HOUSE RESEARCH

Bill Summary

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Section

Article 1: Health Care

Overview

This article sets goals related to universal coverage, establishes a prescription drug discount program, sets requirements for Minnesota health care programs outreach, expands MinnesotaCare eligibility and benefits, reduces MinnesotaCare premiums, eliminates MA copayments, and makes other changes related to health care.

1 **Uniform claims processing.** Adds § 62A.67. (a) Permits the commissioner of commerce to consult with representatives of the health care industry to establish a uniform claim form, billing and claim codes. Permits the commissioner to issue rules requiring payers and providers to use uniform claim forms, uniform billing and uniform claim codes.

(b) Requires the commissioner to adopt rules to establish uniform claim forms, uniform billing and uniform claim codes, beginning January 15, 2008, after seeking recommendation from the health care industry.

(c) Requires all payer and providers to use, commissioner-approved, compatible billing systems, by January 15, 2009. Prohibits payers and providers from modifying the system requirements and prohibits them from imposing any fee for use of the system.

Defines "health carrier" and "health plan" as in section 62A.011. Defines "third-party administrator" and "licensed insurer" as in section 62H.10.

2 **Dependent.** Amends § 62E.02, subd. 7. For purposes of MCHA policies, expands the definition of dependent to include an unmarried child under the age of 25, regardless of enrollment in an educational institution. Provides a January 1, 2008, effective date.

3 **Health information technology and infrastructure.** Amends § 62J.495. Requires all hospitals and health care providers, by January 15, 2012, to have in place an interoperable electronic health records system. Requires the commissioner of health, in consultation with the health information technology and infrastructure advisory committee, to develop a statewide plan to meet this goal, including uniform standards. Requires uniform standards to be developed by January 1, 2009, with a status report on their development to be submitted to the legislature by January 15, 2008. Extends the expiration date of the section, from June 30, 2009, to June 30, 2012.

4 **Electronic health record system.** Adds § 62J.496.

Subd. 1. Account establishment. Requires the commissioner of finance to establish and implement a revolving account to provide loans to physicians or physician group practices to install or support an interoperable health record system.

Subd. 2. Eligibility. Requires applicants to submit a loan application to the commissioner of health and specifies requirements for the application.

Subd. 3. Loans. (a) Requires the commissioner of health to make no interest loans on a first-come, first-served basis and places an unspecified limit on the amount of the loan. Gives the commissioner discretion over the size and number of loans made.

(b) Allows the commissioner to prescribe forms, establish an application process, and impose an application fee.

(c) Requires repayment of the principal no later than two years from the date of the loan, and requires amortization within 15 years from the date of the loan.

(d) Credits repayments to the account.

5 **Hospital information reporting.** Amends § 62J.82. Requires the Minnesota Hospital Association to include on their public web-based system information on hospital specific performance on measures of care related to acute myocardial infarction, heart failure, and pneumonia. Beginning January 1, 2009, requires inclusion of hospital-specific performance measures for hospital-acquired infections. Requires the commissioner of health to provide a link to the reported information on the MDH web site. Allows the commissioner to take action against the license of a hospital that does not provide the required information.

6 **Health care transformation task force.** Adds § 62J.84.

Subd. 1. Task force. States that the membership of the task force consists of: (1) the Legislative Commission on Health Care Access; (2) the commissioners of human services, health, and commerce; (3) four persons designated by the SmartBuy alliance to represent private sector purchasers; and (4) six persons designated by the partnership for action to transform health care.

Subd. 2. Public input. Requires the commissioner of health to review research and conduct surveys, focus groups, and other activities to determine Minnesotan's values and views on health care issues, and to report findings to the task force.

Subd. 3. Inventory and assessment of existing activities. Requires the task force to complete an inventory and assessment of all public and private activities, coalitions, and collaboratives working on health system improvement, and to present

recommendations to the legislature, the governor, and those working on the activities by December 15, 2007, on how the activities may be made more effective and coordination and communication improved.

