HOUSE RESEARCH

Bill Summary

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Article 1: Public Health

Overview

This article establishes a statewide health improvement program and provides certain requirements for local communities to receive funding for this program.

1 Statewide health improvement program. Adds § 145.986. Establishes a statewide health improvement program.

Subd. 1. Goals. E stablishes the goals of the statewide health improvement program.

Subd. 2. Grants to local communities. States that beginning January 1, 2009, the commissioner of health shall award grants to community health boards and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at achieving health improvement goals.

Requires local communities to submit health improvement plans in order to receive a grant and requires a 10 percent local match.

States that by January 15, 2011 , the commissioner must recommend whether funding should be provided to local communities based on health disparities in the populations served.

Subd. 3. Outcomes. Requires the commissioner to set performance measures and annually review the progress of local communities in meeting these measures.

Subd. 4. Technical assistance and oversight. Requires the commissioner to provide technical assistance and training to grant recipients. Requires the commissioner to ensure that the program meets the outcomes by conducting a statewide evaluation and assist recipients to modify interventions if ineffective.

Subd. 5. Evaluation. Requires the commissioner to conduct a biennial evaluation of the program, and requires that grant recipients cooperate in this evaluation and provide the commissioner with necessary information.

Subd. 6. Report. Requires the commissioner to submit a biennial report to the legislature on the health improvement program by January 15 of every other year, beginning in 2010. Requires that the first report include recommendations on sustainable sources of funding.

Subd. 7. Supplantation of existing funds. States that community health boards and tribal governments must use the funds for this program to develop new programs or expand current programs and funds may not supplant current state or federal funding.

Article 2: Health Care Homes

Overview

This article establishes certification and other requirements for health care homes, requires payment of care coordination fees, increases payment rates for certain primary care physicians, and requires a study of workforce issues.

1 Health Care Homes. Adds § 256B.0751.

Subd. 1. Definitions. Defines the following and other terms. "Commissioner" is defined as the commissioner of human services and "commissioners" as the commissioners of human services and health acting jointly. "Personal clinician" is defined as a physician, physician assistant, advanced practice nurse, and other health care providers as determined by the commissioner of health. "State health care program" is defined as the MA, MinnesotaCare, and GAMC programs.

Subd. 2. Development and implementation of standards. (a) By July 1, 2009 , requires the commissioners to develop and implement standards of certification for health care homes for state health care programs. Requires the commissioners to consider existing standards developed by national independent accrediting and medical home organizations. Specifies criteria that the standards must meet.

(b) Requires the commissioners, in developing the standards, to consult with national and local organizations working on health care home models, health care providers, relevant state agencies, health plans, and hospitals. Specifies that the commissioners may meet this requirement by continuing the provider directed care coordination advisory committee.

(c) Exempts the commissioners from the rulemaking requirements of chapter 14, for purposes of developing and implementing these standards.

Subd. 3. Requirements for clinicians certified as health care homes. (a) Allows a personal clinician or primary care clinic (at which all of the clinic's clinicians meet the criteria of a health care home) to be certified as a health care home. Requires clinicians and clinics to meet standards set by the commissioners under this section. Specifies that certification as a health care home is voluntary. Requires annual renewal of certification.

(b) Requires clinicians or clinics certified as health care homes to offer their health care home services to all of their patients with complex or chronic health conditions who are interested in participation.

(c) Requires health care homes to participate in the health care home learning collaborative.

Subd. 4. Alternative models. States that this section does not preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services, and does not preclude the commissioner from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs or certain managed care long-term care programs, or are dually eligible, in the waiting period for Medicare, or have other primary coverage.

Subd. 5. Health care home collaborative. By July 1, 2009 , requires the commissioners to establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 6. Evaluation and continued development. (a) For continued certification, requires health

care homes to meet process, outcome, and quality standards as developed and specified by the commissioners. Requires the commissioners to collect data from health care homes necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on quality, cost, and outcomes.

