronic conditions.

(c) In setting care coordination fees, group purchasers as defined in section 62J.03, subdivision 6, shall consider the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care.

(d) Care coordination fees may be phased in, and must be applied first to persons who have complex or chronic health conditions.

Subd. 3. **Quality-based payments.** The quality-based payments under section 62U.11, when established, must also be included in the care coordination payment system.

Subd. 4. **Implementation.** (a) By July 1, 2009, the commissioner of human services shall implement this payment system for all state health care program enrollees served under fee-for-service as provided under section 256B.0753 and shall require demonstration providers serving state health care program enrollees to implement this payment system by July 1, 2009, for all state health care program enrollees served under managed care and county-based purchasing.

(b) By July 1, 2009, the commissioner of employee relations shall implement this payment system for all participants in the State Employee Group Insurance Program.

(c) By July 1, 2009, all health plan companies shall implement this payment system for all participating providers.

Sec. 10. **[62U.13] COORDINATION WITH THE PRIVATE SECTOR.**

In developing the payment systems required under sections 62U.11 and 62U.12, the Health Care Transformation Commission shall consult and coordinate with the commissioners of human services and health, organizations that work to improve health care quality in Minnesota, health care providers, health plan companies, consumers, and employers and other payors. The commissioners shall publicize and promote the payment systems required under sections 62U.11 and 62U.12, and shall make technical assistance available to entities adopting the payment systems.

Sec. 11. **[62U.14] PAYMENT RESTRUCTURING: PROVIDER INNOVATION TO IMPROVE COSTS AND QUALITY.**

Subdivision 1. **Development.** (a) By January 15, 2009, the Health Care Transformation Commission shall report to the legislature recommendations for advancing an innovative payment system for providing necessary services to patients, including but not limited to patients with coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, and depression.

(b) By January 1, 2010, the Health Care Transformation Commission shall report to the legislature additional changes necessary to accomplish comprehensive payment reform designed to support an innovative payment system to reduce costs and improve quality.

(c) By January 1, 2010, the Health Care Transformation Commission, in cooperation with the commissioner of human services, shall develop a comparable payment system for nonelderly and nondisabled enrollees in the state's public health care programs. This must include an assessment of the impact on enrollee access to quality care and the financial status of the state's health care programs.

(d) By January 1, 2011, the Health Care Transformation Commission shall develop rules to implement a comprehensive payment system that encourages provider innovation to reduce costs and improve quality.

Subd. 2. **Encounter data.** (a) Beginning September 1, 2009, and every three months thereafter, all health plan companies and third-party administrators shall submit encounter data to the Health Care Transformation Commission. The data shall be submitted in a form and manner specified by the commission subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commission shall only use the data submitted under paragraph (a) for the purpose of carrying out its responsibilities in designing and implementing a payment restructuring system. If the commission contracts with other organizations or entities to carry out any of its duties or responsibilities described in this chapter, the contract must require that the organization or entity maintain the data that it receives according to the provisions of this section.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commission shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commission shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commission shall report back to providers analyses and reports that identify specific providers. The provider shall have 21 days to review the data for accuracy.

(f) The commission shall establish an appeals process to resolve disputes from providers regarding the accuracy of the analyses and reports.

Subd. 3. **Utilization and health care costs.** (a) The commission shall establish a uniform definition and methodology for calculating the relative utilization and health care costs of providers. The methodology must include risk adjustment mechanisms that address at least the following factors:

(1) the health status of the individual in the year the individual enters the provider's care;

(2) a worsening of the patient's health condition that was not reasonably preventable by action that the provider could have taken;

(3) socioeconomic and cultural factors that bear directly on the cost of care; and

(4) the percentage of individuals served by the provider or care system whose care is paid for by public health insurance programs. The risk adjustment must be developed according to generally accepted risk adjustment methodologies.

(b) Beginning April 1, 2010, the commission shall disseminate information to providers on their utilization and cost in comparison to an appropriate peer group.

(c) The commission shall develop a system to index providers based on their risk-adjusted resource use and on quality of care for the conditions specified in subdivision 1, paragraph (a). In developing this system, the commission shall consult and coordinate with health care providers as defined in section 62J.03, subdivision 8, health plan companies, and organizations that work to improve health care quality in Minnesota.

Subd. 4. **Care package pricing.** (a) The commission shall develop a standard method and format for providers to use for submitting package prices for the conditions specified in subdivision 1, paragraph (a). The method shall be published in the State Register and must be made available to all providers.

(b) Beginning July 1, 2010, using the information developed in subdivision 3, providers may submit package prices to the commission for the cost of providing necessary services for the conditions specified in subdivision 1, paragraph (a), based on their disclosed prices under section 62U.15 combined with their actual risk-adjusted resource use for the most recent analytic period. The package prices submitted must reflect the providers' commitment to manage the providers' treatment of the patients and chronic conditions specified in subdivision 1, paragraph (a).

