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S.F. No. 1264

(SENATE AUTHORS: WIKLUND)

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02/06/2023	669	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health; eliminating enrollee cost-sharing under medical assistance and MinnesotaCare; prohibiting individual, small group, and State Employee Group Insurance Program plans from including cost-sharing; amending Minnesota Statutes 2022, sections 43A.23, by adding a subdivision; 256B.021, subdivision 4; 256B.04, subdivision 14; 256B.0631, subdivision 1; 256B.6925, subdivisions 1, 2; 256B.6928, subdivision 3; 256L.03, subdivisions 1a, 5; proposing coding for new law in Minnesota Statutes, chapter 62K; repealing Minnesota Statutes 2022, sections 62K.06; 256B.063; 256B.0631, subdivisions 2, 3.

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

Section 1. Minnesota Statutes 2022, section 43A.23, is amended by adding a subdivision to read:

Subd. 5. **Prohibition on cost-sharing.** Beginning January 1, 2024, hospital and medical benefits offered to participants in the State Employee Group Insurance Program must not include deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing.

Sec. 2. **[62K.051] PROHIBITION OF COST-SHARING.**

Notwithstanding any law to the contrary, individual and small group health plans must not require deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing.

EFFECTIVE DATE. This section is effective upon federal approval of the amendment to the state innovation waiver requested in section 11. The commissioner of commerce shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2022, section 256B.021, subdivision 4, is amended to read:

Subd. 4. **Projects.** The commissioner shall request permission and funding to further the following initiatives.

(a) Health care delivery demonstration projects. This project involves testing alternative payment and service delivery models in accordance with sections 256B.0755 and 256B.0756. These demonstrations will allow the Minnesota Department of Human Services to engage in alternative payment arrangements with provider organizations that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement, but are not limited to these models of care delivery or payment. Quality of care and patient experience will be measured and incorporated into payment models alongside the cost of care. Demonstration sites should include Minnesota health care programs fee-for-services recipients and managed care enrollees and support a robust primary care model and improved care coordination for recipients.

(b) Promote personal responsibility and encourage and reward healthy outcomes. This project provides Medicaid funding to provide individual and group incentives to encourage healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight, lowering cholesterol, and lowering blood pressure.

(c) Encourage utilization of high quality, cost-effective care. This project creates incentives ~~through Medicaid and MinnesotaCare enrollee cost-sharing and other means~~ to encourage the utilization of high-quality, low-cost, high-value providers, as determined by the state's provider peer grouping initiative under section 62U.04.

(d) Adults without children. This proposal includes requesting federal authority to impose a limit on assets for adults without children in medical assistance, as defined in section 256B.055, subdivision 15, who have a household income equal to or less than 75 percent of the federal poverty limit, and to impose a 180-day durational residency requirement in MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults without children, regardless of income.

(e) Empower and encourage work, housing, and independence. This project provides services and supports for individuals who have an identified health or disabling condition but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce the need for intensive health care and long-term care services and supports, and to help maintain or obtain employment or assist in return to work. Benefits may include:

(1) coordination with health care homes or health care coordinators;

(2) assessment for wellness, housing needs, employment, planning, and goal setting;

(3) training services;

(4) job placement services;

(5) career counseling;

(6) benefit counseling;

(7) worker supports and coaching;

(8) assessment of workplace accommodations;

(9) transitional housing services; and

(10) assistance in maintaining housing.

(f) Redesign home and community-based services. This project realigns existing funding, services, and supports for people with disabilities and older Minnesotans to ensure community integration and a more sustainable service system. This may involve changes that promote a range of services to flexibly respond to the following needs:

(1) provide people less expensive alternatives to medical assistance services;

(2) offer more flexible and updated community support services under the Medicaid state plan;

(3) provide an individual budget and increased opportunity for self-direction;

(4) strengthen family and caregiver support services;

(5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected needs or foster development of needed services;

(6) use of home and community-based waiver programs for people whose needs cannot be met with the expanded Medicaid state plan community support service options;

(7) target access to residential care for those with higher needs;

(8) develop capacity within the community for crisis intervention and prevention;

(9) redesign case management;

(10) offer life planning services for families to plan for the future of their child with a disability;

(11) enhance self-advocacy and life planning for people with disabilities;

(12) improve information and assistance to inform long-term care decisions; and

(13) increase quality assurance, performance measurement, and outcome-based reimbursement.