(b) Allows the commissioners to contract with a private entity to evaluate the effectiveness of health care homes. Classifies data collected under this subdivision as nonpublic.

Subd. 7. Outreach. Upon implementation of the certification process and standards, requires the commissioner to encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

2 Care coordination fee. Adds § 256B.0752.

Subd. 1. Development. Requires the commissioner of human services to develop a payment system that provides per-person care coordination payments to health care providers for providing care coordination services and managing or employing care coordinators. In order to be eligible for a payment, a health care provider must be certified as a health care home. Requires the care coordination payment to vary with thresholds of care complexity, with the highest fees paid for care provided to individuals requiring the most intensive care coordination and those who face racial, ethnic, or language barriers. Allows the commissioner to phase-in care coordination fees, with fees applied first to individuals who have, or are at risk of developing, complex or chronic health conditions, and to coordinate with implementation of provider-directed care coordination payments. Requires development of the payment system to be complete by January 1, 2010 .

Subd. 2. Payment of care coordination fee. By July 1, 2010 , requires the commissioner of human services to pay each certified health care home a per-person care coordination fee for providing care coordination services to state health care program enrollees served under fee-for-service. Requires the fee to be determined in contracts with health care homes. States that the fee is contingent on the health care home meeting certification standards and is in addition to regular MA reimbursement.

Subd. 3. Managed care and county-based purchasing. By July 1, 2010 , requires the commissioner of human services to require managed care and county-based purchasing plans serving state program enrollees under MA, GAMC, and MinnesotaCare to implement a care coordination payment system for state health care program enrollees receiving care coordination services. Requires the system to be designed in accordance with section 62U.05 (care coordination payment requirements for health plan companies).

Subd. 4. Cost neutrality. If initial savings from the implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner, allows the commissioner to make recommendations to the legislature on reallocating costs within the health care system.

Provides an effective date for the section of July 1, 2010 , or upon federal approval, whichever is later.

3 Health care home reporting requirements. Adds § 256B.0753.

Subd. 1. Standards and criteria review. Prior to implementation, requires the commissioners to report certification standards and evaluation criteria for health care homes to the Legislative Commission on Health Care Access. States that these standards are not subject to chapter 14 and that the provisions in section 14.386 (two year effective period and procedural requirements for exempt rules) also do not apply.

Subd. 2. Annual reports on implementation and administration. Requires the commissioners to report annually to the legislature on the implementation and administration of the health care home model for state health care program enrollees, beginning January 15, 2011 . Requires the annual report

to include a cost benefit analysis of implementation.

Subd. 3. Evaluation reports. Requires the commissioners to provide to the legislature comprehensive evaluations of the health care home model, three and five years after implementation. Specifies criteria for the evaluation report.

4 Primary care physician reimbursement rate increase. Adds § 256B.766. (a) For services provided on or after January 1, 2009 , requires the commissioner of human services to increase reimbursement to primary care physicians who meet the requirements in paragraph (b). Allows reimbursement to be increased by up to 50 percent above the regular rate. Requires payments to health plan companies to be adjusted to reflect the rate increase.

(b) Requires the commissioner, in collaboration with the Office of Rural Health, to determine areas of the state in need of primary care physicians. Requires the commissioner, by September 1, 2008 , and each September 1 thereafter, to accept applications from primary care physicians who agree to practice in an underserved area for at least five years, and determine participant eligibility.

(c) Allows the commissioner to reconsider the designated areas. States that a primary care physician who agrees to practice in an underserved area shall receive the increased payment rate for at least five years, unless the physician discontinues practicing in the designated area.

(d) Allows a clinic or medical group to submit applications on behalf of primary care physicians who will be hired, prior to filling the vacant positions.

5 Workforce shortage study. Requires the commissioner of health, in consultation with licensing boards and professional associations, to address health care workforce shortages by studying changes in health professional licensure and regulation necessary to ensure full utilization of advanced practice registered nurses, physician assistants, and other licensed health care professionals in the health care home and primary delivery system. Requires the commissioner to make recommendations to the legislature by January 15, 2009 .

