HOUSE RESEARCH

Bill Summary

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Overview

This bill establishes a defined contribution program for MinnesotaCare enrollees who are adults without children, or families and children, with incomes equal to or greater than 133 percent of the federal poverty guidelines (FPG). The MinnesotaCare program currently provides coverage to adults without children with incomes up to 250 percent of the federal poverty guidelines and to families and children with incomes up to 275 percent of the federal poverty guidelines, through contracts with managed care and county-based purchasing plans.

The bill also requires the commissioner of human services to: (1) modify the health care programs application form and to refer certain veterans to county veterans service officers for assistance in obtaining veterans benefits; (2) develop a plan to redesign service delivery for MinnesotaCare enrollees who are adults without children or families and children with incomes less than 133 percent of FPG; (3) apply for federal waivers to cover MinnesotaCare families with children, and MinnesotaCare parents, guardian, and caretakers, under the defined contribution program; and (4) apply for federal demonstration waiver that would provide an annual allotment for medical assistance in return for program flexibility.

The bill also requires the Minnesota Comprehensive Health Association to offer a high-deductible, basic plan, and specifies plan benefits and premiums.

1 **Establishment.** Amends § 62E.08, subd. 1. Provides that the MCHA premium for the high-deductible, basic plan offered under § 62E.121 shall range from 101 to 125 percent of the weighted average of rates for comparable plans offered outside of MCHA.

2 **High-deductible, basic plan.** Adds § 62E.121.

Subd. 1. Required offering. Requires MCHA to offer a high deductible, basic plan that meets the requirements in this section. Specifies that the plan is a one-person plan and that dependents must be covered separately.

Subd. 2. Annual deductible; out-of-pocket maximum. (a) Requires the plan to provide in-network annual deductible options of $3,000, $6,000, $9,000, and $12,000, with an in-network out-of-pocket maximum that is $1,000 greater than the amount of the annual deductible.

(b) Provides an annual increase in the deductible, based on the change in the CPI.

Subd. 3. Office visits for nonpreventive care. Specifies different levels of copayments for the first three nonpreventive office visits, depending upon the deductible option chosen. Provides 80 percent

coverage for subsequent visits, after the deductible is met.

Subd. 4. Preventive care. Provides 100 percent coverage for preventive care, with no cost-sharing.

Subd. 5. Prescription drugs. Requires a $10 copayment for preferred generic drugs, and requires enrollees to pay 100 percent of the plan's rate for preferred brand name drugs.

Subd. 6. Convenience care center visits. Requires a $20 copayment for the first three convenience center visits, with 80 percent coverage for subsequent visits after the deductible is met.

Subd. 7. Urgent care center visits. Requires a $100 copayment for the first urgent care visit, and provides 80 percent coverage for subsequent visits after the deductible is met.

Subd. 8. Emergency room visits. Requires a $200 copayment for the first emergency room visit, and provides 80 percent coverage for subsequent visits after the deductible is met.

Subd. 9. Lab and x-ray; hospital services; ambulance; surgery. Provides that these services are covered at 80 percent after the deductible is met.

Subd. 10. Eyewear. Pays $50 per calendar year for eyewear.

Subd. 11. Maternity. Specifies that maternity, labor and delivery, and postpartum care are not covered. Provides 100 percent coverage for prenatal care with no deductible.

Subd. 12. Other eligible health care services. Provides 80 percent coverage for other eligible health care services after the deductible is met.

Subd. 13. Option to remove mental health and substance abuse coverage. Allows enrollees to remove mental health and substance abuse coverage and receive a reduced premium.

Subd. 14. Option to upgrade prescription drug coverage. Allows enrollees to upgrade prescription drug coverage in return for an increased premium.

Subd. 15. Out-of-network services. Provides that: the out-of-network deductible is twice the in-network annual deductible; there is no out-of-pocket maximum for out-of-network services; out-of-network benefits are covered at 60 percent after the deductible is met; and the lifetime maximum for out-of-network services is $1 million.

Subd. 16. Services not covered. Lists services not covered by the plan.

3 **Waiver of preexisting conditions for persons covered by healthy Minnesota contribution program.** Amends § 62E.14, by adding subd. 4f. Allows individuals to enroll in an MCHA plan with a waiver of the preexisting condition limit, if they are eligible for the healthy Minnesota contribution program and have been denied private sector coverage.

4 **Applications for medical assistance.** Amends § 256B.04, subd. 18. Requires the commissioner to modify the Minnesota health care programs application form to add a question asking applicants if they are U.S. military veterans.

5 **Healthy Minnesota contribution program.** Adds § 256L.031.

