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; establishing the Minnesota Health Insurance Exchange; requiring certain employers to offer Section 125 Plan; 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 62A.65, subdivision 3; 62E.141; 62J.26; 62L.12, subdivisions 2, 4; 256.01, by adding subdivisions; 256B.061; 256B.69, by adding a subdivision; 256D.03, 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 13.46, subdivision 2; 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; 254B; 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 and provide financial or other incentives for 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. The commissioner shall pay counties for the administrative cost of processing and verifying state health care program applications and enrolling applicants, on a per-person basis as established by a county-based time study, to the extent county expenditures exceed 2007 baseline expenditures.

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.

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.

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.

Subd. 7. **Care coordinators.** Health care homes must employ care coordinators to manage the care provided to patients with complex or chronic conditions. 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.

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.

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, health plans, 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, decision-making process and incorporating effectively the use of patient-decision aids, when appropriate;

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

(3) ensure accessibility 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 information on the number of state health care program enrollees in health care homes, the number and characteristics of enrollees with complex or chronic conditions, the number and geographic distribution of health care home providers, the performance and quality of care of health care homes, measures of preventative care, costs related to implementation and payment of care coordination fees, health care home payment arrangements, and 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.

ARTICLE 2
INCREASING ACCESS; CONTINUITY OF CARE

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

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

(b) By July 1, 2009, the commissioner shall improve coordination between state health care programs and social service programs including but not limited to WIC, free and reduced school lunch programs, and food stamps, and shall develop and use automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program. The system must also permit enrollees to renew state health care program enrollment through these social services programs. By January 15, 2009, the commissioner shall, as necessary, identify and recommend to the legislature statutory changes to state health care and social service programs necessary to improve coordination and automation of outreach and enrollment efforts, and report estimated local and state costs of implementation and evaluate funding alternatives, including possible federal reimbursement.

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

(d) Beginning July 1, 2008, the commissioner, county social service agencies, and health care providers shall update state health care program enrollee addresses and related contact information at the time of each enrollee contact. The commissioner shall develop methods of automatically updating contact information across programs in a manner that does not increase health care provider or county agency workloads.

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

Sec. 2. **[254B.11] SUBSTANCE ABUSE TREATMENT EFFECTIVENESS; ANNUAL REPORT.**

The commissioner of human services shall issue an annual report to the legislature on the effectiveness of substance abuse treatment. Treatment performance outcome measures in this report shall include rates of homelessness, employment, arrests, alcohol use, illicit drug use, participation in a self-help group, family support in recovery, and treatment readmissions. Scores on the performance outcome measures shall be collected at assessment, treatment intake, discharge, and six months following discharge. The report shall also contain the cost of treatment per person per program. The report shall be submitted to the chairs of the house and senate committees with jurisdiction over chemical health no later than January 30 of each year, beginning January 30, 2009. The commissioner shall make this information available to county placing authorities and consumers through the department's Web site.

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

Sec. 3. 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 is within ten percent of the applicable asset limit. The commissioner may verify nonliquid assets, but is not required to do so.

(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.

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

EFFECTIVE DATE. The amendment to paragraph (c) is effective January 1, 2009. The amendment to paragraph (d) 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. 4. Minnesota Statutes 2006, section 256B.061, is amended to read:

256B.061 ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS; DELAYED VERIFICATION.

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

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2006, section 256D.03, is amended by adding a subdivision to read:

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

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

Sec. 6. 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 enrollees for whom federal funding is not available, and is effective January 1, 2009, or upon federal approval, whichever is later, for enrollees for whom federal funding is available. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. 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 enrollees for whom federal funding is not available, and is effective January 1, 2009, or upon federal approval, whichever is later, for enrollees for whom federal funding is available. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. 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 January 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. 9. 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~~ January 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 January 1, 2009.

