..... moves to amend H.F. No. 214 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2012, section 16A.724, subdivision 3, is amended to read:

Subd. 3. **MinnesotaCare federal receipts.** ~~Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as nondedicated revenue in the health care access fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.~~ All federal funding received by Minnesota for implementation and administration of MinnesotaCare as a basic health program, as authorized in section 1331 of the Affordable Care Act (Public Law 111-148, as amended by Public Law 111-152), is dedicated to that program and shall be deposited into the health care access fund. Federal funding that is received for implementing and administering MinnesotaCare as a basic health program and deposited in the fund shall be used only for that program to purchase health care coverage for enrollees and reduce enrollee premiums and cost-sharing or provide additional enrollee benefits.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 2. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision to read:

Subd. 35. **Federal approval.** (a) The commissioner shall seek federal authority from the U.S. Department of Health and Human Services necessary to operate a health insurance program for Minnesotans with incomes up to 275 percent of the federal poverty guidelines (FPG). The proposal shall seek to secure all federal funding available from at least the following services:

(1) all premium tax credits and cost sharing subsidies available under United States Code, title 26, section 36B, and United States Code, title 42, section 18071, for individuals with incomes above 133 percent and at or below 275 percent of the federal poverty guidelines who would otherwise be enrolled in the Minnesota Insurance Marketplace as defined in Minnesota Statutes, section 62V.02, if enacted in 2013 H.F. No. 5/S.F. No. 1;

(2) Medicaid funding; and

(3) other funding sources identified by the commissioner that support coverage or care redesign in Minnesota.

(b) Funding received shall be used to design and implement a health insurance program that creates a single streamlined program and meets the needs of Minnesotans with incomes up to 275 percent of the federal poverty guidelines. The program must incorporate:

(1) payment reform characteristics included in the health care delivery system and accountable care organization payment models;

(2) flexibility in benefit set design such that benefits can be targeted to meet enrollee needs in different income and health status situations and can provide a more seamless transition from public to private health care coverage;

(3) flexibility in co-payment or premium structures to incent patients to seek high quality, low cost care settings; and

(4) flexibility in premium structures to ease the transition from public to private health care coverage.

(c) The commissioner shall develop and submit a proposal consistent with the above criteria and shall seek all federal authority necessary to implement the coverage program. In developing the request, the commissioner shall consult with appropriate stakeholder groups and consumers.

(d) The commissioner is authorized to seek any available waivers or federal approvals to accomplish the goals under paragraph (b) prior to 2017.

(e) The commissioner shall report progress on implementing this section to the chairs and ranking minority members of the legislative committees with jurisdiction over the health and human services policy and financing by December 1, 2014.

(f) The commissioner is authorized to accept and expend federal funds that support the purposes of this section.

Sec. 3. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 1b. **Affordable Care Act.** "Affordable Care Act" means Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

Sec. 4. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 4b. **Minnesota insurance Marketplace.** "Minnesota Insurance Marketplace" means the Minnesota Insurance Marketplace as defined in Minnesota Statutes, section 62V.02, if enacted in 2013 H.F. No. 5/S.F. No. 1.

Sec. 5. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 6. **MinnesotaCare.** "MinnesotaCare" means a health coverage program that meets the standards of this chapter and the requirements for a basic health program under section 1331 of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 6. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 7. **Modified adjusted gross income and household income.** "Modified adjusted gross income" and "household income" have the meanings provided in section 2002 of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 7. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 8. **Participating entity.** "Participating entity" means a health plan company as defined in section 62Q.01, subdivision 4; a county-based purchasing plan established under section 256B.692; an accountable care organization or other entity operating a health care delivery systems demonstration project authorized under section 256B.0755; an entity operating a county integrated health care delivery network pilot project authorized under section 256B.0756; or a network of health care providers established to offer services under MinnesotaCare.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 8. Minnesota Statutes 2012, section 256L.02, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all ~~eligible providers~~ participating entities under contract with the commissioner. The commissioner shall adopt rules to administer the MinnesotaCare program as a basic health program in accordance with section 1331 of the Affordable Care Act and this chapter and shall adopt any necessary rules. Nothing in this chapter is intended to violate the requirements of the Affordable Care Act. The commissioner shall not implement any provision of this chapter if the provision is found to violate the Affordable Care Act. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services. A toll-free telephone number must be used to provide information about medical programs and to promote access to the covered services.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 9. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision to read:

Subd. 5. **Determination of funding adequacy.** The commissioners of revenue and Minnesota Management and Budget, in consultation with the commissioner of human services, shall conduct an assessment of health care taxes, including the gross premiums tax, the provider tax, and Medicaid surcharges, and their relationship to the long-term solvency of the health care access fund, as part of the state revenue and expenditure forecast in November 2013. The commissioners shall determine the amount of state funding that will be required after December 31, 2019, in addition to the federal payments made available under section 1331 of the Affordable Care Act, for the MinnesotaCare program. The commissioners shall evaluate the stability and likelihood of long-term federal funding for the MinnesotaCare program under section 1331. The commissioners shall report the results of this assessment to the legislature by January 15, 2014, along with recommendations for changes to state revenue for the health care access fund, if state funding will continue to be required beyond December 31, 2019.

