

**SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION**

S.F. No. 3555

(SENATE AUTHORS: GRUENHAGEN)

DATE	D-PG	OFFICIAL STATUS
02/17/2026	6309	Introduction and first reading Referred to Health and Human Services

1.1 A bill for an act

1.2 relating to human services; establishing a Family Medical Account service delivery

1.3 model; authorizing rulemaking; requiring reports; proposing coding for new law

1.4 in Minnesota Statutes, chapter 256B.

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

1.6 Section 1. **[256B.697] FAMILY MEDICAL ACCOUNT SERVICE DELIVERY**

1.7 **MODEL.**

1.8 Subdivision 1. **Establishment.** The commissioner of human services shall establish the

1.9 Family Medical Account (FMA) service delivery model under this section. The commissioner

1.10 shall place all new and reenrolling medical assistance enrollees eligible under subdivision

1.11 4, and not excluded by subdivision 5, on an FMA service delivery model beginning January

1.12 1, 2027.

1.13 Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the

1.14 meanings given.

1.15 (b) "Chronically ill individual" has the meaning given in United States Code, title 26,

1.16 section 7702B(c)(2)(A).

1.17 (c) "Disability" has the meaning given in United States Code, title 42, section 12102.

1.18 (d) "Enrollee" means an individual enrolled in the FMA service delivery model.

1.19 (e) "Financial institution" has the meaning given in section 47.59, subdivision 1,

1.20 paragraph (k).

1.21 (f) "FMA debit account" means the debit account to which the monthly installments of

1.22 the yearly contribution amount are made and from which costs for service fees are paid.

2.1 (g) "FMA debit card" means the physical card an FMA enrollee uses to access money
2.2 in the enrollee's FMA debit account to pay for service fees.

2.3 (h) "FMA investment account" means the account to which unspent money in an FMA
2.4 enrollee's FMA debit account is deposited at the end of each calendar year.

2.5 (i) "Medical care" has the meaning given in section 213(d) of the Internal Revenue Code.

2.6 (j) "Service fee" means the price that the commissioner pays for individual health care
2.7 services under the FMA service delivery model.

2.8 (k) "Yearly contribution amount" means the total annual contribution amount by the
2.9 commissioner into the FMA debit account of an enrollee.

2.10 Subd. 3. **General model requirements.** (a) The FMA service delivery model must
2.11 provide enrollees with medical assistance benefits according to subdivision 6.

2.12 (b) The FMA service delivery model must provide:

2.13 (1) enrollment counseling to enrollees with individual guidance regarding the enrollment
2.14 process and related information; and

2.15 (2) access for enrollees to negotiated provider service fee rates updated monthly.

2.16 (c) The FMA service delivery model must provide ongoing education to enrollees on:

2.17 (1) the high cost of medical care;

2.18 (2) reducing the inappropriate use of health care services; and

2.19 (3) taking individual enrollee responsibility for health care outcomes.

2.20 (d) The commissioner shall provide for retrospective medical billing as allowed under
2.21 medical assistance guidelines.

2.22 Subd. 4. **Enrollee participation requirements.** (a) The commissioner must require any
2.23 new or reenrolling medical assistance enrollee who meets all the following qualifications
2.24 to receive medical assistance through the FMA service delivery model:

2.25 (1) the person is eligible for medical assistance under section 256B.055, subdivision 3a,
2.26 9, 10, 15, or 16;

2.27 (2) the person has an income of 138 percent or less of the federal poverty guideline;

2.28 (3) the person would otherwise receive medical assistance services under a managed
2.29 care organization; and

2.30 (4) the person is not excluded under subdivision 5.

3.1 (b) Enrollment in the FMA service delivery model is effective for 12 months and may
3.2 be extended for additional 12-month periods. Enrollment is subject to the individual
3.3 maintaining eligibility for medical assistance.

3.4 (c) The commissioner shall provide all eligible persons information for contacting the
3.5 Ombudsperson for Managed Care. The Ombudsperson for Managed Care shall fully inform
3.6 eligible persons of the comparative attributes of the FMA service delivery model and
3.7 fee-for-service or demonstration project service delivery models.

3.8 Subd. 5. **Excluded persons.** (a) A person who, when applying, has a disability or is 65
3.9 years of age or older is excluded from enrollment in the FMA service delivery model.

3.10 (b) A medical assistance enrollee subject to a federal waiver or demonstration project
3.11 that requires a specific service delivery model is excluded from enrollment in the FMA
3.12 service delivery model.