Subd. 4. Action plan. Requires the task force to develop and present to the legislature and the governor, by December 15, 2007, a statewide plan for transforming the health care system to improve affordability, quality, and access. Specifies plan requirements.

7 **Dependent.** Amends § 62L.02, subd. 11. For purposes of the small employer market, expands the definition of dependent to include an unmarried child under the age of 25, regardless of enrollment in an educational institution. Provides a January 1, 2008, effective date.

8 **Definition.** Amends § 62Q.165, subd. 1. Amends a definition of universal coverage, to provide that it is the commitment of the state to achieve universal health care coverage by 2010.

9 **Goal.** Amends § 62Q.165, subd. 2. Amends a goal statement on universal coverage, to specify that all Minnesota residents are to have access to affordable health care by January 1, 2010.

10 **Federally qualified health centers.** Adds § 145.9269.

Subd. 1. Definitions. Defines federally qualified health center.

Subd. 2. Allocation of subsidies. Requires the commissioner of health to distribute subsidies to federally qualified health centers operating in Minnesota, to continue, expand, and improve services provided by these centers to low-income populations. Requires each subsidy to be in proportion to each center's amount of discounts granted to patients, except that each center must receive at least 2 percent but no more than 30 percent of the total amount of money available.

11 **Prescription drug discount program.** Adds § 256.9545. Establishes a prescription drug discount program.

Subd. 1. Establishment; administration. Directs the commissioner of human services to establish and administer the program.

Subd. 2. Commissioner's authority. Directs the commissioner to administer a drug rebate program for drugs purchased according to the prescription drug discount program, using the terms and conditions of the federal Medicaid rebate program.

Subd. 3. Definitions. Defines the following terms: commissioner, covered prescription drug, enrolled individual, health carrier, participating manufacturer, and participating pharmacy.

Subd. 4. Eligibility. (a) To be eligible, requires applicants to: (1) be permanent residents of Minnesota; (2) not be enrolled in MA, GAMC, or MinnesotaCare; (3) not have prescription drug coverage under a health plan or a pharmacy benefit program offered by a pharmaceutical manufacturer; and (4) not have prescription drug coverage under a Medicare supplement policy.

(b) For persons enrolled in a Medicare Part D plan or Medicare Advantage plan, allows coverage under the program for drugs that are not covered under the Medicare plan, or for covered drugs for which the individual is responsible for 100 percent of the cost.

Subd. 5. Application procedure. (a) Specifies application procedures and requires

the commissioner to determine eligibility within 30 days of receipt of an application. Specifies that enrollment begins the month after the enrollment fee is received.

(b) Requires eligibility to be renewed every 12 months.

(c) Requires the commissioner to develop an application form that does not exceed one page in length.

Subd. 6. Participating pharmacy. (a) Requires participating pharmacies, between the date of implementation through January 1, 2009, to sell covered drugs to enrolled individuals at the MA rate.

(b) After January 1, 2009, requires pharmacies to sell covered drugs at the MA rate, minus an amount equal to the rebate, and plus the amount of any switch fee.

(c) Requires pharmacies to provide the commissioner with all information necessary to administer the program.

Subd. 7. Notification of rebate amount. Requires the commissioner to notify participating manufacturers of the amount of rebate owed on prescriptions drugs sold under the program.

Subd. 8. Provision of rebate. Requires manufacturers to provide rebates equal to that provided under MA, and to provide the commissioner with any information necessary to verify the rebate. Requires payment of rebates within 38 days of receipt of the state invoice, or according to a schedule established by the commissioner. Requires the commissioner to deposit rebates into the Minnesota prescription drug dedicated fund.

Subd. 9. Payment to pharmacies. Beginning January 1, 2009, requires the commissioner to distribute to each participating pharmacy, on a biweekly basis, an amount equal to the rebate that is based on the prescription drugs sold by that pharmacy to enrolled individuals on or after January 1, 2009.

Subd. 10. Enrollment fee; switch fee. (a) Requires the commissioner to establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates.

(b) Requires the commissioner to establish a reasonable switch fee that covers pharmacy expenses related to formatting claims for electronic submission.