Article 3: Increasing Access; Continuity of Care

Overview

This article contains provisions relating to increasing access and improving the continuity of care.

1 **Free and reduced school lunch program data sharing.** Adds § 124D.1115. (a) Requires each school participating in the federal school lunch program to electronically send to the Department of Education eligibility information on each child participating in the program, unless the child's parent or legal guardian elects not to have this information disclosed.

(b) Requires the Department of Education to enter into an agreement with the Department of Human Services to share the eligibility information provided under paragraph (a), to identify persons eligible for MA or MinnesotaCare. Specifies duties for the Department of Human Services related to maintaining the privacy of the data.

2 Automation and coordination for state health care programs. Amends § 256.01, by adding subd. 27. (a) Defines "state health care program" as the MA, MinnesotaCare, and GAMC programs.

(b) Requires the commissioner, by July 1, 2009, to improve coordination between state health care and social service programs, and to develop and use automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program. Requires the commissioner, by January 15, 2009 , to recommend to the legislature any changes necessary to improve coordination and automation.

(c) Requires the commissioner, by January 15, 2010 , to establish and implement an automated process to send out, upon request, state health care program renewal forms in the appropriate foreign language, and to inform applicants of this option.

(d) Beginning July 1, 2008 , requires the commissioner, county social service agencies, and health care providers to update state health care program enrollee addresses and contact information, at the time of each enrollee contact.

3 Incentive Program. Amends § 256.962, subdivision 5. Increases from $20 to $25 the application assistance bonus for organizations that identify and assist potential state health care program enrollees.

4 School Districts . Amends § 256.962, subdivision 6. Modifies the outreach requirements for school districts by requiring the district to provide information on how to obtain an application for the Minnesota health care programs and application assistance instead of mailing an application to families who are eligible for the free or reduced school lunch program. Also modifies the requirement that districts provide follow-up services to families who are eligible for the free or reduced lunch program, by requiring the district to provide application assistance and follow-up to families who have indicated an interest in receiving information or an application. Clarifies that a district is eligible for the application assistance bonus.

5 Children under age two. Amends § 256B.057, subd. 8. Increases the MA income standard for children under age two from 280 to 305 percent of FPG. Provides an effective date of January 1, 2010 , or upon federal approval, whichever is later.

6 Families with children. Amends § 256L.04, subd. 1. Increases the MinnesotaCare income limit for families and children from 275 to 300 percent of the federal poverty guidelines (FPG). Eliminates the "hard" income limit of $50,000 for parents on MinnesotaCare. Provides an effective date of July 1, 2010 , or upon federal approval, whichever is later.

7 Single adults and households with no children. Amends § 256L.04, subd. 7. Increases the MinnesotaCare income limit for adults with no children from 200 to 300 percent of FPG, effective July 1, 2010 . (Under current law, this income limit is scheduled to be increased to 215 percent of FPG, effective July 1, 2009 .)

8 Renewal of eligibility. Amends § 256L.05, subdivision 3a. The amendment to paragraph (b) , allows MinnesotaCare enrollees to renew eligibility at community clinics, provider offices, and other designated locations if there is no change in circumstances that affects eligibility. Requires the designated sites to forward renewal forms to the commissioner.

Paragraph (d) allows MinnesotaCare enrollees who fail to submit renewal forms and related documentation in a timely manner to remain eligible for one additional month beyond the current eligibility period before being disenrolled. Provides that the enrollee remains responsible for premiums for the additional month.

Provides an effective date of January 1, 2009 , or upon federal approval, whichever is later.

9 Delayed verification. Amends § 256L.05, by adding subd. 6. Provides that MinnesotaCare applicants with gross income less than 90 percent of the program income standard who meet all other eligibility requirements, including documenting citizenship or nationality at the time of application, shall be determined eligible based on information in the application and enrolled upon premium payment. Provides that applicants who do not provide all verifications within 60 days will have eligibility denied or cancelled. Prohibits these individuals from being eligible for coverage using delayed verification for 12 months. Provides an effective date of January 1, 2009 , or upon federal approval, whichever is later.