This project may include different levels of long-term supports that allow seniors to remain in their homes and communities, and expand care transitions from acute care to community care to prevent hospitalizations and nursing home placement. The levels of support for seniors may range from basic community services for those with lower needs, access to residential services if a person has higher needs, and targets access to nursing home care to those with rehabilitation or high medical needs. This may involve the establishment of medical need thresholds to accommodate the level of support needed; provision of a long-term care consultation to persons seeking residential services, regardless of payer source; adjustment of incentives to providers and care coordination organizations to achieve desired outcomes; and a required coordination with medical assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve access to housing and improve capacity to maintain individuals in their existing home; adjust screening and assessment tools, as needed; improve transition and relocation efforts; seek federal financial participation for alternative care and essential community supports; and provide Medigap coverage for people having lower needs.

(g) Coordinate and streamline services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions. This project will coordinate and streamline medical assistance benefits for people with complex needs and multiple diagnoses. It would include changes that:

(1) develop community-based service provider capacity to serve the needs of this group;

(2) build assessment and care coordination expertise specific to people with multiple diagnoses;

(3) adopt service delivery models that allow coordinated access to a range of services for people with complex needs;

(4) reduce administrative complexity;

(5) measure the improvements in the state's ability to respond to the needs of this population; and

(6) increase the cost-effectiveness for the state budget.

(h) Implement nursing home level of care criteria. This project involves obtaining any necessary federal approval in order to implement the changes to the level of care criteria in

section 144.0724, subdivision 11, and implement further changes necessary to achieve reform of the home and community-based service system.

(i) Improve integration of Medicare and Medicaid. This project involves reducing fragmentation in the health care delivery system to improve care for people eligible for both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term care. The proposal may include:

(1) requesting an exception to the new Medicare methodology for payment adjustment for fully integrated special needs plans for dual eligible individuals;

(2) testing risk adjustment models that may be more favorable to capturing the needs of frail dually eligible individuals;

(3) requesting an exemption from the Medicare bidding process for fully integrated special needs plans for the dually eligible;

(4) modifying the Medicare bid process to recognize additional costs of health home services; and

(5) requesting permission for risk-sharing and gain-sharing.

(j) Intensive residential treatment services. This project would involve providing intensive residential treatment services for individuals who have serious mental illness and who have other complex needs. This proposal would allow such individuals to remain in these settings after mental health symptoms have stabilized, in order to maintain their mental health and avoid more costly or unnecessary hospital or other residential care due to their other complex conditions. The commissioner may pursue a specialized rate for projects created under this section.

(k) Seek federal Medicaid matching funds for Anoka-Metro Regional Treatment Center (AMRTC). This project involves seeking Medicaid reimbursement for medical services provided to patients to AMRTC, including requesting a waiver of United States Code, title 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services provided by hospitals with more than 16 beds that are primarily focused on the treatment of mental illness. This waiver would allow AMRTC to serve as a statewide resource to provide diagnostics and treatment for people with the most complex conditions.

(l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in residential facilities. This proposal would seek Medicaid reimbursement for any Medicaid-covered service for children who are placed in residential settings that are

determined to be "institutions for mental diseases," under United States Code, title 42, section 1396d.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 4. Minnesota Statutes 2022, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes ~~and recipient cost-sharing~~ under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 5. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** ~~(a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:~~ The medical assistance program must not require deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing.