Subd. 11. Dedicated fund; use of fund. (a) Establishes the Minnesota prescription drug dedicated fund as an account in the state treasury. Requires the commissioner of finance to credit to the fund all prescription drug rebates, any federal funds received, all enrollment fees, and any appropriations or allocations for the fund. Specifies procedures for fund investment.

(b) Appropriates money in the fund to the commissioner to reimburse participating pharmacies, to reimburse the commissioner for administrative costs, and to repay the appropriation provided for the section. Requires the commissioner to administer the program so that costs total no more than funds appropriated plus prescription drug proceeds.

Provides a July 1, 2007 effective date.

12 **Minnesota health care programs outreach.** Adds § 256.962.

Subd. 1. Public awareness and education. Requires the commissioner to design and implement a statewide campaign to raise awareness of health coverage available through MA, GAMC, and MinnesotaCare and to educate the public on the importance of obtaining and maintaining health care coverage. Requires the

commissioner to collaborate with public and private entities and to ensure that outreach materials are available in languages other than English.

Subd. 2. Outreach grants. Requires the commissioner to award grants to public and private organizations to provide information, applications, and assistance in obtaining coverage through Minnesota public health care programs. In awarding grants, requires priority to be given to community organizations with a proven ability to provide multilingual and cultural outreach efforts in areas with high uninsured populations.

Subd. 3. Application and assistance. (a) Requires the Minnesota health care programs application to be made available at specified sites. Requires the commissioner to ensure that applications are available in languages other than English and that persons needing assistance due to language or cultural barriers receive necessary services.

(b) Requires local human services agencies, hospitals, and health care community clinics receiving state funds to provide assistance in completing the application form. Requires other locations to either provide direct assistance or information on where an applicant can receive assistance.

(c) Requires counties to offer applications and application assistance when providing child support collection services.

(d) Requires local public health agencies and counties that provide immunization clinics to offer applications and application assistance during these clinics.

Subd. 4. Statewide toll-free telephone number. Requires the commissioner to provide funds to establish a statewide toll-free number to provide information on public and private health coverage options and sources of free and low-cost health care.

Subd. 5. Incentive program. Requires the commissioner to establish an incentive program for organizations that identify and assist potential enrollees in filling out and submitting an application for a state health care program. Requires the commissioner to pay a $25 application assistance fee to organizations for each applicant who successfully enrolls. Allows the organization to provide gift certificates or other incentives to applicants upon enrollment.

Subd. 6. School districts. Requires school districts to: (1) provide information to students on Minnesota health care programs; (2) provide an application for Minnesota health care programs and information on application assistance to the families of children who are eligible for a free or reduced priced lunch; (3) ensure that applications and information on application assistance are available at early childhood education sites and public schools; (4) designate an enrollment specialist to provide application assistance and follow-up services; and (5) provide on their web site a link to information on how to obtain an application and application assistance.

Subd. 7. Renewal notice. (a) Requires the commissioner to mail renewal notices at 90 days prior to the renewal date and 60 days prior to the renewal date.

(b) Requires managed care plans to provide a follow-up renewal call at least 60 days prior to the renewal date.

(c) Requires the commissioner to include end of coverage dates on monthly rosters of enrollees provided to managed care organizations.

13 **Primary care access initiative.** Adds § 256.963.

Subd. 1. Establishment. Requires the commissioner to award a grant to implement a Web-based primary care access pilot project in Hennepin and Ramsey counties to connect patients with primary care medical homes and schedule patients for community-based appointments as an alternative to non-emergency use of a hospital emergency room. Specifies program criteria.

Subd. 2. Evaluation. Requires the grantee to report specified information to the commissioner on a quarterly basis. Requires the commissioner, in consultation with the Minnesota Hospital Association, to evaluate the emergency room diversion project and submit results to the legislature by January 15, 2009.

14 **Eligibility verification.** Amends § 256B.056, subd. 10. Eliminates the requirement that the commissioner modify the application form for Minnesota health care programs to require more detailed information on verification of assets and income, and also eliminates the requirement that the commissioner verify assets and income for all applicants and persons renewing eligibility. Eliminates the requirement that Minnesota health care program recipients report and verify new or increased earned income within 10 days, and eliminates the requirement that recipients who fail to verify new or an increase in earned income be disenrolled.