(c) Until January 1, 2013, no provider shall submit package prices for the risk-adjusted total cost of care for the conditions specified in subdivision 1, paragraph (a), that represents an increase of more than the increase in the previous calendar year's Consumer Price Index for all urban consumers plus two percentage points, or a decrease of more than 15 percent below the providers' risk-adjusted cost of care calculated based on the providers' average pricing levels for the previous calendar year.

(d) Beginning January 1, 2011, the commission shall annually publish the results of the process described in paragraph (b), and shall include only providers who choose to submit package prices. The results that are published must be on a risk-neutral basis.

Subd. 5. **Provider assistance.** The commissioner shall provide education and technical assistance to providers on how to calculate and submit package prices for the risk-adjusted cost of care for the conditions specified in subdivision 1, paragraph (a).

Subd. 6. **Payments.** The commission shall establish a method by which providers who have submitted package prices shall be paid for their cost of care in treating the conditions specified in subdivision 1, paragraph (a), with periodic adjustments to the payment they receive to reflect their actual risk-adjusted cost relative to the package price. The commission shall report to the legislature recommendations on how to implement the adjustments.

Subd. 7. **Implementation.** By January 1, 2012, or upon federal approval, whichever is later:

(1) the commissioner of human services shall pay providers based on their package prices for all enrollees in the state's public health care programs;

(2) the commissioner of employee relations shall pay providers based on their package prices for all participants in the state employee group insurance program;

(3) all political subdivisions, as defined in section 13.02, subdivision 11, that offer health benefits to their employees must pay providers based on their package prices for all participants, or purchase a health plan that uses this payment system;

(4) all health plan companies shall use the information and methods developed under this section to develop health plans that encourage consumers to use high-quality, low-cost providers; and

(5) health plan companies that issue health plans in the individual market or the small employer market must offer at least one health plan that uses the information developed under subdivision 3 to establish financial incentives for consumers to use high-quality, low-cost providers through enrollee cost-sharing or selective provider networks.

Sec. 12. **[62U.15] PROVIDER PRICE AND QUALITY DISCLOSURE.**

(a) By January 1, 2009, and annually thereafter, each physician clinic and hospital shall establish a list of prices for each health care procedure, service, package of services, or basket of care the provider provides and provide this information electronically to the Health Care Transformation Commission in the form and manner specified by the commission, and the commission shall provide this information at no cost to the public, upon request. Providers may update this list periodically to reflect new services, supply cost changes, and other factors.

(b) The commission shall develop a plan to expand the provisions of paragraph (a) to all health care providers by January 1, 2010. Notwithstanding this provision, health plan companies shall submit provider price information to the commission for the purposes of paragraph (a), for providers who do not submit prices to the commission for analysis and provider cost performance purposes.

Sec. 13. **[62U.16] PROVIDER PRICING.**

(a) Effective July 1, 2010, no health care provider subject to the requirements of section 62U.14 shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, a contractual relationship with a payer, the identity of the patient, or whether the patient has coverage through a group purchaser.

(b) This section does not apply to services provided to patients who are enrolled in Medicare, workers' compensation, no fault auto insurance, or a state public health care program.

(c) This section 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.

Sec. 14. **AMENDMENTS TO CURRENT HEALTH BENEFIT SETS.**

The commissioners of health, commerce, and employee relations shall report to the legislature under Minnesota Statutes, section 3.195, on necessary changes to current mandated benefit sets to align these with the standard benefit set and design developed by the Health Care Transformation Commission established in Minnesota Statutes, section 62U.04.

Sec. 15. **RISK ADJUSTMENT.**

The Risk Adjustment Advisory Council shall review Minnesota Comprehensive Health Association financing and whether the affordability needs of persons with health problems can be addressed through guaranteed issue, with no premium penalty for health history and not allowing preexisting condition limitations. This must include assessing whether stability of the insurance market could be managed through risk sharing that transfers funds between health plan companies. The goal is to discontinue Minnesota Comprehensive Health Association assessment and replace it with a broader and fairer funding mechanism, preferably one that does not involve a fee-based mechanism. The council shall make recommendations to the legislature by November 1, 2009. The Risk Adjustment Advisory Council shall include representatives of insurance companies, the Minnesota Comprehensive Health Association's board of directors, safety net providers, and consumer representatives. It shall be convened by the commissioner of commerce with staffing from that agency and the Minnesota Department of Health.