Sec. 10. 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. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include 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. 11. 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 beginning in the month of application. The applicant shall provide all required verifications within 60 days' notice of the eligibility determination, or eligibility shall be terminated. Applicants who are terminated for failure to provide all required verifications

are not eligible to apply 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. 12. 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. 13. 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 January 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. 14. 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. 15. 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 January 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 January 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. 16. 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. 17. **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. 18. **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 14, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 3
INSURANCE REFORM

Section 1. Minnesota Statutes 2006, section 62J.26, is amended to read:

62J.26 EVALUATION OF ~~PROPOSED~~ HEALTH COVERAGE MANDATES.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given unless the context otherwise requires:

(1) "commissioner" means the commissioner of ~~commerce~~ health;

(2) "cost-effective" means that the economic costs of using a particular service, device, or health technology to achieve improvement 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;

(3) "enacted mandated health benefit" means a mandated health benefit that is already enacted and contained in chapter 62A or 62Q;

~~(2)~~ (4) "health plan" means a health plan as defined in section 62A.011, subdivision 3, but includes coverage listed in clauses (7) and (10) of that definition;

~~(3)~~ (5) "mandated health benefit ~~proposal~~" means a ~~proposal that would statutorily require~~ statutory or regulatory requirement that a health plan ~~to~~ do the following:

(i) provide coverage or increase the amount of coverage for the treatment of a particular disease, condition, or other health care need;

(ii) provide coverage or increase the amount of coverage of a particular type of health care treatment or service or of equipment, supplies, or drugs used in connection with a health care treatment or service; or

(iii) provide coverage for care delivered by a specific type of provider.

"Mandated health benefit ~~proposal~~" does not include a health benefit ~~proposals amending~~ provision that solely amends the scope of practice of a licensed health care professional~~.~~;

(6) "proposed mandated health benefit" means a mandated health benefit proposed for enactment in a bill that is pending in the legislature or under consideration as a regulatory requirement by a state agency; and

(7) "regulatory mandated health benefit" means a mandated health benefit that a regulatory agency of this state has in effect required through an order, action, review, policy, or approval or denial of a request for approval of a policy or other contract of health coverage, where there is not an enacted mandated health benefit that clearly supports the regulatory agency's position.

Subd. 2. **Evaluation process and content.** (a) The commissioner, in consultation with the ~~commissioners of health and employee relations~~ commissioner of commerce, must evaluate mandated health benefit proposals as provided under subdivision 3.

(b) The purpose of the evaluation is to provide ~~the legislature with~~ a complete and timely analysis of all ramifications of any mandated health benefit proposal. The evaluation must include, in addition to other relevant information, the following:

(1) an evidence-based scientific review of the proposed treatment, service, equipment, supply, or drug. "Evidence-based scientific review" means a review that examines reliable scientific evidence regarding safety, effectiveness, and effect on health outcomes. The standard for the review must use a preponderance of reliable evidence as described in Minnesota Rules, part 4685.0700, subpart 2, item F;

~~(1)~~ (2) scientific and medical information on the ~~proposed health benefit, on the potential for harm or benefit to the patient, and on the~~ comparative benefit or harm from alternative forms of treatment;

~~(2)~~ (3) public health, economic, and fiscal impacts of the proposed ~~mandate~~ mandated health benefit on persons receiving health services in Minnesota~~, on the relative cost-effectiveness of the benefit,~~ and on the health care system in general;

(4) the extent to which the proposed mandated health benefit would be cost-effective;

~~(3)~~ (5) the extent to which the ~~service~~ proposed mandated health benefit is generally utilized by a significant portion of the population;

~~(4)~~ (6) the extent to which insurance coverage for the proposed mandated health benefit is already generally available;

~~(5)~~ (7) the extent to which the mandated coverage will increase or decrease the cost of the service; and

~~(6)~~ (8) the commissioner may consider actuarial analysis done by health ~~insurers~~ plan companies in determining the cost of the proposed mandated benefit.

(c) The commissioner must summarize the nature and quality of available information on these issues, and, if possible, must provide preliminary information to the public. The commissioner may conduct appropriate new research on these issues or may determine that existing research is sufficient ~~to meet the informational needs of the legislature~~. The commissioner must include the opinion of two or more private firms that specialize in independent evaluation of health care treatments, services, equipment, supplies, or drugs, using evidence-based scientific review as defined in this subdivision. Additionally, the commissioner may seek the assistance and advice of researchers, community leaders, or other persons or organizations with relevant expertise.