15 **Other clinic services.** Amends § 256B.0625, subd. 30. Specifies that the alternative MA payment methodology for federally qualified health centers and rural health clinics is 100 percent of costs as determined by generally accepted accounting principles, and annual Medicare cost reports, including Medicaid-eligible cost add-ons. Under current law, costs are determined according to Medicare cost principles.

16 **Medical assistance co-payments.** Adds § 256B.0632. Retains the $6 MA copayment for non-emergency visits to a hospital-based emergency room. (Existing copayments for non-preventive visits, eyeglasses, and prescription drugs are eliminated elsewhere in the bill.)

17 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. Exempts GAMC enrollees who are homeless from MinnesotaCare enrollment. Makes a conforming change related to the switch to annual MinnesotaCare renewals.

18 **General assistance medical care; services.** Amends § 256D.03, subd. 4. Establishes a $25 copayment for non-emergency visits to a hospital emergency room.

19 **Scope.** Amends § 256L.01, subd. 1. Makes a technical change in a cross-reference.

20 **Gross individual or gross family income.** Amends § 256L.01, subd. 4. Eliminates the requirement that depreciation be added back when determining income under MinnesotaCare for the farm self-employed. Also makes conforming changes related to the switch to annual MinnesotaCare renewals. Provides a July 1, 2007, effective date.

21 **Covered health services.** Amends § 256L.03, subd. 1. Makes a conforming change related to the elimination of the MinnesotaCare limited benefit set for adults without children with incomes above 75 percent of the federal poverty guidelines (FPG).

22 **Inpatient hospital services.** Amends § 256L.03, subd. 3. Increases the MinnesotaCare inpatient hospital annual limit from $10,000 to $20,000. Also increases from 175 to 200 percent of FPG the income limit above which parents on MinnesotaCare are subject to this limit. (The limit also applies to all adults without children.)

23 **Co-payments and coinsurance.** Amends § 256L.03, subd. 5. Eliminates unnecessary language related to a copayment for inpatient hospital services and makes conforming changes related to the increase in the income limit for parents subject to the inpatient hospital annual limit and the increase in the dollar amount of the annual limit.

24 **Social Security number required.** Amends § 256L.04, subd. 1a. Specifies that the requirement that MinnesotaCare applicants provide a Social Security number does not apply

to an undocumented noncitizen or nonimmigrant eligible for MinnesotaCare.

25 **Single adults and households without children.** Amends § 256L.04, subd. 7. Increases the MinnesotaCare income limit for single adults and households without children from 175 to 200 percent of FPG ($26,652/year for a household of two).

26 **Citizenship requirements.** Amends § 256L.04, subd. 10. Provides MinnesotaCare coverage for children who are nonimmigrants and undocumented noncitizens. The amendment to paragraph (c) requires state and county workers to assist MinnesotaCare applicants in obtaining satisfactory documentary evidence of citizenship or nationality.

27 **Application and information availability.** Amends § 256L.05, subd. 1. Requires MinnesotaCare applications to be made available at additional sites. Also requires application assistance to be made available at these sites.

28 **MinnesotaCare enrollment by county agencies.** Amends § 256L.05, subd. 1b. Makes a conforming change related to switch to 12-month MinnesotaCare renewals.

29 **Commissioner's duties.** Amends § 256L.05, subd. 2. Eliminates the requirement that applicants and enrollees seeking renewal of MinnesotaCare eligibility verify both earned and unearned income. Also eliminates the requirement that applicants and enrollees submit the name of their employers and a contact name for purposes of verifying eligibility for employer-subsidized coverage.

30 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. Beginning July 1, 2007, requires MinnesotaCare eligibility to be renewed every 12 months. Strikes language that required six-month renewals beginning October 1, 2004.

