HOUSE RESEARCH

Bill Summary

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This bill establishes the Minnesota health plan and the Minnesota health board, and establishes the Minnesota health fund. The bill specifies eligibility, covered services, and payment and governance procedures. The bill also establishes regional health boards, the office of health quality and planning, the ombudsman office for patient advocacy, and other entities to assist in implementation and administration of the plan.

Article 1: General Provisions

Section

1 **Health plan requirements.** Adds § 62V.01. Requires the Minnesota health plan, in order to keep Minnesotans healthy and provide the best quality of health care, to meet the following requirements:

(1) ensure all Minnesotans receive quality care, regardless of income;

(2) not restrict, delay, deny, or reduce the quality of care to hold down costs, but reduce costs through prevention, efficiency, and reduction of bureaucracy;

(3) cover all necessary care, including all coverage required by law, complete mental health services, chemical dependency treatment, prescription drugs, medical equipment and supplies, dental care, long-term care, and home care services;

(4) allows patients to choose their providers;

(5) be funded through premiums based on ability to pay and other revenue sources;

(6) focus on preventive care and early intervention;

(7) ensure an adequate number of providers;

(8) continue Minnesota's leadership in medical education, training, research, and technology; and

(9) provide adequate and timely payments to providers.

2 **Minnesota health plan general provisions.** Adds § 62V.02.

Subd. 1. Short title. States that this chapter may be cited as the Minnesota Health Act.

Subd. 2. Purpose. Requires the Minnesota health plan to provide all medically necessary health care services for all Minnesota residents in a manner that meets the requirements of § 62V.01.

Subd. 3. Definitions. Defines the following terms: board, plan, fund, medically necessary, institutional provider, and noninstitutional provider.

Subd. 4. Ethics and conflict of interest. (a) States that all requirements of § 43A.38 (code of ethics for executive branch employees) apply to employees and the executive director of the Minnesota health plan, members and directors of the Minnesota health board, the regional health boards, the director of the office of health quality and planning, the director of the Minnesota health fund, and the ombudsman. Provides that failure to comply is grounds for disciplinary action.

(b) Prohibits the Minnesota health plan executive officer from engaging in specified activities, in order to avoid the appearance of political bias or impropriety.

(c) Prohibits the individuals specified in paragraph (a), with the exception of the five provider members of the board, from being currently employed by a medical provider or pharmaceutical, medical insurance, or medical supply company.

Subd. 5. Data practice. Requires other state agencies to cooperate with data sharing and provide all requested information to the board or board designee, the ombudsman, the director of the office of health quality and planning, and the inspector general.

3 **Rulemaking procedures.** Amends § 14.03, subd. 3. States that the definition of a rule does not include any schedules or provisions for payment under § 62V.05.

Article 2: Eligibility

1 **Eligibility.** Adds § 62V.03.

Subd. 1. Residency. States that all Minnesota residents are eligible for the Minnesota health plan. Requires the board to establish standards to prevent people from moving to the state for medical care.

Subd. 2. Enrollment; identification. Requires the board to establish a procedure to enroll residents and provide each with identification to be used by health care providers to confirm eligibility. Requires the application to be no more than two

pages.

Subd. 3. Residents temporarily out of state. (a) Requires the plan to provide coverage to Minnesota residents who are temporarily out of state who intend to return and reside in Minnesota.

(b) Requires coverage for emergency care obtained out of state to be at prevailing local rates, and coverage for nonemergency care obtained out of state to be at rates set by the board. Allows the board to require residents to be transported back to Minnesota if certain conditions are met.

Subd. 4. Visitors. Requires nonresidents visiting Minnesota to be billed for all services received under the plan, and allows the board to enter into agreements for reciprocal coverage.

Subd. 5. Nonresident employed in Minnesota. Allows the board to extend eligibility to nonresidents employed in Minnesota using a sliding premium scale.

Subd. 6. Retiree benefits. (a) Provides that persons eligible for retiree medical benefits shall remain eligible, provided the contractually mandated payments for those benefits are made to the Minnesota health fund. Requires the fund to assume financial responsibility for care under the contract and for additional benefits covered by the plan. Provides that retirees residing outside of Minnesota are eligible for benefits under the terms and conditions of the employer-employee contract.

(b) Allows the board to establish financial arrangements with states and foreign countries to facilitate meeting the terms of the contracts under paragraph (a). Requires care provided by non-Minnesota providers to Minnesota retirees to be reimbursed at rates established by the board.