Subd. 3. **Requests for evaluation.** (a) Whenever a legislative measure containing a proposed mandated health benefit ~~proposal~~ is introduced as a bill or offered as an amendment to a bill, ~~or is likely to be introduced as a bill or offered as an amendment,~~ ~~a~~ the chair of ~~any~~ the standing legislative committee that has primary jurisdiction over the subject matter of the proposal ~~may~~ shall request that the commissioner complete an evaluation of the proposal under this section, to inform ~~any committee of~~ the legislature prior to floor action by either house of the legislature. The chair may request review of a proposed mandated health benefit proposal that is likely to be introduced as a bill or offered as an amendment. The legislature must not act on the measure on the house or senate floor until it receives the report under subdivision 5.

(b) Whenever a regulatory agency proposes to adopt any regulatory mandated health benefit, the proponent of the proposed regulatory mandated health benefit shall request the

commissioner to complete an evaluation described in subdivision 2, in order to inform the proponent prior to final order, action, or contract review. The agency shall not adopt the proposed regulatory health benefit mandate until completion of the review by a report described in subdivision 5. If the proponent is the commissioner of health, the commissioner of commerce shall do the review.

~~(b)~~ (c) The commissioner must conduct an evaluation described in subdivision 2 of each mandated health benefit proposal for which an evaluation is requested under paragraph (a)~~, unless the commissioner determines under paragraph (c) or subdivision 4 that priorities and resources do not permit its evaluation~~ or (b).

~~(c)~~ (d) If requests for evaluation of multiple proposals are received, the commissioner must consult with the chairs of the standing legislative committees having primary jurisdiction over the subject matter of the mandated health benefit proposals, and the regulatory agency, in the case of a proposed regulatory mandated health benefit, to prioritize the requests and establish a reporting date for each proposal to be evaluated. The commissioner is not required to direct an unreasonable quantity of the commissioner's resources to these evaluations.

Subd. 4. **Sources of funding.** (a) The mandated health benefit review account is created as an account in the general fund. Money in the account does not cancel and is available until spent.

~~(a)~~ (b) The commissioner need not use any funds for purposes of this section other than as provided in this subdivision or as specified in an appropriation.

~~(b)~~ (c) The commissioner may seek and accept funding from sources other than the state to pay for evaluations under this section to supplement or replace state appropriations. Any money received under this paragraph must be deposited in the state treasury, credited to a separate account for this purpose in the special revenue fund, and is appropriated to the commissioner for purposes of this section.

~~(c)~~ (d) If a request for an evaluation under this section has been made, the commissioner may use for purposes of the evaluation:

(1) funds in the mandated health benefit review account;

~~(1)~~ (2) any other funds appropriated to the commissioner specifically for purposes of this section; or

~~(2)~~ (3) funds available under paragraph ~~(b)~~ (c), if use of the funds for evaluation of that mandated health benefit proposal is consistent with any restrictions imposed by the source of the funds.

~~(d)~~ (e) The commissioner must ensure that the source of the funding has no influence on the process or outcome of the evaluation.

Subd. 5. **Report ~~to legislature.~~** (a) For a report under subdivision 3, paragraph (a), the commissioner must submit a written report on the evaluation to the legislature no later than 180 days after the request. The report must be submitted in compliance with sections 3.195 and 3.197.

(b) For a report under subdivision 3, paragraph (b), the commissioner must submit a written report on the evaluation to the requesting agency proponent no later than 180 days after the request and concurrently publish a notice in the State Register of the availability of the report to the public.

Subd. 6. **Evaluation of enacted mandated health benefits.** The commissioner of health shall contract with an unbiased reputable organization experienced in analysis of health care services to conduct a scientific evaluation of all enacted mandated health benefits and assess each benefit's cost-effectiveness based upon the existing scientific and medical technology or knowledge. The commissioner shall determine the appropriate scope of each evaluation based upon the apparent cost and controversy of each enacted mandated health benefit.

Sec. 2. **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. 3. **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. Minnesota Statutes 2007 Supplement, section 13.46, subdivision 2, is amended to read:

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

(1) according to section 13.05;

(2) according to court order;

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

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

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

(6) to administer federal funds or programs;

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

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

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

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

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

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

(iv) to analyze public assistance employment services and program utilization, cost, effectiveness, and outcomes as implemented under the authority established in Title II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of

1999. Health records governed by sections 144.291 to 144.298 and "protected health information" as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code of Federal Regulations, title 45, parts 160-164, including health care claims utilization information, must not be exchanged under this clause;

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

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

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

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

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

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

(i) the participant:

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

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

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

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

(16) the current address of a recipient of general assistance or general assistance medical care may be disclosed to probation officers and corrections agents who are

supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

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

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

(i) the member:

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

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

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

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

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

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

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

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

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

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free

and reduced price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Except for policies issued under section 62U.03, subdivision 5, paragraph (b), premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

(i) An insurer may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this paragraph. The rating practices guarantee must be in writing and must guarantee that the policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to

policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. An insurer that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (c), (f), and (h).