3.13 Subd. 6. **Medical assistance benefits.** (a) Enrollees in the FMA service delivery model
3.14 must be deemed consumers and must receive the following medical assistance benefits:

3.15 (1) coverage for medical expenses for medical goods and services for which benefits
3.16 are otherwise provided under medical assistance after the enrollee fully spends the yearly
3.17 contribution amount in the enrollee's FMA debit account;

3.18 (2) monthly contributions equaling one-twelfth of the total yearly contribution amount
3.19 deposited into an FMA debit account for use by the enrollee for medical care expenses; and

3.20 (3) an FMA investment account to which unspent yearly contributions are transferred
3.21 at the end of each calendar year.

3.22 (b) Use of an FMA debit account is limited to outpatient and emergency room goods
3.23 and services, including monthly fees for direct primary care.

3.24 (c) Any outpatient treatment service is limited to a \$300 service fee per occurrence.

3.25 (d) The following services are covered by medical assistance and not subject to the
3.26 yearly contribution amount:

3.27 (1) preventive services as specified by the commissioner;

3.28 (2) prescription drugs prescribed for the treatment of diabetes, high blood pressure, high
3.29 cholesterol, epilepsy, respiratory diseases, and other health conditions as determined by the
3.30 commissioner;

3.31 (3) lifesaving devices needed for the treatment of anaphylaxis;

4.1 (4) medical equipment necessary for the treatment of respiratory diseases; and

4.2 (5) inpatient hospital care and services at surgery centers. The commissioner must not
4.3 deduct an FMA emergency room service fee if the enrollee is admitted to inpatient care.

4.4 (e) After an enrollee spends the full yearly contribution amount, medical assistance
4.5 benefits for that enrollee consist of the benefits that would otherwise be provided to that
4.6 enrollee under medical assistance had the enrollee not enrolled in the FMA service delivery
4.7 model.

4.8 (f) The commissioner shall contract directly with health care providers as defined in
4.9 section 62A.63, subdivision 2, to provide the medical assistance benefits specified in
4.10 paragraph (a), clause (1), and may purchase reinsurance through open national bids for the
4.11 cost of providing these medical assistance benefits. The commissioner must not purchase
4.12 reinsurance from a managed care organization.

4.13 Subd. 7. **Operation of accounts.** (a) The commissioner shall contribute a yearly
4.14 contribution amount into the FMA debit account of each enrollee.

4.15 (b) Enrollees must use an FMA debit card to pay medical expense service fees at the
4.16 prices set under the FMA service delivery model.

4.17 (c) For the initial calendar year of the FMA service delivery model, the full yearly
4.18 contribution amount for the FMA debit card is:

4.19 (1) \$1,500 for children;

4.20 (2) \$2,500 for adults with children; and

4.21 (3) \$2,500 for adults without children.

4.22 (d) The commissioner shall pay a monthly amount into the FMA debit account equal to
4.23 one-twelfth of the total yearly contribution amount on the first day of every month as long
4.24 as the enrollee is eligible.

4.25 (e) The commissioner shall annually adjust the amount under paragraph (c) to meet 40
4.26 percent of Centers for Medicare and Medicaid Services annual enrollee costs as determined
4.27 using data available to the commissioner.

4.28 (f) The commissioner must transfer unspent FMA debit account money under paragraph
4.29 (c) to the enrollee's FMA investment account one year after enrollment, according to
4.30 paragraph (i). Accumulated money transferred to an FMA investment account must not be
4.31 counted toward the money available in the enrollee's FMA debit account in a subsequent
4.32 year.

5.1 (g) If an enrollee is disenrolled from the FMA service delivery model or otherwise
5.2 becomes ineligible for any reason other than fraud, the operation of the FMA debit account
5.3 and any associated FMA investment account is controlled by subdivision 9.

5.4 (h) The commissioner shall contract with a third-party administrator to administer the
5.5 FMA service delivery model. The third-party administrator must be audited annually by an
5.6 independent auditor under parameters determined by the commissioner. A health plan
5.7 company or a financial institution under contract under paragraph (i) must not serve as a
5.8 third-party administrator. The commissioner must contract with a nationwide third-party
5.9 administrator.

5.10 (i) The commissioner shall contract with a financial institution to establish FMA
5.11 investment accounts for enrollees with unspent FMA debit account money at the end of the
5.12 eligibility year. FMA investment accounts do not have a dollar maximum. The commissioner
5.13 shall negotiate, as part of the contract, the interest rate to be paid by the financial institution
5.14 to an enrollee.

5.15 (j) The commissioner may contract for private bank services.

5.16 (k) The commissioner shall not count amounts in or contributed to an FMA debit account
5.17 or FMA investment account as income or assets for purposes of determining medical
5.18 assistance eligibility.