Subd. 7. Presumptive eligibility. (a) States that an individual is presumed eligible for coverage under the plan if the individual arrives at a health facility unconscious, comatose, or unable to document eligibility or act on the individual's behalf. Also provides that a minor is presumed eligible.

(b) States that an individual brought to a facility under § 253B.05 (emergency holds) is presumed eligible.

(c) States that an individual involuntarily committed to an acute psychiatric facility or a hospital with psychiatric beds under § 253B.05 is presumed eligible.

(d) Requires health facilities to comply with state and federal provisions governing emergency medical treatment.

Article 3: Benefits

1 **Benefits.** Adds § 62V.04

Subd. 1. General provisions. Allows eligible individuals to receive plan services

from any licensed participating provider. Prohibits a provider from refusing care to a patient on a basis specified in the definition of unfair employment practice.

Subd. 2. Covered benefits. States that covered benefits include all medically necessary care, subject to the limitations of subdivision 4. Lists specific covered services.

Subd. 3. Benefit expansion. Allows the board to expand benefits beyond the minimum benefits described in this section, when expansion meets the intent of this chapter and there are sufficient funds.

Subd. 4. Exclusions. Lists health care services excluded under the plan.

Subd. 5. Prohibition. States that the plan shall not pay for prescription drugs from pharmaceutical companies that directly market drugs to consumers.

2 **Care coordination.** Adds § 62V.041. (a) Requires all patients to have a primary care provider, which may include registered nurses, physician assistants, or other providers. Allows a specialist to serve as the care coordinator if certain conditions are met.

(b) States that referrals are not required to see a specialist. Requires a patient choosing a specialist to choose a care coordinator, if the patient does not have one, and allows the plan to assist with choosing a primary care provider to coordinate care.

(c) Allows the board to establish or ensure the establishment of a computerized referral registry.

Article 4: Funding

1 **Minnesota health fund.** Adds § 62V.19.

Subd. 1. General provisions. (a) Requires the board to establish a Minnesota health fund to implement the plan and receive premiums and other revenues. Requires the fund to be administered by a director appointed by the board.

(b) Requires money collected, received, and transferred to be deposited in the fund to finance the plan.

(c) Requires money in the fund to be used exclusively to implement this chapter.

(d) Requires all claims for services rendered to be made to the fund.

(e) Requires all payments for health care services to be disbursed from the fund.

(f) Requires premiums and other revenues collected each year to be sufficient to cover that year's projected costs.

Subd. 2. Accounts. Requires the fund to have operating, capital, and reserve accounts.

Subd. 3. Budgets within the operating account. Requires the operating account

in the fund to be comprised of the following accounts and budgets:

(a) Medical services budget and account

(b) Prevention budget and account

(c) Program administration, evaluation, planning, and assessment budget and account

(d) Training, development, and continuing education budget and account

(e) Medical research budget and account

Subd. 4. Capital account. Requires the capital account to be used solely to pay for capital expenditures for institutional providers and all capital expenditures requiring board approval under § 62V.05, subd. 4.

Subd. 5. Reserve account. Specifies requirements for the plan's reserve. These include a requirement that reserves for state, city, and county health programs be transferred to the fund when the plan replaces these programs.

2 Revenue sources. Adds § 62V.20.

Subd. 1. Minnesota health plan premium. (a) Requires the board to:

(1) determine the aggregate costs of providing health care according to this chapter;

(2) develop an equitable and affordable premium structure, and a business health tax;

(3) develop a premium structure with an appropriate range and a cap on the maximum premium;

(4) in consultation with the Department of Revenue, develop an efficient means of collecting premiums and the business health tax; and

(5) coordinate with existing, ongoing funding sources from federal and state programs.

(b) Requires the board to submit to the governor and the legislature a report on the premium and business health tax structure, by January 15, 2011.

Subd. 2. Funds from outside sources. Allows institutional providers to raise and expend funds from sources other than the plan, including private or foundation donors. Requires contributions in excess of $500,000 to be reported to the board.

Subd. 3. Governmental payments. Requires the executive officer, and if required under the federal law the commissioners of health and human services, to seek all necessary waivers, exemptions, agreements, or legislation so that federal payments to the state for health care are paid directly to the plan, which shall then assume responsibility for all benefits and services previously paid for by the federal government. Specifies criteria for the federal contributions that are to be obtained.

Subd. 4. **Federal preemption.** (a) Requires the board to secure a repeal or waiver of any federal law that would preempt any provision of this chapter, and requires the commissioners of health and human services to provide all necessary

assistance.