10 Commissioner's duties and payment. Amends § 256L.06, subd. 3. Provides that MinnesotaCare enrollees who fail to pay premiums will be disenrolled effective the first day of the calendar month following the month for which the premium was due. (Under current law, disenrollment is effective the month for which the premium is due.) Requires the commissioner to waive premium repayment for this coverage when disenrolled persons reapply under § 256L.05, subd. 3b. (This section requires persons who reapply after a lapse of one

month or more to meet all eligibility criteria. These include criteria in rule that require persons disenrolled for failure to pay premiums to pay any unpaid premiums when re-enrolling.)

Provides an effective date of January 1, 2009 , or upon federal approval, whichever is later.

11 General requirements. Amends § 256L.07, subd. 1. Eliminates the "hard" income cap of $50,000 a year for parents on MinnesotaCare that applies whether or not income exceeds the 275 percent of FPG program income limit. Makes conforming changes related to elimination of the four-month insurance barrier and the increase in the program income limit. Provides that the change related to the four-month requirement is effective January 1, 2009 , or upon federal approval, whichever is later. The changes related to the increase in the income standard and to elimination of the income cap are effective July 1, 2010 .

12 Other health coverage. Amends § 256L.07, subd. 3. Eliminates the requirement that MinnesotaCare applicants and enrollees have no health coverage for at least four months prior to application and renewal, and makes conforming changes. Provides an effective date of January 1, 2009 , or upon federal approval, whichever is later.

13 Sliding fee scale; monthly gross individual or family income. Amends § 256L.15, subd. 2. Beginning July 1, 2009 , requires MinnesotaCare enrollees to pay premiums based on the affordability scale established in § 62U.09, which would require a maximum enrollee contribution of seven percent of income. (Under current law, the maximum MinnesotaCare premium is 9.8 percent of gross household income; this includes a 2003 premium increase that the Legislature eliminated, but for which federal approval of the elimination is still pending.) Retains the $4 monthly premiums for children with family incomes that do not exceed 150 percent of FPG. Makes a conforming change related to the increase in the program income limit. Provides an effective date of January 1, 2009 , or upon federal approval, whichever is later, except that the change related to the income limit is effective July 1, 2010 , or upon federal approval, whichever is later.

14 Effective date. Amends Laws 2007, chapter 147, article 5, section 19. Creates an effective date of July 1, 2008 , (regardless of whether federal approval has been received) for the change in the income definition for self-employed farmers passed last session (elimination of the requirement that depreciation be added back to income).

15 Repealer. Repeals § 256L.15, subd. 3 ($4 monthly MinnesotaCare premium for low-income children; this provision is reinstated elsewhere in the bill). Provides an effective date of July 1, 2009 , or upon federal approval of the amendments to § 256L.15, subd. 2, paragraph (c), whichever is later.

Article 4: Health Insurance Purchasing and Affordability Reform

Overview

This article contains provisions related to health insurance purchasing and making health coverage more affordable. The provisions related to reform include:

1. establishing an electronic prescription drug program;
2. establishing a value-based health benefit and set design;
3. reviewing existing health technology assessments;
4. developing a system of quality incentive payments to providers who meet specified targets;
5. developing a method to calculate providers' relative cost of care and relative quality of care;
6. developing a peer grouping system for providers;
7. establishing uniform definitions for baskets of care, starting with a minimum of 15 baskets;
8. specifying an affordability standard;
9. establishing Section 125 Plans;
10. developing a plan to provide employees with income below 400 percent of FPG and with employer-subsidized coverage with a subsidy; and
11. establishing a health care review council.

1 Interoperable electronic health record requirements. Amends § 62J.495, subdivision 3. R equires hospitals and health care providers, when implementing an interoperable health records system within their hospital or clinical practice, to use an electronic health record that is certified by the Certification Commission for Healthcare Information Technology or its successor.