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

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to all employees or through the Minnesota Health Insurance Exchange under section 62U.02 to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. Except as provided in section 62U.03, subdivision 5, paragraph (b), the requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the premium and merely collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier or to the Minnesota Health Insurance Exchange under section 62U.02. Except for coverage under section 62A.65, subdivision 5, paragraph (b), or 62E.16, at the request of an employee, the health carrier or the Minnesota Health Insurance Exchange under section 62U.02 may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier or the Minnesota Health Insurance Exchange, as applicable, shall provide a cancellation notice

directly to the primary insured at least ~~ten~~ 20 days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

The employer must provide a written and signed statement to the health carrier or the Minnesota Health Insurance Exchange, as applicable, stating that the employer is not contributing directly or indirectly to the employee's premiums. The Minnesota Health Insurance Exchange under section 62U.02 shall provide all health carriers with enrolled employees of the employer with a copy of the employer's statement. The health carrier may rely on the employer's statement and is not required to guarantee-issue individual health plans to the employer's ~~other current or future~~ employees, except as required under section 62U.03, subdivision 5, paragraph (b).

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

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

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

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

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

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

Sec. 6. **[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. **Exchange.** "Exchange" means the Minnesota Health Insurance Exchange established in section 62U.02.

Subd. 7. **Health plan.** "Health plan" means a health plan as defined in section 62A.011.

Subd. 8. **Health plan company.** "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

Subd. 9. **Health technology.** "Health technology" means medical and surgical devices and procedures, medical equipment, and diagnostic tests.

Subd. 10. **Section 125 Plan.** "Section 125 Plan" means a cafeteria or premium-only plan under section 125 of the Internal Revenue Code that allows employees to pay for health insurance premiums with pretax dollars.

Subd. 11. **State health care program.** "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 12. **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. 7. **[62U.02] MINNESOTA HEALTH INSURANCE EXCHANGE.**

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

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

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

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

(b) "Commissioner" means:

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

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

(3) either commissioner's designated representative.

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

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

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

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

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

(b) Each health plan made available by a health plan company through the exchange must meet the minimum benefit set and design requirements provided under section 62U.04, subdivision 8.

(c) Any health plan company that issues health plans in the individual or small employer market in this state must offer through the exchange at least one health plan that meets the benefit set and design established by the Health Care Transformation Commission under section 62U.04.

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

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

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

Subd. 5. **Comparison of health plans.** The exchange shall help consumers understand and compare the standardized health plan options established under section 62U.04. The exchange shall also make consumers aware of eligibility for premium assistance under section 62U.09 based on the employer's contribution and the employee's income. Within each standardized plan grouping, the exchange shall provide easy ways for consumers to select among the offerings by comparing quality ratings, searching for a particular provider in its network, or by cost factors. This information must be made available via the Internet as well as by toll-free telephone assistance and written materials.

Subd. 6. **Individual participation and eligibility.** (a) Individuals are eligible to purchase health plans directly through the exchange or through an employer Section 125 Plan under section 62U.03.

(b) Nothing in this section requires guaranteed issue of individual market health plans offered through the exchange except as provided under section 62U.03, subdivision 5, paragraph (b).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) establish bank accounts and borrow money; and

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

Subd. 11. **Dispute resolution.** The exchange shall establish procedures for resolving disputes with respect to the eligibility of an individual to participate in the exchange. The exchange shall not have the authority or responsibility to intervene in or resolve disputes between an individual and a health plan or health plan company. If the exchange receives complaints involving such disputes from individuals participating in the exchange, the exchange shall inform the individual about the right to make such complaints to the commissioner to be resolved according to sections 62Q.68 to 62Q.73.

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

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health; and

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

and Administration of the senate; two nonlegislators appointed by the speaker of the house of representatives; and four members appointed by the governor.