31 **Retroactive coverage.** Amends § 256L.05, subd. 3c. Provides that the effective date of MinnesotaCare coverage for persons terminated from MA or GAMC, and who have submitted a written request for retroactive coverage, is the day following termination. (Under current law, the effective date of coverage is the first day of the month following termination.)

32 **Presumptive eligibility.** Amends § 256L.05, by adding subd. 3d. Allows coverage for children to be provided during a presumptive eligibility period that begins when a health care provider or other entity determines, based on preliminary information, that the child's family income does not exceed the income standard. The presumptive eligibility period ends on the earlier of the day on which an eligibility determination is made or the last day of the month following the month in which the preliminary determination of eligibility was made.

33 **Continuous eligibility.** Amends § 256L.05, by adding subd. 3e. Provides that children shall be continuously eligible until the earlier of the next renewal period, or the time the child exceeds age 21.

34 **General requirements.** Amends § 256L.07, subd. 1. Eliminates the income cap ($25,000 for a six-month period) for parents on MinnesotaCare. Also makes conforming changes related to the exemption of children from insurance barriers, the increase in the income limit for adults without children, the switch to 12-month renewals, and continuous eligibility for children.

35 **Must not have access to employer-subsidized coverage.** Amends § 256L.07, subd. 2. Exempts children from the requirement that applicants for MinnesotaCare not have access to employer-subsidized insurance and not have had access to such coverage through a current employer for 18 months prior to application and renewal. Also modifies the definition of employer-subsidized coverage for adults to exclude plans that require an employee to pay more than 8 percent of gross income in copayments, deductibles, or coinsurance.

36 **Other health coverage.** Amends § 256L.07, subd. 3. Exempts children from the requirement that MinnesotaCare enrollees have no health coverage while enrolled or for four months prior to application and renewal.

37 **Exception for certain adults.** Amends § 256L.07, subd. 6. Makes a conforming change related to the switch to 12-month renewals under MinnesotaCare.

38 **Eligibility as Minnesota resident.** Amends § 256L.09, subd. 4. Allows individuals to demonstrate an intent to live in the state permanently by showing evidence of residence at a place of public accommodation. Also corrects a cross-reference.

39 **Premium determination.** Amends § 256L.15, subd. 1. Eliminates MinnesotaCare premiums for 12 months for members of the military and their families for whom eligibility is approved within 24 months following the end of a tour of active duty. Provides an effective date of July 1, 2007, or upon federal approval, whichever is later.

40 **Sliding scale fee; monthly gross individual or family income.** Amends § 256L.15, subd. 2. Eliminates in paragraph (a) a MinnesotaCare premium increase that took effect October 1, 2003, and eliminates an additional increase in paragraph (c). Provides a July 1, 2007, effective date.

41 **Limit on total assets.** Amends § 256L.17, subd. 2. Exempts workers' compensation settlements received due to a work-related injury from being counted toward the MinnesotaCare asset limit.

42 **Documentation.** Amends § 256L.17, subd. 3. Eliminates the requirement that the MinnesotaCare asset check-off form include specific language describing the asset limit.

43 **Exception for certain adults.** Amends § 256L.17, subd. 7. Makes a conforming change related to the switch to 12-month MinnesotaCare renewals.

44 Amends Laws 2005, 1st spec. sess., ch. 4, art. 9, § 3, subd. 2. Eliminates the reduction to family planning grants scheduled to take effect July 1, 2007.

45 **Appropriation.** (a) Appropriates money from the health care access fund to the commissioner of human services for the biennium beginning July 1, 2007, for MinnesotaCare outreach grants and the enrollment incentive program.

(b) Appropriates $1.156 million each fiscal year beginning July 1, 2007, from the general fund to the commissioner of health for family planning grants.

(c) Appropriates money for the biennium beginning July 1, 2007, from the general fund to the commissioner of human services for critical access dental provider reimbursement.

(d) Appropriates money for the biennium beginning July 1, 2007, from the general fund to the commissioner of health for subsidies for federally qualified health centers.

(e) Appropriates money for the biennium beginning July 1, 2007, from the general fund to the commissioner of human services for the patient incentive health program.