Sec. 10. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision to read:

Subd. 6. **Federal approval.** (a) The commissioner of human services shall seek federal approval to implement the MinnesotaCare program under this chapter as a basic

health program. In any agreement with the Centers for Medicare and Medicaid Services to operate MinnesotaCare as a basic health program, the commissioner shall seek to include procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of MinnesotaCare. These procedures must address issues related to the timing of federal payments, payment reconciliation, enrollee risk adjustment, and minimization of state financial risk. The commissioner shall consult with the commissioner of Minnesota Management and Budget, when developing the proposal for establishing MinnesotaCare as a basic health program to be submitted to the Centers for Medicare and Medicaid Services.

(b) The commissioner of human services, in consultation with the commissioner of Minnesota Management and Budget, shall work with the Centers for Medicare and Medicaid Services to establish a process for reconciliation and adjustment of federal payments that balances state and federal liability over time. The commissioner of human services shall request that the secretary of health and human services hold the state, and enrollees, harmless in the reconciliation process for the first three years, to allow the state to develop a statistically valid methodology for predicting enrollment trends and their net effect on federal payments.

(c) The commissioner of human services, through December 31, 2015, may modify the MinnesotaCare program as specified in this chapter, if it is necessary to enhance health benefits, expand provider access, or reduce cost-sharing and premiums in order to comply with the terms and conditions of federal approval as a basic health program. The commissioner may not reduce benefits, impose greater limits on access to providers, or increase cost-sharing and premiums by enrollees under the authority granted by this paragraph. If the commissioner modifies the terms and requirements for MinnesotaCare under this paragraph, the commissioner shall provide the legislature with notice of implementation of the modifications at least ten working days before notifying enrollees and participating entities. The costs of any changes to the program necessary to comply with federal approval shall become part of the program's base funding for purposes of future budget forecasts.

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

Sec. 11. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision to read:

Subd. 7. **Coordination with Minnesota Insurance Marketplace.** MinnesotaCare shall be considered a MAGI public health care program for purposes of Minnesota Statutes, chapter 62V if enacted in 2013 H.F. No. 5/S.F. No. 1.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 12. Minnesota Statutes 2012, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** ~~(a)~~ "Covered health services" means the health services reimbursed under chapter 256B, and all essential health benefits required under section 1302 of the Affordable Care Act, with the exception of ~~inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services~~ nursing facility services and intermediate care facility for persons with developmental disabilities (ICF/DD) services, and except as provided in this section.

~~(b)~~ No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

~~(c) Covered health services shall be expanded as provided in this section.~~

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 13. Minnesota Statutes 2012, 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.~~

(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, 2014.

Sec. 14. Minnesota Statutes 2012, section 256L.03, is amended by adding a subdivision to read:

Subd. 4a. **Cost-sharing.** (a) Except as provided in paragraph (b), the MinnesotaCare program shall include the following cost-sharing requirements for all enrollees:

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

(2) $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

(3) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval.

(b) Paragraph (a), clause (2), does not apply to mental health services.

(c) The commissioner, through the contracting process under section 256L.121, may allow participating entities to waive the family deductible described under paragraph (a), clause (4). The value of the family deductible shall not be included in any capitation or other payment made by the commissioner to participating entities. Participating entities shall certify annually to the commissioner the dollar value of the family deductible.

(d) 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.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 15. Minnesota Statutes 2012, section 256L.03, is amended by adding a subdivision to read:

Subd. 4b. **Loss ratio.** Health coverage provided through the MinnesotaCare program must have a medical loss ratio of at least 85 percent, as defined using the loss ratio methodology described in section 1001 of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 16. Minnesota Statutes 2012, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Except as provided in ~~paragraphs~~ paragraph (b) ~~and (c)~~, the MinnesotaCare benefit plan shall include the following cost-sharing 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;~~

~~(2)~~ (1) $3 per prescription for adult enrollees;

~~(3)~~ (2) $25 for eyeglasses for adult enrollees;

~~(4)~~ (3) $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;

~~(5)~~ (4) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

~~(6)~~ (5) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

~~(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.~~

~~(c)~~ (b) Paragraph (a) does not apply to pregnant women and children under the age of 21.