Subd. 1. Defined contribution to enrollees. (a) Requires the commissioner, beginning January 1, 2012, to provide MinnesotaCare enrollees who are adults without children, with gross family income equal to or greater than 133 percent of FPG, with a monthly defined contribution to purchase a health plan. Requires the commissioner, beginning January 1, 2012, or upon federal approval, whichever is later, to provide MinnesotaCare enrollees who are families and children, with gross family income equal to or greater than 133 percent of FPG, with a monthly defined contribution to purchase a health plan.

(b) Exempts these enrollees from MinnesotaCare premiums, and required enrollment in a managed care or county-based purchasing plan.

(c) Provides that the provisions related to MinnesotaCare covered services and cost-sharing (§ 256L.03), the effective date of coverage (§ 256L.05, subd. 3), and provider payment rates (§ 256L.11) do not apply to these enrollees. Covered services, cost-sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage are as provided by the terms of the health plan purchased by the enrollee.

(d) States that all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration continue to apply, unless otherwise provided in this section.

Subd. 2. Use of defined contribution. Allows enrollees to use up to the monthly defined contribution only to pay premiums for coverage under a health plan.

Subd. 3. Determination of defined contribution amount. (a) Requires the commissioner to determine the defined contribution amount using a sliding scale, under which the per-person defined contribution is a function of age and income. Specifies the monthly per-person base contribution for age groups, ranging from $122.79 for persons under age 21 to $357.19 for persons age 60 and over. The base contribution is multiplied by a percentage inversely related to income, ranging from 150 to 80 percent, to obtain the monthly per-person defined contribution amount.

(b) Requires the defined contribution amount calculated under paragraph (a) to be increased by 20 percent for enrollees who are denied coverage in the private individual market and who purchase coverage through the Minnesota Comprehensive Health Association (MCHA).

(c) Limits the monthly defined contribution to 90 percent of the maximum monthly premium for the health plan purchased by the enrollee. Reduces the monthly defined contribution amount by five percent if the enrollee purchases coverage that does not include mental health services and chemical dependency treatment services.

Subd. 4. Administration by commissioner. Requires the commissioner to administer the defined contributions, by calculating and processing defined contributions for enrollees and paying the defined contribution to health plan companies or MCHA, as applicable.

Subd. 5. Assistance to enrollees. Requires the commissioner of human services, in consultation with the commissioner of commerce, to develop an efficient and cost-effective method to refer applicants to professional insurance agent associations.

Subd. 6. MCHA. Beginning July 1, 2012, makes MinnesotaCare enrollees who are denied coverage under an individual health plan eligible for coverage under MCHA. Requires incremental costs to MCHA resulting from implementation of this act to be paid from the health care access fund.

Subd. 7. Federal approval. Requires the commissioner to seek all federal approvals and waivers necessary to implement coverage for enrollees eligible as families and children, with gross family incomes equal to or greater than 133 percent of FPG, while continuing to receive federal funds.

6 **Referral of veterans.** Amends § 256L.05, by adding subd. 6. Requires the commissioner to ensure that all MinnesotaCare applicants with incomes less than 133 percent of FPG, who identify themselves as veterans, are referred to a county veterans service officer for assistance in applying to the U.S. Department of Veterans Affairs for any VA benefits for which they are eligible.

7 **Coverage for lower-income MinnesotaCare enrollees.** Requires the commissioner of human services to develop and present to the legislature, by December 15, 2011, a plan to redesign service delivery for MinnesotaCare enrollees who are adults without children or families and children, with incomes less than 133 percent of FPG. Specifies plan criteria and requires the commissioner to consider innovative methods of service delivery, including but not limited to increasing the use and choice of private health plan coverage and encouraging the use of community clinics as health care homes.

8 **Direction to commissioner; federal waiver.** (a) Requires the commissioner of human services to apply to the Centers for Medicare and Medicaid Services, by July 1, 2011, for federal waivers to cover: (1) MinnesotaCare families and children; and (2) MinnesotaCare parents, guardians and caretakers, under the Healthy Minnesota

Contribution Program. Requires the commissioner to report to the relevant legislative committees whether or not the waiver application is accepted, within ten working days of the decision. Provides an immediate effective date.

(b) Requires the commissioner of human services to apply to CMS for a demonstration waiver and any other necessary waivers and amendments, that would provide the state with medical assistance program flexibility in exchange for federal budget certainty. Requires the commissioner to seek federal approval to enter into an agreement with CMS under which Minnesota would accept an aggregate annual allotment for MA, trended forward and with protections to cover medical inflation and projected caseload growth, and receive federal waivers of specified medical assistance program requirements.

Provides an immediate effective date.