46 **Repealer.** Repeals sections 62A.301 (coverage for full-time students), 256B.0631 (MA copayments), and 256L.035 (MinnesotaCare limited benefit set).

Article 2: Minnesota health Insurance Exchange; Section 125 Plans

Overview

This article establishes the Minnesota health insurance exchange, requires employers with more than 10 employees to offer a section 125 plan through the exchange, and makes other related changes.

1 **General.** Amends section 13.46, subd. 2. Allows data on individuals to be shared between the welfare system and the Minnesota health insurance exchange, in order to enroll and collect premiums from MinnesotaCare enrollees and to administer the MinnesotaCare

program.

2 **Minnesota health insurance exchange.** Adds § 62A.67.

Subd. 1. Title; citation. States that this section may be cited as the "Minnesota Health Insurance Exchange."

Subd. 2. Creation; tax exemption. States that the exchange is created to provide individuals with greater access, choice, portability, and affordability of health insurance products. Provides that the exchange is a not-for-profit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.

Subd. 3. Definitions. Defines terms. "Commissioner" is defined as the commissioner of commerce for health insurers subject to the jurisdiction of that commissioner, and the commissioner of health for health insurers subject to the jurisdiction of that commissioner.

Subd. 4. Insurer and health plan participation. Requires all plans issued or renewed in the individual market to participate in the exchange, and prohibits these plans from being issued or renewed outside of the exchange. Prohibits group health plans from being offered through the exchange. Provides that health plans offered through MCHA are offered through the exchange as determined by MCHA, and that health plans offered through MinnesotaCare are offered through the exchange as determined by the commissioner of human services.

Subd. 5. Approval of health plans. Prohibits a health plan from being offered through the exchange unless the commissioner has certified that the insurer is licensed to issue health insurance in the state, the health plan meets the requirements of this section, and the health plan and insurer are in compliance with all other applicable laws.

Subd. 6. Individual market health plans. Provides that individual market plans offered through the exchange continue to be regulated by the commissioner as provided in other law and must include the following provisions: (1) premiums for children under age 19 shall not vary by age; and (2) premiums for children under age 19 must excluded from the individual market rating factor requirements related to age in section 62A.65, subdivision 3, paragraph (b).

Subd. 7. Individual participation and eligibility. Allows individuals to purchase health plans directly through the exchange or an employer section 125 plan. States that this section does not require guaranteed issue of individual market health plans offered through the exchange. Provides that individuals are eligible to purchase individual market plans through the exchange by meeting one or more of the following qualifications: (1) the individual is a Minnesota resident; (2) the individual is a student attending an institution outside of Minnesota and maintains Minnesota residency; (3) the individual is not a Minnesota resident but is employed by an employer located in the state, and the employer does not offer a group plan but does offer a section 125 plan through the exchange; (4) the individual is not a Minnesota resident but is self-employed and the principal place of business is in the state; or (5) the individual is a dependent of an eligible individual.

Subd. 8. Continuation of coverage. Allows enrollment in a health plan to be cancelled for nonpayment of premiums, fraud, or changes in MinnesotaCare eligibility. Prohibits enrollment in an individual plan from being cancelled or not renewed due to a change in employer or employment status, marital status, health status, age, residence, or any other change that does not affect eligibility.

Subd. 9. Responsibilities of the exchange. Requires the exchange to serve as the sole entity for enrollment and collection and transfer of premium payments for health plans offered through the exchange. Requires the exchange to: (1) publicize the exchange; (2) provide assistance to employers in setting up a section 125 plan; (3) create a system to allow individuals to compare and enroll in health plans; (4) create a system to collect and transmit premium payments and other contributions to applicable plans; (5) refer individuals interested in MinnesotaCare to DHS to determine eligibility; (6) establish a mechanism with DHS to transfer MinnesotaCare premiums and subsidies to qualify for federal matching payments; (7) collect and assess information for eligibility for premium incentives under chapter 256L; (8) upon request, issue certificates of previous coverage; (9) establish procedures to account for all funds received and disbursed; and (10) make available to the public, at the end of each calendar year, an independent audit.