~~(d)~~ (c) Paragraph (a), clause ~~(4)~~ (3), 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 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 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.~~

~~(g)~~ (d) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause ~~(5)~~ (4), effective January 1, 2011.

~~(h)~~ (e) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause ~~(6)~~ (5). 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.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 17. Minnesota Statutes 2012, section 256L.03, subdivision 6, is amended to read:

Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015. For purposes of this subdivision, "state agency" includes ~~prepaid health plans~~ participating entities, under contract with the commissioner according to ~~sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; and county-based purchasing entities under section 256B.692~~ section 256L.121.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 18. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision to read:

Subd. 1c. **General requirements.** To be eligible for coverage under MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare shall not be treated as a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through the health benefit exchange under section 1331 of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 19. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision to read:

Subd. 1d. **Eligible groups; income limits.** (a) To be eligible under MinnesotaCare, a person must:

(1) be a resident of Minnesota;

(2) not be eligible under medical assistance;

(3) have a household income that is greater than 133 percent but does not exceed 200 percent of the federal poverty guidelines for family size, except that a noncitizen lawfully present in the United States, who is not eligible for the Medicaid program under title XIX of the Social Security Act due to immigration status, may have a household income that is less than or equal to 133 percent of the federal poverty guidelines for family size;

(4) not be eligible for minimum essential coverage, as defined in section 5000A(f) of the Internal Revenue Code of 1986, except that a person may be eligible for an employer-sponsored plan that is not affordable coverage, as defined in section 5000A(e)(2) of the Internal Revenue Code of 1986; and

(5) not have attained the age of 65 as of the beginning of the plan year.

(b) The commissioner shall calculate income eligibility under MinnesotaCare using modified adjusted gross income and shall apply a standard five percent income disregard, as provided under section 2012 of the Affordable Care Act.

EFFECTIVE DATE. Paragraph (a) of this section is effective January 1, 2015. Paragraph (b) of this section is effective January 1, 2014.

Sec. 20. Minnesota Statutes 2012, section 256L.05, subdivision 1, is amended to read:

Subdivision 1. **Application assistance and information availability.** (a) Applicants may submit applications online, in person, by mail, or by phone in accordance with the Affordable Care Act, and by any other means by which medical assistance applications may be submitted. Applicants may submit applications through the Minnesota Insurance Marketplace or through the MinnesotaCare program. Applications and application assistance must be made available at provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, Women, Infants and Children (WIC) program sites, Head Start program sites, public housing councils, crisis nurseries, child care centers, early childhood education and preschool program sites, legal aid offices, and libraries, and at any other locations at which medical assistance applications must be made available. These sites may accept applications and forward the forms to the commissioner or local county human services agencies that choose to participate as an enrollment site. Otherwise, applicants may apply directly to the commissioner or to participating local county human services agencies.

(b) Application assistance must be available for applicants choosing to file an online application through the Minnesota Insurance Marketplace.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 21. Minnesota Statutes 2012, section 256L.05, is amended by adding a subdivision to read:

Subd. 1d. **Streamlined application and enrollment process.** The commissioner shall work with the board of the Minnesota Insurance Marketplace and local human services agencies to develop a single, streamlined application and automatic enrollment process that meets the requirements of the Affordable Care Act, including but not limited to being structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for MinnesotaCare and medical assistance. Each application shall give an applicant the option, to the extent feasible, of specifying their current primary care clinic or physician as their primary care provider for purposes of continuity of care.

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

Sec. 22. Minnesota Statutes 2012, section 256L.05, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** The commissioner or county agency shall use electronic verification through the Minnesota Insurance Marketplace as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification to the extent permitted under the Affordable Care Act. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility ~~and premium payment under the MinnesotaCare program~~.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 23. Minnesota Statutes 2012, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved ~~and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a~~

~~family receiving covered health services is the month of placement. The effective date of coverage for other new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added~~.