~~(1) $3 per nonpreventive visit, except as provided in paragraph (b). 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 assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;~~

~~(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;~~

~~(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;~~

~~(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and~~

~~(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.~~

~~(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.~~

~~(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.~~

~~(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.~~

~~(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.~~

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 6. Minnesota Statutes 2022, section 256B.6925, subdivision 1, is amended to read:

Subdivision 1. **Information provided by commissioner.** The commissioner shall provide to each potential enrollee the following information:

(1) basic features of receiving services through managed care;

(2) which individuals are excluded from managed care enrollment, subject to mandatory managed care enrollment, or who may choose to enroll voluntarily;

(3) for mandatory and voluntary enrollment, the length of the enrollment period and information about an enrollee's right to disenroll in accordance with Code of Federal Regulations, part 42, section 438.56;

(4) the service area covered by each managed care organization;

(5) covered services, including services provided by the managed care organization and services provided by the commissioner;

(6) the provider directory and drug formulary for each managed care organization;

~~(7) cost-sharing requirements;~~

~~(8)~~ (7) requirements for adequate access to services, including provider network adequacy standards;

~~(9)~~ (8) a managed care organization's responsibility for coordination of enrollee care; and

~~(10)~~ (9) quality and performance indicators, including enrollee satisfaction for each managed care organization, if available.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 7. Minnesota Statutes 2022, section 256B.6925, subdivision 2, is amended to read:

Subd. 2. **Information provided by managed care organization.** The commissioner shall ensure that managed care organizations provide to each enrollee the following information:

(1) an enrollee handbook within a reasonable time after receiving notice of the enrollee's enrollment. The handbook must, at a minimum, include information on benefits provided, how and where to access benefits, ~~cost-sharing requirements,~~ how transportation is provided, and other information as required by Code of Federal Regulations, part 42, section 438.10, paragraph (g);

(2) a provider directory for the following provider types: physicians, specialists, hospitals, pharmacies, behavioral health providers, and long-term supports and services providers, as appropriate. The directory must include the provider's name, group affiliation, street address, telephone number, website, specialty if applicable, whether the provider accepts new enrollees, the provider's cultural and linguistic capabilities as identified in Code of Federal Regulations, part 42, section 438.10, paragraph (h), and whether the provider's office accommodates people with disabilities;

(3) a drug formulary that includes both generic and name brand medications that are covered and each medication tier, if applicable;

(4) written notice of termination of a contracted provider. Within 15 calendar days after receipt or issuance of the termination notice, the managed care organization must make a good faith effort to provide notice to each enrollee who received primary care from, or was seen on a regular basis by, the terminated provider; and

(5) upon enrollee request, the managed care organization's physician incentive plan.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 8. Minnesota Statutes 2022, section 256B.6928, subdivision 3, is amended to read:

Subd. 3. **Rate development standards.** (a) In developing capitation rates, the commissioner shall:

(1) identify and develop base utilization and price data, including validated encounter data and audited financial reports received from the managed care organizations that demonstrate experience for the populations served by the managed care organizations, for the three most recent and complete years before the rating period;

(2) develop and apply reasonable trend factors, including cost and utilization, to base data that are developed from actual experience of the medical assistance population or a similar population according to generally accepted actuarial practices and principles;

(3) develop the nonbenefit component of the rate to account for reasonable expenses related to the managed care organization's administration; taxes; licensing and regulatory fees; contribution to reserves; risk margin; cost of capital and other operational costs associated with the managed care organization's provision of covered services to enrollees;

~~(4) consider the value of cost-sharing for rate development purposes, regardless of whether the managed care organization imposes the cost-sharing on the enrollee or the cost-sharing is collected by the provider;~~

~~(5)~~ (4) make appropriate and reasonable adjustments to account for changes to the base data, programmatic changes, changes to nonbenefit components, and any other adjustment necessary to establish actuarially sound rates. Each adjustment must reasonably support the development of an accurate base data set for purposes of rate setting, reflect the health status of the enrolled population, and be developed in accordance with generally accepted actuarial principles and practices;

~~(6)~~ (5) consider the managed care organization's past medical loss ratio in the development of the capitation rates and consider the projected medical loss ratio; and

~~(7)~~ (6) select a prospective or retrospective risk adjustment methodology that must be developed in a budget-neutral manner consistent with generally accepted actuarial principles and practices.