Sec. 16. **GLOBAL MODELING OF HEALTH CARE REFORMS.**

To the extent of available appropriations, the commissioner of health shall award a grant to the University of Minnesota School of Public Health, Health Policy and Management Division, to develop a model that will assess the impact of proposed health care reforms or major health care-related legislation on all sectors of the health care system, including access to the full range of health care, public health, public and private health

insurance coverage, long-term and continuing care, programs for persons with disabilities, social services, and other sectors related to Minnesotans' health. The model must be:

(1) developed with safeguards to make sure that the model and its assumptions and formulas are based on valid and objective data, research, and expert opinions;

(2) designed to enable policy makers and state agencies to enter into the model and study each component of health care reform, including access to all aspects of health care services, health care homes, payment reforms, populationwide prevention, health status of Minnesotans, and incidence of chronic disease;

(3) capable of assessing the interaction of different legislative and policy changes to determine the net effect on costs, access, and health status within sectors of the health care system, and the net overall impact across all sectors;

(4) designed to identify risks of unpredictable or unintended consequences, cost shifting between or within sectors of the health care system, and opportunities to make changes in one sector that will produce a benefit to other sectors; and

(5) capable of being adjusted based on both the proposed changes and the resulting impact in the following areas:

(i) access to all aspects of health care services;

(ii) health status of Minnesotans, including the incidence of chronic disease, health disparities, and risk factors such as obesity and smoking;

(iii) utilization of preventive care services such as screenings, immunizations, and physical examinations; and

(iv) costs and cost distribution, including costs to individuals and families, businesses, and government, including for total cost of health care, health-related services, and social services.

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

Sec. 17. **ECONOMIC ANALYSIS OF HEALTH CARE REFORM PLANS.**

(a) To the extent of available appropriations, the commissioner of health shall award a grant to the University of Minnesota School of Public Health, Health Policy and Management Division, to conduct a study and economic analysis of costs and benefits of various health care reform proposals, including an analysis of the recommendations of the Legislative Health Care Access Commission, the governor's Health Care Transformation Task Force, and a single statewide plan.

(b) The analysis of each proposal must measure the impact on total public and private health care spending in Minnesota that would result from each proposal, including whether there are savings or additional costs due to:

(1) increased or reduced insurance, billing, underwriting, marketing, and other administrative functions;

(2) timely and appropriate use of medical care;

(3) market-driven or negotiated prices on medical services and products, including pharmaceuticals;

(4) a shortage or excess capacity of medical facilities and equipment;

(5) increased utilization, better health outcomes, increased wellness due to prevention, early intervention, and health-promoting activities;

(6) increases or decreases in administrative expenses and health care expenses due to payment reforms;

(7) increases or decreases in administrative expenses and health care expenses due to coordination of care;

(8) increases or decreases in up-front and long-term utilization due to access to comprehensive medically necessary benefits, including dental care, mental health care, prescription drugs, and other health care; and

(9) non–health care impacts on state and local expenditures such as reduced out-of-home placement or crime costs due to mental health or chemical dependency coverage.

(c) The study must also analyze for each proposal the number of Minnesotans without access to health care, including those lacking access to certain types of medical care, such as dental care, mental health care, and prescription drugs.

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

Sec. 18. **APPROPRIATION.**

$15,000,000 is appropriated in fiscal year 2009 from the health care access fund to the Health Care Transformation Commission. This is a onetime appropriation.

ARTICLE 5
PUBLIC HEALTH

Section 1. **[145.986] STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

Subdivision 1. **Goals.** The initial goals of the public health improvement program are to reduce the percentage of Minnesotans who are obese or overweight to less than 50 percent by the year 2020 and to reduce tobacco smoking by two percent annually starting in 2011. By 2011, and considering available funding, the commissioner of health, in consultation with the State Community Health Advisory Committee established in section

145A.10, subdivision 10, and other stakeholders, may make recommendations as to future goals related to alcohol use and illegal drug use.

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

Subd. 3. **Outcomes.** (a) The commissioner of health must set measurable outcomes to meet the goals specified in subdivision 1, and annually review the progress of local communities in meeting these outcomes. The commissioner of health must provide technical assistance and corrective action plans to ensure that local communities are making sufficient progress.

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

Subd. 4. **Evaluation.** The commissioner shall conduct an evaluation of the statewide health improvement program using outcome measures established in subdivision 3. Local communities shall cooperate with the commissioner in the evaluation of this program.

Sec. 2. **APPROPRIATIONS.**

$20,000,000 is appropriated from the health care access fund in fiscal year 2009 to the commissioner of health to implement the statewide health improvement program under Minnesota Statutes, section 145.986. Beginning January 1, 2009, the commissioner of health shall provide funding to community health boards to implement local public health programs.

APPENDIX
Article locations in H3391-3

256L.15 PREMIUMS.

Subd. 3. **Exceptions to sliding scale.** Children in families with income at or below 150 percent of the federal poverty guidelines pay a monthly premium of $4.