2 Electronic prescription drug program. Adds § 62J.497. E stablishes an electronic prescription drug program.

Subd. 1. Definitions. Defines terms.

Subd. 2. Requirements for electronic prescribing. Requires all providers, group purchasers, prescribers, and dispensers to establish and maintain an electronic prescription drug program for transmitting prescriptions and prescription-related information using electronic media. States that this section does not require the use of electronic transmitting but, if it is used, then it must be done electronically using the standards described in the section.

Subd. 3. Standards for electronic prescribing. Requires prescribers and dispensers to use the NCDP SCRIPT Standard for the communication of a prescription or prescription-related information. States when this standard is to be used.

3 Definitions. Adds § 62U.01. D efines terms for chapter 62U.

4 Value-based benefit set and design. Adds § 62U.02. R equires the establishment of a value-based benefit and design.

Subd. 1. Creation. Requires the commissioner of health, by October 15, 2009 , to make recommendations to the legislature on the components and design of a value-based set of health benefits. Requires the commissioner to convene an advisory committee to assist in these recommendations.

Subd. 2. Operations of advisory committee. D escribes the operations of the advisory committee. Requires the members appointed by the commissioner to have expertise in benefit design and

development, including outcomes, actuarial analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits. Requires the committee to convene on or before September 1, 2008 , and requires meeting at least once a year and other times as necessary. Requires the commissioner to provide office space, equipment and supplies, and technical support. Specifies governance and provides that the committee does not expire.

Subd. 3. Immunity of liability. Establishes immunity of liability for the members of the advisory committee.

Subd. 4. Benefit set design. (a) R equires that the value-based set of health benefits provide individuals and families with access to a broad range of health care services, procedures, and diagnostic tests that are scientifically proven to be clinically effective and cost effective. Permits the benefit set to have differentiated co-pays and deductibles based on clinical effectiveness and cost effectiveness of a particular health care service. Requires the advisory committee to consider including dental care, mental health services, chemical dependency treatment, vision care, language interpreter services, emergency transportation, and prescription drugs.

(b) Requires the benefit set to identify certain services with minimal or no cost-sharing requirements.

(c) Requires the benefit set, to the extent possible, be designed to be affordable to Minnesotans consistent with the standard established in section 62U.09.

(d) Requires the benefit design to include a limited number of maximum cost-sharing variations based upon deductibles and maximum out-of-pocket costs. States that there must be no maximum lifetime benefit.

(e) Requires the Commissioners of Human Services and Finance to consider incorporating the benefit design into the state public health care programs and the state employee group insurance program.

(f) Requires the Commissioners of Health and Commerce to report to the Legislature on necessary changes to current mandated benefit sets to incorporate the benefit set design into these benefit sets.

Subd. 5. Continued review. R equires the commissioner to review the benefit set on an ongoing basis and adjust the benefit set as necessary, to ensure that the benefit design continues to be safe, effective, and scientifically based.

5 Health technology assessment review. Adds § 62U.03. Requires the commissioner to review existing health technology assessments of existing and new health technologies that have been conducted by existing programs, for possible inclusion in the value-based benefit set and design.

6 Payment restructuring; incentive payments based on quality of care. Adds § 62U.04. E stablishes a system of quality incentive payments.

Subd. 1. Development. Requires the commissioner to develop a standardized set of measures to access the quality of health care services offered by health care providers. Requires the measures to be based on medical evidence and be developed through a process in which providers participate. Requires the measures to be used for the incentive payment system developed under subdivision 2 .

Subd. 2. Quality incentive payments. Requires the commissioner, by July 1, 2009 , to develop a quality incentive payment system in which providers would be eligible for quality-based payments that are in addition to existing payment levels, based on provider performance against specified targets and, to the extent possible, adjusted for variations in patient population. States that the requirements of section 62Q.101, do not apply under this system.