(b) If a repeal or waiver cannot be secured, requires the board to adopt rules or seek state legislation consistent with federal law, to fulfill the purposes of this chapter.

(c) States that the plan is secondary to federal programs, to the extent federal funding is not transferred or that the transfer is delayed beyond the date initial benefits under the plan are provided.

Subd. 5. No-cost sharing. States that no deductible, copayment, coinsurance, or other cost-sharing shall be imposed for covered benefits.

3 Subrogation. Adds § 62V.21.

Subd. 1. Collateral source. Requires health care costs to be collected from collateral sources when available, or when the individual has a right of action. Defines "collateral source" and requires the board to negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources into the plan.

Subd. 2. Collateral source; negotiation. Specifies procedures for providing information on collateral sources to the board.

Subd. 3. Reimbursement. Specifies procedures for seeking and obtaining reimbursement from collateral sources.

Subd. 4. Defaults, underpayments, and late payments. (a) Provides that default, underpayment, or late payment of any tax or other obligation imposed by this chapter shall result in the remedies and penalties provided by law, except as otherwise provided.

(b) States that eligibility for benefits shall not be impaired by any default, underpayment, or later payment of premium or other obligation.

Article 5: Payments

1 Provider payments. Adds § 62V.05.

Subd. 1. General provisions. (a) Allows all health care providers licensed to practice in Minnesota to participate in the plan.

(b) Requires participating providers to comply with all federal laws and regulations governing referral fees and fee splitting, whether or not reimbursed by federal funds.

(c) States that a fee schedule or financial incentive may not adversely affect patient care.

Subd. 2. Payments to noninstitutional providers. (a) Requires the board to establish and oversee a uniform fee schedule for noninstitutional providers.

(b) Requires payment based on negotiated rates, and allows rates to factor in geographic differences to address provider shortages.

(c) Requires the board to examine the need for and methods of paying providers for care coordination.

(d) Allows providers to request reimbursement of ancillary health care or social services previously funded by money now received and disbursed by the fund.

(e) Prohibits providers accepting plan payments from billing patients for covered services.

(f) Requires providers to be paid within 30 business days for claims filed.

Subd. 3. Payments to institutional providers. (a) Requires the board to establish annual budgets for institutional providers, consisting of an operating and capital budget. Requires annual budgets to be negotiated to cover anticipated services for the next year based on past performance and projected changes in prices and service levels.

(b) Prohibits providers accepting plan payments from billing patients for covered services.

Subd. 4. Capital management plan. (a) Requires the board to periodically develop a capital investment plan for determining annual budgets of institutional providers and deciding whether to approve applications for capital expenditures by noninstitutional providers.

(b) Requires providers who propose to make capital purchases over $500,000 to obtain board approval, allows the board to alter the threshold expenditure level, and sets related requirements.

Article 6: Governance

1 **Contested case procedures.** Amends § 14.03, subd 2. States that contested case proceedings do not apply to the Minnesota health plan.

2 **Group I salary limits.** Amends § 15A.0815, subd. 2. Prohibits the salary of the executive director of the Minnesota health plan from exceeding 95 percent of the governor's salary.

3 **Minnesota health board.** Adds § 62V.06.

Subd. 1. Establishment. Establishes the Minnesota health board. Requires the board to administer the Minnesota health plan and to oversee the office of health quality and planning, and the Minnesota health fund.

Subd. 2. Board composition. Specifies that the 15 member board shall include a representative selected by each of the five rural regional planning boards and three representatives selected by the metropolitan regional health planning board, who shall in turn select one consumer member, one employer member, and five health care providers (including one primary care physician, one registered nurse, one mental health provider, one dentist, and one facility director).

Subd. 3. Term and compensation; selection of chair. Specifies terms, compensation, and selection of a chair.

Subd. 4. General duties. Requires the board to:

(1) ensure that the requirements of § 62V.01 are met;

(2) hire an executive officer for the Minnesota health plan;

(3) hire a director for the office of health quality and planning;

(4) hire a director of the Minnesota health fund;

(5) provide technical assistance to regional boards;

(6) conduct necessary investigations and inquiries and require the submission of information necessary to carry out the purposes of the chapter;

(7) establish a process for the board to receive public input and the means of addressing public concerns;

(8) conduct other activities the board considers necessary to carry out the purposes of this chapter;

(9) collaborate with agencies that license facilities;

(10) adopt necessary rules;

(11) establish conflict of interest standards for providers;

(12) establish conflict of interest standards for pharmaceutical marketing; and

(13) create a program to provide support and retraining for workers dislocated by the creation of the plan. Also specifies related criteria.