~~(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.~~

~~(c) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.~~

~~(d)~~ (b) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

~~(e) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (d), is the first day of the month following the month in which verification of American Indian status is received or eligibility is approved, whichever is later.~~

~~(f)~~ (c) The effective date of coverage for children eligible under section 256L.07, subdivision 8, is the first day of the month following the date of termination from foster care or release from a juvenile residential correctional facility.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 24. Minnesota Statutes 2012, 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. ~~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 children enrolled in MinnesotaCare under section 256L.07, subdivision 8, the first period of renewal begins the month the enrollee turns 21 years of age.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 25. Minnesota Statutes 2012, section 256L.05, subdivision 3c, is amended to read:

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. ~~For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. General assistance medical care recipients may qualify for retroactive coverage under this subdivision at six-month renewal.~~

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 26. Minnesota Statutes 2012, 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 200 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.~~

Parents enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 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 250 percent of the federal poverty guidelines on or after July 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) Children may remain enrolled in MinnesotaCare if their gross family income as defined in section 256L.01, subdivision 4, is greater than 275 percent of federal poverty

guidelines. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraph (a), parents are not eligible for MinnesotaCare if gross household income exceeds $57,500 for the 12-month period of eligibility.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 27. Minnesota Statutes 2012, section 256L.09, subdivision 2, is amended to read:

Subd. 2. **Residency requirement.** To be eligible for health coverage under the MinnesotaCare program, ~~pregnant women, individuals, and families with children must meet the residency requirements~~ individuals must be a resident of the state as provided by ~~Code of Federal Regulations, title 42, section 435.403, except that the provisions of section 256B.056, subdivision 1, shall apply upon receipt of federal approval~~ section 1331 of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 28. Minnesota Statutes 2012, section 256L.11, subdivision 1, is amended to read:

Subdivision 1. **Medical assistance rate to be used.** ~~(a)~~ Payment to providers under ~~sections 256L.01 to 256L.11~~ this chapter shall be at the same rates and conditions established for medical assistance, except as provided in ~~subdivisions 2 to 6~~ this section.

~~(b) Effective for services provided on or after July 1, 2009, total payments for basic care services shall be reduced by three percent, in accordance with section 256B.766. Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.~~

~~(c) Effective for services provided on or after July 1, 2009, payment rates for physician and professional services shall be reduced as described under section 256B.76, subdivision 1, paragraph (c). Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.~~

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 29. Minnesota Statutes 2012, section 256L.11, is amended by adding a subdivision to read:

Subd. 1a. **Rate increases.** Effective for services provided on or after January 1, 2015, the commissioner of human services shall increase payments for basic care services, physician and professional services, and dental services by … percent from the rates in

effect for the MinnesotaCare program on December 31, 2014. Payments to participating entities established through the competitive process under section 256L.121 must reflect this increase.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 30. **[256L.121] SERVICE DELIVERY.**

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in, and meet the requirements of, section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic area.

Subd. 2. **Other requirements for participating entities.** The commissioner shall require participating entities, as a condition of contract, to document to the commissioner:

(1) the provision of culturally and linguistically appropriate services, including marketing materials, to MinnesotaCare enrollees; and

(2) the inclusion in provider networks of providers designated as essential community providers under section 62Q.19.

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

(1) establishing geographic areas for MinnesotaCare that are consistent with the geographic areas of the medical assistance program, within which participating entities may offer health plans;

(2) requiring, as a condition of participation in MinnesotaCare, participating entities to also participate in the medical assistance program; and

(3) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through the Minnesota health benefit exchange.

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

Sec. 31. **PLAN FOR CONSOLIDATION OF PUBLIC PROGRAMS.**

The commissioner of human services shall develop and present to the legislature by January 15, 2014, a plan for a consolidated and streamlined state health care program that combines the current medical assistance and MinnesotaCare programs, uses a standard and simplified application process through the Minnesota Insurance Marketplace, and provides seamless delivery and coordination of care between state health care programs and health coverage available through the Minnesota Insurance Marketplace.

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

Sec. 32. **REVISOR'S INSTRUCTION.**

The revisor shall remove cross-references to the sections repealed in this act wherever they appear in Minnesota Statutes and Minnesota Rules and make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

Sec. 33. **REPEALER.**

(a) Minnesota Statutes 2012, sections 256L.01, subdivisions 4a and 5; 256L.031; and 256L.07, subdivisions 2 and 3, are repealed, effective July 1, 2014.

(b) Minnesota Statutes 2012, sections 256L.01, subdivisions 3 and 3a; 256L.02, subdivision 3; 256L.03, subdivisions 1a, 3, 4, and 5; 256L.04, subdivisions 1, 1b, 2a, 7, 7a, 8, 9, and 13; 256L.05, subdivisions 1b, 1c, and 5; 256L.06, subdivision 3; 256L.07, subdivisions 1, 4, 5, 8, and 9; 256L.09, subdivisions 1, 4, 5, 6, and 7; 256L.11, subdivisions 2a, 3, and 6; 256L.12; 256L.15, subdivisions 1, 1a, 1b, and 2; and 256L.17, subdivisions 1, 2, 3, 4, and 5, are repealed effective January 1, 2015."

Amend the title accordingly