CHAPTER 62J

HEALTH CARE ACCESS PROGRAM

62J.01 FINDINGS.

The legislature finds that substantial numbers of Minnesotans have no health care coverage and that most of these residents are wage earners or their dependents. One-third of these individuals are children.

The legislature further finds that when these individuals enter the health care system they have often foregone preventive care and are in need of more expensive treatment that often exceeds their financial resources. Much of the cost for these uncompensated services to the uninsured are already in the health care system in the form of increased insurance and provider rates and property and income taxes.

The legislature further finds that these costs, spread among the already insured, represent a woefully inefficient method for providing basic preventive and acute care for the uninsured and represent an added cost to employers now providing health insurance to their employees.

The legislature further finds that it is necessary to ensure basic and affordable health care to all Minnesotans while addressing the economic pressures on the health care system as a whole in Minnesota.

History: *1989 c 327 s 1*

62J.02 HEALTH CARE ACCESS COMMISSION.

Subdivision 1. **Membership; compensation; chair.** The Minnesota health care access commission consists of 15 members. Five members are appointed by the governor, one of whom must be an experienced health care professional, one of whom must be a representative of small business, and one of whom must be a representative of consumers. Three members are appointed under the rules of the senate and three members are appointed under the rules of the house of representatives. The commissioners of health, human services, employee relations, and commerce, or their designated representatives, are also members. The governor shall appoint the chair of the commission from among the members who are not agency commissioners. The terms, compensation, and removal of the members appointed by the governor are as provided in section 15.0575.

Subd. 2. **Staff; office space; equipment.** The commission shall select a director to serve at its pleasure as the chief administrative officer of the commission. The director may hire advisors, consultants, and employees, as authorized by the commission, and prescribe their duties. Employees are not state employees, but are covered by section 3.736. At the option of the commission, the employees may participate in the following plans for employees in the unclassified service: the state retirement plan, the state deferred compensation plan, and the health insurance and life insurance plans. The commissioner of state planning shall provide to the commission, at a reasonable cost, administrative assistance, office space, and access to office equipment and services.

Subd. 3. **Duties.** The health care access commission, with the assistance of the commissioner of state planning, shall develop and recommend to the legislature a plan to provide access to health care for all state residents. In developing the plan, the commission shall:

(1) develop a system to estimate the total number of uninsured Minnesotans by age, sex, employment status, income level, geography, and other relevant characteristics;

(2) explore all potential insurance options including size and makeup of risk groups;

(3) prepare a legal analysis of restrictions and other potential legal issues of the Employee Retirement Income Security Act, United States Code, title 29, sections 1001 to 1461;

(4) study and make recommendations on insurance and health care law changes that will improve access to health care;

(5) study and make recommendations on incentives and disincentives to ensure that employers continue to provide health insurance coverage;

(6) study and make recommendations regarding benefits to be covered by health plans that would be available through the health care access program, including preventive, well-child, and prenatal care;

(7) identify cost savings to public programs that would result from implementation of the health care access program;

(8) develop a cost containment policy after reviewing cost containment methods such as hospital admission precertification, concurrent review of hospital stays, discharge planning, hospital bill audit prior to discharge, primary gatekeepers, claims data analysis, a drug formulary, pharmacy data analysis, bulk discounts, emergency room use, outpatient surgery oversight, protocols for preventive care and common acute care, practice data compared to peers, practitioner rewards and penalties, and other cost containment methods;

(9) develop a system to administer the health care access program, including recommendations for eligibility criteria, enrollment procedures, and options for contracting with carriers, health plans, and providers, to ensure access to affordable health care in all geographic areas of the state;

(10) define the number, functions, and duties of administrative staff;

(11) study alternatives for financing the state share of the cost of the premiums in an amount sufficient to generate one-half of the total costs of the health care access program, but not more than $150,000,000 a year, including, but not limited to, an actuarial analysis, a sliding fee scale analysis, and reserve fund requirements;

(12) develop a system for collection of premium payments;

(13) examine and make recommendations on gatekeeping mechanisms for access to health care services, different benefit and service packages for the minimum core coverage plan, and dollar limitations for prescription drug costs;

(14) consider limits on provider reimbursement and covered services and make recommendations;

(15) examine the effect of different copayment levels on access to health care for persons with low incomes and provide recommendations based on this analysis;

(16) examine and make recommendations on maximum lifetime benefits;

(17) develop methods to ensure representation in service delivery by eligible practitioners, without regard to race, color, or sex;

(18) develop methods to coordinate the health care access program with other government-subsidized programs; and

(19) conduct other activities it considers necessary to carry out the intent of the legislature as expressed in section 1 and this section.

Subd. 4. **Report.** The commission shall report to the legislature by February 15, 1990, on its progress in developing the plan, including preliminary data analysis and other appropriate information. The commission shall provide a final report and implementation plan to the legislature by January 1, 1991.

History: *1989 c 327 s 2*

NOTE: This section is repealed effective July 1, 1991. See Laws 1989, chapter 327, section 4.