1.1 .... moves to amend H.F. No. 3717, the first engrossment, as follows:

1.2 Page 6, after line 16, insert:

1.3 "Sec. 9. **DELIVERY REFORM ANALYSIS REPORT.**

1.4 (a) The commissioner of human services shall present to the chairs and ranking minority
1.5 members of the legislative committees with jurisdiction over health care policy and finance,
1.6 by January 15, 2024, a report comparing service delivery and payment system models for
1.7 delivering services to medical assistance enrollees for whom income eligibility is determined
1.8 using the modified adjusted gross income methodology under Minnesota Statutes, section
1.9 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible
1.10 under Minnesota Statutes, chapter 256L. The report must compare the current delivery
1.11 model with at least two alternative models. The alternative models must include a state-based
1.12 model in which the state holds the plan risk as the insurer and may contract with a third-party
1.13 administrator for claims processing and plan administration. The alternative models may
1.14 include but are not limited to:

1.15 (1) expanding the use of integrated health partnerships under Minnesota Statutes, section
1.16 256B.0755;

1.17 (2) delivering care under fee-for-service through a primary care case management system;
1.18 and

1.19 (3) continuing to contract with managed care and county-based purchasing plans for
1.20 some or all enrollees under modified contracts.

1.21 (b) The report must include:

1.22 (1) a description of how each model would address:

1.23 (i) racial and other inequities in the delivery of health care and health care outcomes;

2.1 (ii) geographic inequities in the delivery of health care;

2.2 (iii) the provision of incentives for preventive care and other best practices;

2.3 (iv) reimbursing providers for high-quality, value-based care at levels sufficient to sustain 2.4 or increase enrollee access to care; and

2.5 (v) transparency and simplicity for enrollees, health care providers, and policymakers;

2.6 (2) a comparison of the projected cost of each model; and

2.7 (3) an implementation timeline for each model, that includes the earliest date by which 2.8 each model could be implemented if authorized during the 2024 legislative session, and a 2.9 discussion of barriers to implementation.

2.10 Sec. 10. **PROPOSAL FOR A PUBLIC OPTION.**

2.11 (a) The commissioner of human services shall consult with the Centers for Medicare 2.12 and Medicaid Services, the Internal Revenue Service, and other relevant federal agencies 2.13 to develop a proposal for a public option program. The proposal may consider multiple 2.14 public option structures, at least one of which must be through expanded enrollment into 2.15 MinnesotaCare. Each option must:

2.16 (1) allow individuals with incomes above the maximum income eligibility limit under 2.17 Minnesota Statutes, section 256L.04, subdivision 1 or 7, the option of purchasing coverage 2.18 through the public option;

2.19 (2) allow undocumented noncitizens the option of purchasing through the public option;

2.20 (3) establish a small employer public option that allows employers with 50 or fewer 2.21 employees to offer the public option to the employer's employees and contribute to the 2.22 employees' premiums;

2.23 (4) allow the state to:

2.24 (i) receive the maximum pass through of federal dollars that would otherwise be used 2.25 to provide coverage for eligible public option enrollees if the enrollees were instead covered 2.26 through qualified health plans with premium tax credits, emergency medical assistance, or 2.27 other relevant programs; and

2.28 (ii) continue to receive basic health program payments for eligible MinnesotaCare 2.29 enrollees; and

3.1 (5) be administered in coordination with the existing MinnesotaCare program to maximize
3.2 efficiency and improve continuity of care, consistent with the requirements of Minnesota
3.3 Statutes, sections 256L.06, 256L.10, and 256L.11.

3.4 (b) Each public option proposal must include:

3.5 (1) a premium scale for public option enrollees that at least meets the Affordable Care
3.6 Act affordability standard for each income level;

3.7 (2) an analysis of the impact of the public option on MNsure enrollment and the consumer
3.8 assistance program and, if necessary, a proposal to ensure that the public option has an
3.9 adequate enrollment infrastructure and consumer assistance capacity;

3.10 (3) actuarial and financial analyses necessary to project program enrollment and costs;
3.11 and

3.12 (4) an analysis of the cost of implementing the public option using current eligibility
3.13 and enrollment technology systems, and at the option of the commissioner, an analysis of
3.14 alternative eligibility and enrollment systems that may reduce initial and ongoing costs and
3.15 improve functionality and accessibility.

3.16 (c) The commissioner shall incorporate into the design of the public option mechanisms
3.17 to ensure the long-term financial sustainability of MinnesotaCare and mitigate any adverse
3.18 financial impacts to MNsure. These mechanisms must minimize: (i) adverse selection; (ii)
3.19 state financial risk and expenditures; and (iii) potential impacts on premiums in the individual
3.20 and group insurance markets.

3.21 (d) The commissioner shall present the proposal to the chairs and ranking minority
3.22 members of the legislative committees with jurisdiction over health care policy and finance
3.23 by December 15, 2023. The proposal must include recommendations on any legislative
3.24 changes necessary to implement the public option. Any implementation of the proposal that
3.25 requires a state financial contribution must be contingent on legislative approval."

3.26 Renumber the sections in sequence and correct the internal references

3.27 Amend the title accordingly