Subd. 10. Powers of the exchange. Grants the exchange the power to: (1) contract with insurance vendors to perform functions assigned to the exchange; (2) contract with employers to act as the plan administrator for section 125 plans; (3) establish and assess fees on premiums to fund the cost of administration; (4) seek and receive grants; (5) establish and administer rules and procedures to govern operations; (6) establish one or more service centers within the state; (7) sue or be sued and take legal action; (8) establish bank accounts and borrow money; and (9) enter into any necessary agreements with state agencies.

Subd. 11. Dispute resolution. Requires the exchange to establish procedures to resolve disputes concerning individual eligibility to participate in the exchange. Provides that the exchange does not have the authority or responsibility to intervene in disputes between an individual and a health plan or insurer. Requires the exchange to refer complaints from participants to the commissioner of human services to be resolved according to the complaint resolution procedures that apply to health plan companies.

Subd. 12. Governance. Provides that the exchange is governed by an 11-member board of directors. Requires the board to convene on or before July 1, 2007. Specifies initial board membership.

Subd. 13. Subsequent board membership. Specifies ongoing membership of the board, effective July 1, 2010.

Subd. 14. Operations of the board. Specifies procedures for board operation.

Subd. 15. Operations of the exchange. Requires the board to appoint an exchange director, and specifies duties of the director.

Subd. 16. Insurance producers. Allows health plans to pay producer commissions.

Subd. 17. Implementation. Specifies that health plan coverage through the exchange begins January 1, 2009. Requires the exchange to be operational to provide assistance to individuals and employers by September 1, 2008, and prepared for enrollment by December 1, 2008. Provides that enrollees of individual market plans, MinnesotaCare, and MHCA as of December 2, 2008, are automatically enrolled in the exchange on January 1, 2009, in the same health plan and at the same premium, subject to this section. Requires enrollees to make premium payments to the exchange as of January 1, 2009.

Subd. 18. Study of insurer issue requirements. Requires the exchange, in consultation with the commissioners of commerce and health, to study and present

recommendations on rating requirements and risk adjustment mechanisms that would increase enrollment through section 125 plans. Requires findings and recommendations to be reported to the chairs of the legislative committees with jurisdiction over commerce and health, by January 15, 2011.

3 **Section 125 plans.** Adds § 62A.68.

Subd. 1. Definitions. Defines terms.

Subd. 2. Section 125 plan requirement. Effective January 1, 2009, requires all employers with 11 or more employees to offer a section 125 plan through the exchange, to allow their employees to pay for health insurance premiums with pretax dollars. Exempts from the requirement employers that offer a group insurance plan, offer group health insurance through a self-insured plan, and those with fewer than 11 employees (but allows these employers to voluntarily offer a section 125 plan).

Subd. 3. Tracking compliance. Requires the exchange, in consultation with specified agency commissioners, to establish a method to track employer compliance with the section 125 plan requirement.

Subd. 4. Employer requirements. Requires employers offering a section 125 plan to enter into a binding agreement with the exchange, that includes the following terms:

(a) The employer shall designate the exchange director as the plan's administrator, who shall then agree to undertake these obligations;

(b) The coverage and benefits offered by exchange insurers constitute the coverage and benefits of the employer plan.

(c) Any eligible individual may elect coverage, and neither the employer nor the exchange shall limit choice of coverage from among participating plans.

(d) The employer shall deduct premium amounts on a pretax basis.

(e) The employer shall not offer individuals eligible to participate in the exchange any separate or competing group health plan.

(f) The employer reserves the right to determine the terms and amounts of the employer's contribution to the plan, if any.

(g) The employer shall make available to the exchange records and information necessary to verify employer compliance and individual eligibility.

(h) The exchange shall not provide the employer plan with any services or benefits not otherwise provided or offered to all other employer plans.

Subd. 5. Section 125 eligible health plans. Allows individuals eligible for the exchange through a section 125 plan to enroll in any health plan offered through the exchange for which the individual is eligible.