(b) The base data must be derived from the medical assistance population or, if data on the medical assistance population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to the medical assistance population. Data must be in accordance with actuarial standards for data quality and an explanation of why that specific data is used must be provided in the rate certification. If

the commissioner is unable to base the rates on data that are within the three most recent and complete years before the rating period, the commissioner may request an approval from the Centers for Medicare and Medicaid Services for an exception. The request must describe why an exception is necessary and describe the actions that the commissioner intends to take to comply with the request.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 9. Minnesota Statutes 2022, section 256L.03, subdivision 1a, is amended to read:

Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except special education services and that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. ~~Children are exempt from the provisions of subdivision 5, regarding co-payments.~~ Children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 10. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** ~~(a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.~~ The MinnesotaCare program must not require deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing.

~~(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.~~

~~(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.~~

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 11. **REQUEST FOR WAIVER.**

The commissioner of commerce shall submit a request to the secretary of health and human services under United States Code, title 42, section 18052, to amend the state's approved state innovation waiver. The amendment must seek to prohibit individual and small group health plans sold in Minnesota from including enrollee cost-sharing. For purposes of this section "cost-sharing" includes but is not limited to deductibles, co-payments, and coinsurance. The commissioner must submit the amendment request to the secretary of health and human services by December 31, 2024.

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

Sec. 12. **REPEALER.**

(a) Minnesota Statutes 2022, sections 256B.063; and 256B.0631, subdivisions 2 and 3, are repealed.

(b) Minnesota Statutes 2022, section 62K.06, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective January 1, 2024. Paragraph (b) is effective upon federal approval of the amendment to the state innovation waiver requested in section 11. The commissioner of commerce shall notify the revisor of statutes when federal approval is obtained.

62K.06 METAL LEVEL MANDATORY OFFERINGS.

Subdivision 1. **Identification.** A health carrier that offers individual or small group health plans in Minnesota must provide documentation to the commissioner of commerce to justify actuarial value levels as specified in section 1302(d) of the Affordable Care Act for all individual and small group health plans offered inside and outside of MNsure.

Subd. 2. **Minimum levels.** (a) A health carrier that offers a catastrophic plan or a bronze level health plan within a service area in either the individual or small group market must also offer a silver level and a gold level health plan in that market and within that service area.

(b) A health carrier with less than five percent market share in the respective individual or small group market in Minnesota is exempt from paragraph (a), until January 1, 2017, unless the health carrier offers a qualified health plan through MNsure. If the health carrier offers a qualified health plan through MNsure, the health carrier must comply with paragraph (a).

Subd. 3. **MNsure restriction.** MNsure may not, by contract or otherwise, mandate the types of health plans to be offered by a health carrier to individuals or small employers purchasing health plans outside of MNsure. Solely for purposes of this subdivision, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clause (6).

Subd. 4. **Metal level defined.** For purposes of this section, the metal levels and catastrophic plans are defined in section 1302(d) and (e) of the Affordable Care Act.

Subd. 5. **Enforcement.** The commissioner of commerce shall enforce this section.

256B.063 COST SHARING.

Notwithstanding the provisions of section 256B.05, subdivision 2, the commissioner is authorized to promulgate rules pursuant to the Administrative Procedure Act, and to require a nominal enrollment fee, premium, or similar charge for recipients of medical assistance, if and to the extent required by applicable federal regulation.

256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room;

(10) services, fee-for-service payments subject to volume purchase through competitive bidding;

(11) American Indians who meet the requirements in Code of Federal Regulations, title 42, sections 447.51 and 447.56;

(12) persons needing treatment for breast or cervical cancer as described under section 256B.057, subdivision 10; and

(13) services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130.

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum for prescription drug co-payments; or

(2) for a recipient who has met their monthly five percent cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.