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

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

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

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

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

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

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

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

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

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

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

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

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

Subd. 19. **Implementation.** By November 15, 2008, the board of the exchange shall submit a detailed implementation and financial plan to the legislature for its review, and beginning January 1, 2009, shall submit quarterly progress reports on implementation to the commission. Health plan coverage through the exchange shall begin July 1, 2009, on a pilot basis, with full market access for enrollment beginning January 1, 2010.

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

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

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

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

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

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

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

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

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

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

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

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

(2) allow employees to purchase an individual market health plan directly through the exchange or to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an individual market health plan;

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

(4) provide notice to employees that individual market health plans purchased by employees through payroll deduction are not employer-sponsored or administered. Employers shall be held harmless from any and all liability claims related to the individual market health plans purchased by employees under a Section 125 Plan.

(b) Employees earning less than $30,000 per year may choose to opt in to Section 125 plan participation after being provided, by their employer, information developed by the exchange on the potential negative impact on their Social Security retirement benefits. Employers may not in any way attempt to influence those employees in their decision on whether or not to participate in the Section 125 plan pretax premium payment. Those not choosing to opt in to Section 125 plan participation shall still remain eligible for premium collection and payment via the exchange. This also applies to anyone who may not be eligible for Section 125 plan benefits due to federal definitions of eligibility. Persons with dependents who differ in their eligibility must have their participation in the Section 125 pretax benefit plan proportionately established.

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

(b) Individuals who purchase an individual market health plan through a Section 125 Plan may purchase coverage on a guaranteed issue basis during an annual open enrollment

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

Sec. 9. **[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, 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.** (a) 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 for total cost of care for a patient group, including 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 1; and

(9) carry out other duties assigned in this chapter and this act.

(b) The data collected on services for persons in state public health care programs under paragraph (a), clause (1), must provide for separate evaluation and reporting of measures based on length of enrollment, enrollee characteristics, and program, in order to ensure appropriate health improvement outcomes and accountability for public investments. The commission shall provide the commissioner of human services and county agencies with access to the data without charge, to conduct special analyses and reporting on public investments, ensure appropriate accountability for public investments, respond to state and federal reporting requirements, evaluate potential changes in public policy and public programs, and evaluate progress on addressing health disparities and other state health care program goals.

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 sought during the legislative interim or with appropriate legislative committees on any federal changes sought during the legislative session; and

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

Subd. 7. **Rulemaking; exemption from administrative procedures.** To carry out the purposes of this section and section 62U.055, the commission may adopt rules under chapter 14.

Subd. 8. **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. 9. **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. 10. **Expiration.** The commission shall expire December 31, 2011.

Sec. 10. **[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 Minnesota Health Insurance Exchange.

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 used as a minimum requirement for health plans offered throughout the exchange and be the only benefit plan eligible for premium subsidies under section 62U.09. 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. 11. **[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. 12. **[62U.07] SAVINGS RECAPTURE ASSESSMENT.**

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.** (a) 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. If the actual spending is less than the projected spending, the commissioner shall determine an aggregate savings offset amount not to exceed 40 percent of the difference.

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

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.

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

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

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

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

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

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

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

Sec. 13. **[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. 14. **[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 is purchased through the Minnesota Health Insurance Exchange established under section 62U.02; 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 is purchased through the Minnesota Health Insurance Exchange established under section 62U.02; 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 Minnesota Health Insurance Exchange, and this payment shall be credited toward the employee's share of premium. Any additional amount paid by the commissioner to the Minnesota Health Insurance Exchange 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. 15. **[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, quality measures 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; and

(7) other indicators of care quality and efficiency must be incorporated where appropriate. These indicators may include care infrastructure, collection and reporting of results, measures of efficiency for specific procedures, 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. 16. **[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 employing care coordinators, as specified in section 256B.0752, subdivisions 3 and 7.

(b) The care coordination fee must be determined by the commission, 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.

(c) In setting care coordination fees, the commission 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 must be phased in, and must be applied first to persons who have complex or chronic health conditions.