5.19 (l) All payments must be made by the commissioner and the third-party administrator
5.20 directly to providers of medical goods and services through the FMA debit card.

5.21 (m) The commissioner shall create a process to coordinate care for high-cost, chronically
5.22 ill enrollees with any medical illness, addiction, mental illness, dental care needs, or high
5.23 medical costs due to prolonged acute illness or injury. The use of enrollee personal clinical
5.24 data for this process must include each enrollee's authorized release of information, except
5.25 that no enrollee approval is required for release of information if the chronic illness severity
5.26 requires that the enrollee be transferred to a fee-for-service delivery model.

5.27 Subd. 8. Using money in an FMA debit account. (a) Except as provided in subdivision
5.28 9, enrollees must only use money in an FMA debit account for paying for medical care
5.29 service fees.

5.30 (b) Enrollees must not use money in an FMA debit account to pay a provider for medical
5.31 goods and services unless:

5.32 (1) the provider is licensed or otherwise authorized under state law to provide the goods
5.33 or services;

6.1 (2) the provider meets medical assistance program standards, except there must be no
6.2 mandated electronic health records or report requirement for cash clinics; and

6.3 (3) the provider complies with medical assistance prohibitions related to fraud and abuse.

6.4 (c) The commissioner shall establish procedures to:

6.5 (1) penalize or disenroll from the FMA service delivery model enrollees and providers
6.6 who make nonqualified withdrawals from an FMA debit account; and

6.7 (2) recoup costs that derive from nonqualified withdrawals.

6.8 (d) If the service fee for medical care exceeds the current amount in an enrollee's FMA
6.9 debit account, the enrollee may overdraw from the FMA debit account up to the full yearly
6.10 contribution amount. Subsequent monthly FMA debit account contributions must be withheld
6.11 until the overdrawn amount is fully paid, after which monthly payments must resume.

6.12 (e) Medical assistance payment rates for medical care service fees only apply if the
6.13 enrollee remains on medical assistance in the FMA service delivery model. For those
6.14 individuals no longer enrolled in the FMA service delivery model, use of remaining FMA
6.15 debit account money for medical goods and services must be at the individual's share of
6.16 cost under a different insurance plan or the full cost of service.

6.17 **Subd. 9. Maintaining an FMA debit account for enrollees who become ineligible. (a)**
6.18 **If an enrollee becomes ineligible for medical assistance, the commissioner must make no**
6.19 **further monthly contributions to the individual's FMA debit account.**

6.20 (b) If an enrollee becomes ineligible for medical assistance, money in the FMA debit
6.21 account remains available to the account holder in the FMA debit account for one year from
6.22 the date on which the individual became ineligible for medical assistance under the same
6.23 terms and conditions that would apply had the individual remained eligible for the FMA
6.24 service delivery model, except that the money is not subject to medical assistance rates
6.25 pursuant to subdivision 8, paragraph (e). The commissioner must transfer unspent FMA
6.26 debit account money remaining after one year from the date on which the individual became
6.27 ineligible for medical assistance to the enrollee's FMA investment account subject to all
6.28 other requirements under subdivisions 7 and 10.

6.29 (c) For those individuals no longer enrolled in the FMA service delivery model, money
6.30 from an FMA debit account used for medical care must be transferred by the commissioner
6.31 or the third-party administrator directly from the FMA debit account to the medical provider
6.32 of goods and services.

7.1 Subd. 10. Use of money from FMA investment account (a) An individual must only
7.2 use money in an FMA investment account for medical care that is not already covered by
7.3 the FMA yearly contribution amount and subsequent medical assistance benefit coverage.

7.4 (b) An individual who is no longer on medical assistance must use money in the FMA
7.5 investment account only for medical care. Medical assistance terms, conditions, and rates
7.6 do not apply to money in an FMA investment account of an individual who is no longer on
7.7 medical assistance. Money from an FMA investment account used for medical care must
7.8 be transferred by the third-party administrator directly from the FMA investment account
7.9 to the medical provider of goods and services.

7.10 (c) The money in the FMA investment account is not recoverable by the state.

7.11 (d) Enrollee use of FMA investment account money after reaching age 65 is governed
7.12 by federal health savings account rules.

7.13 Subd. 11. Data. All data under the FMA service delivery model, including protected
7.14 enrollee identified data, is available to the commissioner. All data except protected health
7.15 information is available to any party pursuant to chapter 13, and the commissioner must
7.16 not declare FMA service delivery model data as protected data or trade secret.