Subd. 5. Conflict of interest committee. Requires the board to establish a conflict of interest committee, and specifies duties.

Subd. 6. Financial duties. Lists financial duties of the board. These include, but are not limited to, establishing and collecting premiums, approving statewide and regional budgets, establishing provider payment rates, paying claims, and ensuring appropriate cost control.

Subd. 7. Minnesota health board management duties. Lists management duties of the board. These include, but are not limited to, developing and implementing enrollment procedures for providers and eligible persons, implementing eligibility standards, establishing an electronic claims and payment system, establishing a public web site, and reporting annually to the legislature.

Subd. 8. Policy duties. Lists policy duties of the board.

4 **Health planning regions.** Adds § 62V.07. Establishes a metropolitan health planning region. Requires the commissioner of health, by October 1, 2010, to designate five rural

health planning regions, based on specified criteria.

5 **Regional health planning board.** Adds § 62V.08.

Subd. 1. Regional planning board composition. Specifies membership and governance.

Subd. 2. Regional health board duties. Requires regional health boards to recommend health standards, goals, priorities, and guidelines for the region, prepare and operating and capital budget for the region to recommend to the Minnesota health board, and carry out other listed duties.

6 **Office of health quality and planning.** Adds § 62V.09.

Subd. 1. Establishment. Requires the Minnesota health board to establish an office of health quality and planning to assess the quality, access, and funding adequacy of the Minnesota health plan.

Subd. 2. General duties. Requires the office to make annual recommendations to the board on specified subjects, analyze health care workforce shortages and develop plans to meet these needs, and assist in coordination of the Minnesota health plan and public health programs.

Subd. 3. Assessment and evaluation of benefits. Requires the office to consider and evaluate benefit additions, establish a process for providers to request authorization of services and treatments not included in the plan, evaluate proposals to increase the efficiency and effectiveness of health care delivery, and identify complementary and alternative modalities.

7 **Ombudsman office of patient advocacy.** Adds § 62V.10. Establishes the ombudsman office for patient advocacy to represent the interests of consumers and serve as a patient advocate. Lists duties of the ombudsman.

8 **Grievance system.** Adds § 62V.11. Requires the ombudsman for patient advocacy to establish a grievance system for all complaints. Specifies procedures to be followed. Specifies that the ombudsman's order of corrective action is binding on the Minnesota health plan. Allows decisions to be appealed in district court.

9 **Inspector general for the Minnesota health plan.** Adds § 62V.12. Establishes the inspector general for the Minnesota health plan within the Office of Attorney General and specifies that the inspector general is appointed by the attorney general. Requires the inspector general to investigate, audit, and review the financial and business records of entities providing services or products to the plan, investigate allegations of misconduct and patterns of fraud, and carry out other listed duties.

10 **Examination by legislative auditor.** Adds § 62V.13. Provides that the books and all operating policies and procedures of the Minnesota health board are subject to examination by the legislative auditor.

Article 7: Implementation

1 **Appropriation.** Appropriates money for FY 2011 from the general fund to the Minnesota health fund, to provide start-up funding for this act.

2 **Repealer.** Repeals unspecified sections related to the provider tax, MinnesotaCare, medical assistance, and general assistance medical care.

3 **Effective date and transition.**

Subd. 1. Notice and effective date. States that the act is effective the day following final enactment. Requires the commissioner of finance to notify the chairs of the house and senate committees with jurisdiction over health care when the Minnesota health fund has sufficient revenues to implement the act.

Subd. 2. Timing to implement. Requires the Minnesota health plan to be operational within two years of enactment.

Subd. 3. Prohibition. Once the Minnesota health plan becomes effective, states that health plans may not be sold in Minnesota for services provided by the plan.

Subd. 4. Transition. (a) Requires the commissioners of health and human services to prepare an analysis of the state's capital expenditure needs to assist the board in adopting the statewide capital budget for the year following implementation.

(b) Specifies the following implementation timelines:

(1) the commissioner of health shall designate health planning regions three months after enactment;

(2) the regional health boards shall be established six months after enactment;

(3) the Minnesota health board shall be established nine months after enactment; and

(4) the commissioner of health, or a designee, shall convene the first meeting of each regional board and the Minnesota health board within 30 days after each of the boards has been established.