4 **Inclusion in employer-sponsored plan.** Amends § 6E.141. Limits the prohibition on employees eligible for employer coverage enrolling in or continuing enrollment in an MCHA plan to enrollees eligible for a group plan.

5 **Exceptions.** Amends § 62L.12, subd. 2. States that nothing in chapter 62L restricts the offer, sale, issuance or renewal of an individual health plan through the Minnesota Health Insurance Exchange.

6 **Financial management.** Amends § 256L.02, subd. 3. Requires the commissioner of human services to work with the Minnesota Health Insurance Exchange, when making any program adjustments necessary to ensure that MinnesotaCare expenditures remain within the limits of available revenues. Provides an effective date of January 1, 2009.

7 **Enrollment responsibilities.** Amends § 256L.02, by adding subd. 5. Effective January 1, 2009, gives the exchange the responsibility for enrolling eligible applicants and enrollees in a health plan for MinnesotaCare coverage. Specifies that the commissioner retains responsibility for determining eligibility. Provides a January 1, 2009, effective date.

8 **Exchange of data.** Amends § 256L.02, by adding subd. 6. Allows the exchange and an entity that is part of the welfare system to exchange private data about individuals without consent, in order to enroll and collect premiums for MinnesotaCare, and administer participation in the program.

9 **Availability of private insurance.** Amends § 256L.05, subd. 5. Requires the commissioner to provide information about the exchange upon initial enrollment and annually thereafter. Also requires the notice of ineligibility to provide information about coverage through the exchange. Strikes language requiring information about private sector coverage to be provided to enrollees with certain income levels. Provides a January 1, 2009, effective date.

10 **Minnesota health insurance exchange.** Amends § 256L.05, by adding subd 6. Requires the commissioner to refer all MinnesotaCare applicants and enrollees to the exchange for enrollment in a managed care plan or private market health plan. Requires the exchange to provide these individuals with assistance in selecting a managed care plan and in analyzing health plans. Provides a January 1, 2009, effective date.

11 **Managed care vendor requirements.** Amends § 256L.12, subd. 7. Requires managed care vendors under MinnesotaCare to participate in the exchange for purposes of enrolling individuals. Provides a January 1, 2009, effective date.

12 **Payment options.** Amends § 256L.15, subd. 1a. States that the exchange is responsible for collecting MinnesotaCare premiums. Provides a January 1, 2009, effective date.

13 **Premium discount incentive.** Amends § 256L.15, by adding subd. 5. States the adults and families with children are eligible for a premium reduction of $3 per month for each child who meets goals for preventive care or an adult who meets goals for cardiac or diabetes care in the previous calendar year. Sets the maximum premium reduction at $15 per month per family. Requires the commissioner, in consultation with the exchange, to establish goals for preventive care, including cardiac and diabetes care. Requires the premium discount to be administered by the exchange. Provides a January 1, 2009, effective date.

Article 3: Health Information

Overview

This article contains provisions related to telemedicine, information exchange, and pay-for-use programs.

1 **Telemedicine consultations.** Amends § 256b.0625, subd. 3b. Requires the commissioner to develop policies for coverage of and payment for additional telemedicine services, including patient communications by e-mail, teleconferencing, telephone consultations, and other virtual visits or consultations. Strikes language stating that a telephone conversation between two physicians is not a telemedicine consultation.

2 **Statewide information exchange.** Authorizes the Minnesota health care connection to build a statewide information exchange, assist in local and regional data exchange efforts, and ensure that data exchange projects are consistent with national technology platforms and networks.

3 **Pay-for-use programs.** Requires the commissioner of human services to adopt pay-for-use programs that offer financial incentives to providers to implement and use health care information technology in clinical practice. In order to be eligible for payments, requires the information technology to meet national standards and provide clinicians with data to

improve the quality and safety of patient care.

Appropriation. (a) Appropriates money from the health care access fund to the commissioner of health for FY 2008, to provide grants under section 144.3345 to health care providers in rural and underserved communities for interoperable and transferable health information technologies.

(b) Appropriates money from the general fund to the commissioner of human services for fiscal years 2008 and 2009, for electronic health information pay-for-use programs.