7.17 Subd. 12. Incentives for preventive care and care coordination. The commissioner
7.18 may develop and provide positive incentives for enrollees to obtain prenatal care and other
7.19 appropriate preventive care. In developing these incentives, the commissioner may consider
7.20 various rewards for enrollees demonstrating healthy prevention practices.

7.21 Subd. 13. Electronic transactions required. The commissioner shall require all
7.22 withdrawals and payments from FMA debit accounts be made electronically through an
7.23 FMA debit card. The method developed or selected for the FMA service delivery model
7.24 must include photo identification and electronic locks to prevent unauthorized use and must
7.25 provide real-time, encounter-level payment to health care providers. The method used must:

7.26 (1) allow information from an enrollee's medical record to be stored and accessed by
7.27 the enrollee and health care providers;

7.28 (2) allow storage and transfer of encounter-level data for analysis for both provider- and
7.29 enrollee-specific and aggregate health care quality measurement and monitoring; and

7.30 (3) enable the provider to confirm that the electronic means accurately identify the
7.31 enrollee.

7.32 Subd. 14. Access to negotiated provider payment rates. The commissioner shall allow
7.33 enrollees in the FMA service delivery model to obtain medical goods and services from

8.1 providers, including cash only clinics, individual clinics, and individual mental health clinics,
8.2 that choose to serve enrollees at payment rates that do not exceed the medical assistance
8.3 payment rates.

8.4 Subd. 15. **Death of current or former enrollee.** In the event of the death of a current
8.5 or former enrollee, the amount in the FMA debit account and the FMA investment account
8.6 must be distributed to the primary beneficiary of the estate or, if there is no named
8.7 beneficiary, to the estate.

8.8 Subd. 16. **Commissioner duties.** (a) The commissioner shall establish and publish
8.9 service fees for the benefits provided to an enrollee under the FMA service delivery model
8.10 every month.

8.11 (b) The commissioner shall provide enrollment counselors and ongoing education for
8.12 enrollees. The counseling and education must be designed to:

8.13 (1) meet the FMA service delivery model requirements specified in subdivision 3,
8.14 paragraphs (b) and (c);

8.15 (2) provide enrollees with assistance accessing providers and obtaining negotiated
8.16 provider payment rates; and

8.17 (3) provide enrollees with information on the benefits of maintaining continuity of care
8.18 both before and after enrollees spend the yearly contribution amount.

8.19 (c) The commissioner shall make the services of the Office of the Ombudsperson for
8.20 Managed Care available to enrollees in the FMA service delivery model and shall require
8.21 the office to address access, service, and billing problems related to providing medical
8.22 assistance benefits under subdivision 6.

8.23 (d) The commissioner shall provide FMA service delivery model enrollees a monthly
8.24 report detailing transactions, including FMA debit account and FMA investment account
8.25 balances.

8.26 (e) The commissioner shall implement a streamlined medical assistance renewal process
8.27 for FMA service delivery model enrollees. This process must include:

8.28 (1) requiring eligibility renewals every 12 months;

8.29 (2) allowing for passive renewal in which an enrollee receives a completed renewal form
8.30 from the commissioner; and

8.31 (3) allowing enrollees to provide to the commissioner updated information or a signed
8.32 statement attesting that the enrollee's eligibility information has not changed.

9.1 (f) The commissioner may adopt rules under chapter 14 to establish criteria for the
9.2 operation of the FMA service delivery model and may establish conditions limiting the use
9.3 of money in an FMA debit account, including but not limited to a deduction of \$25 from
9.4 the enrollee's FMA debit account if the enrollee does not contact the nurse hotline before
9.5 going to the emergency room. If the medical event requires hospitalization, this deduction
9.6 must not apply. Except for necessary emergency services that do not result in hospitalization,
9.7 the commissioner must charge an enrollee an ambulance service fee.

9.8 (g) To ensure access, the commissioner shall recruit willing medical assistance providers
9.9 and shall publish monthly updated provider listings on the department's website, including
9.10 location and ordinary office business and call hours and procedure prices that medical
9.11 assistance pays for health care services.

9.12 (h) In implementing the FMA service delivery model, the commissioner shall also raise
9.13 all service fees for medical assistance provided under the FMA service delivery model to
9.14 levels equivalent to the federal Medicare service fee rates.

9.15 (i) The commissioner shall present progress reports on the FMA service delivery model
9.16 to the legislative committees with jurisdiction over health and human services finance and
9.17 policy by October 1, 2027, and October 1, 2028. The commissioner shall include in the
9.18 progress reports recommendations for any changes in law necessary to improve operation
9.19 of the FMA service delivery model or to comply with federal requirements.

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