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

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. 17. **[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. 18. **[62U.14] PAYMENT RESTRUCTURING: PROVIDER INNOVATION TO IMPROVE COSTS AND QUALITY.**

Subdivision 1. **Development.** By January 1, 2010, the Health Care Transformation Commission shall develop a payment system that encourages provider innovation to improve costs and 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 may publish analyses and reports that identify specific providers but only after the provider has been provided the opportunity by the commission to review

the data and submit comments. The provider shall have 21 days to review and comment, after which time the commission may release the data along with any comments submitted by the provider.

Subd. 3. **Utilization and health care costs.** (a) The commission shall develop a method of calculating the relative utilization and health care costs of providers. The method must include risk adjustments to reflect the differences in the demographics, health, and special needs of the providers' patient population. The risk adjustment must be developed in accordance with generally accepted risk adjustment methodologies.

(b) Beginning April 1, 2009, 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 total risk-adjusted resource use per person and on quality of care. 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. **Total care bids.** (a) The commission shall develop a standard method and format for providers to use for submitting a bid under this subdivision. This method shall be published in the State Register and must be made available to all providers.

(b) Beginning July 1, 2009, and annually thereafter, using the information developed in subdivision 3, providers may submit bids to the commission for total costs of providing care based on their disclosed prices under section 62U.15 combined with their actual risk-adjusted resource use for the most recent analytic period. The bid submitted must reflect the providers' commitment to manage their risk-adjusted patient population within this total cost.

(c) A provider who does not want to submit a bid as part of a care system may submit a bid on the services that the provider offers using formats specified by the commission that include, but are not limited to, contracted payment rates with health plans and capitation arrangements.

(d) Until January 1, 2012, no provider shall submit a bid for risk-adjusted total cost of care 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 provider's risk-adjusted total cost of care calculated based on their average pricing levels for the previous calendar year.

(e) Beginning January 1, 2010, the commission shall annually publish the results of the process described in paragraph (b), and shall include only providers who choose to submit bids. The results that are published must be on a risk-neutral basis. Effective

January 1, 2011, the published results shall include all providers. For providers that have not bid, these results must be based on their weighted average contract prices for all health plan companies and third-party administrators, combined with their risk adjusted historic resource use.

Subd. 5. **Provider assistance.** The commission shall provide education and technical assistance to providers on how to calculate and submit bids for the total risk-adjusted cost of care per patient.

Subd. 6. **Payments.** The commission shall establish a method by which providers who have submitted a bid shall be paid for their total cost of care, with periodic adjustments to the payment they receive to reflect their actual risk-adjusted cost relative to their submitted bid price. If there is mutual agreement, plans and providers may use other methodologies that will result in provider reimbursement for the amount bid for the total cost of care. Providers who choose not to bid shall be paid based on the prices they have established under section 62U.15.

Subd. 7. **Implementation.** By January 1, 2011:

(1) the commissioner of human services shall implement this payment system for all enrollees in the state's public health care programs;

(2) the commissioner of employee relations shall implement this payment system 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 implement this payment system 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 choose high-quality, low-cost providers through enrollee cost-sharing or selective provider networks.

Sec. 19. **[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, 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.

(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.

(c) By January 1, 2009, the commission shall require physician clinics and hospitals to submit standardized electronic information on the outcomes and processes associated with patient care.

(d) By January 15, 2009, the commission shall make recommendations to the legislative committees with jurisdiction over health care policy and finance on the feasibility of collecting standardized electronic information on the outcomes and processes associated with patient care from health care providers not included under paragraph (c).

Sec. 20. **[62U.16] PROVIDER PRICING.**

(a) 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 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. 21. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 28. **Exchange of data.** An entity that is part of the welfare system as defined in section 13.46, subdivision 1, paragraph (c), and the Minnesota Health Insurance Exchange under section 62U.02 may exchange private data about individuals without the individual's consent in order to collect premiums from individuals in the medical assistance employed persons with disabilities program and the MinnesotaCare program under chapters 256B and 256L. This subdivision only applies if the entity that is part of the welfare system and the Minnesota Health Insurance Exchange have entered into an agreement that complies with the requirements in Code of Federal Regulations, title 45, section 164.314.

Sec. 22. **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. 23. **RISK SHARING.**

The Risk Sharing 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 Legislative Commission on Health Care Access by November 1, 2009. The Risk Sharing 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. 24. **APPROPRIATION.**

$..... 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.**

$..... is appropriated from the general 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.