Subd. 3. Quality transparency. Requires the commissioner to establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue annual public reports on provider quality, beginning July 1, 2010 . Requires physician clinics and hospitals by January 1,

2010 , to submit standardized electronic information on the outcomes and processes associated with patient care to the commissioner or the commissioner's designee. Requires the commissioner to ensure that any quality reporting requirements are not duplicative of quality reporting activities currently underway.

Subd. 4. Contracting. Authorizes the commissioner to contract with a private entity or consortium of private entities to complete tasks in subdivisions 1, 2, and 3. Requires the private entity or consortium to be nonprofit and have governance that includes representatives of various stakeholders. States that no stakeholder group may have a majority of the votes on any issue or hold extraordinary powers not granted to any other stakeholder.

Subd. 5. Implementation. Requires, by January 1, 2010 , health plan companies to use the standardized quality measures and not require providers to use and report health plan company specific quality and outcomes measures.

Requires by July 1, 2010 :

- DHS to implement the incentive payment system in the state health care programs consistent with relevant state and federal statute and rule;
- commissioner of finance to implement the system for participants in the state employees group insurance program (SEGIP); and
- All health plan company incentive-based performance payment systems to comply with subdivision 2 for all participating providers.

7 Payment restructuring; care coordination payments. Adds § 62U.05. R equires health plan companies, by July 1, 2010 , to integrate health care homes into their provider networks and to develop a payment system that provides care coordination payments to health care providers for providing care coordination services for enrollees who enroll in health care homes certified under section 256B.0751. States that nothing in this section shall restrict the ability of health plan companies to selectively contract with health care providers, including health care homes.

8 Payment reform to reduce health care costs and improve quality. Adds § 62U.06. E stablishes a payment reform framework to reduce health care costs and improve quality.

Subd. 1. Development of uniform standards. Requires the commissioner to develop uniform standards needed to implement an innovative payment reform that rewards quality and efficiency by January 1, 2010 .

Subd. 2. Calculation of health care costs and quality. R equires the commissioner to develop a method of calculating providers' (1) relative cost of care, defined as a measure of health care spending, including resource use and unit prices; and (2) relative quality of care. In developing this method the commissioner must address the following issues:

(1) Provider attribution of costs and quality;

(2) Appropriate adjustment for outlier or catastrophic cases;

(3) Appropriate risk adjustment;

(4) Specific types of providers that should be included in the calculation;

(5) Specific types of services that should be included in the calculation;

(6) Appropriate adjustment for variation in payment rates;

(7) The appropriate provider level for analysis;

(8) Payer mix adjustments; and

(9) Other factors that are determined by the commissioner to be needed to ensure validity and comparability of the analysis.

Subd. 3. Provider peer grouping. (a) R equires the commissioner to develop a peer grouping system for providers based on a combined measure of their risk-adjusted cost of care and quality of care and for specific conditions as determined by the commissioner. Requires the commissioner to consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota . States that in developing this system, the commissioner shall not contract with any entity that has or will have a direct financial interest in the outcome of the system.

(b) Requires the commissioner to disseminate information to providers on their cost of care, resource use, quality of care, and results of the index developed under this subdivision in comparison to an appropriate peer group, beginning June 1, 2010. States that any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the designee to review the underlying data and submit comments. Gives the provider 21 days to review the data for accuracy.

(c) Requires the commissioner to establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses and reports.

(d) Requires the commissioner, beginning September 1, 2010, and no less than annually thereafter, to publish information on provider cost, quality, and the results of the peer grouping process. States that published results must be on a risk-adjusted basis.

Subd. 4. Encounter data. (a) Requires health plan companies and third-party administrators to submit encounter data to a private entity designated by the commissioner of health, beginning July 1, 2009, and every six months thereafter. States the form and the requirements for submitting the data.

(b) Requires the commissioner or the commissioner's designee to use the data only for the purpose of carrying out its responsibilities under paragraph (a), and to maintain the data that it receives in accordance with this section.

(c) States that data collected under this subdivision are private data on individuals or nonpublic data as defined in section 13.02. Permits summary data prepared under this section to be derived from public data. Requires the commissioner to establish procedures and safeguards to protect the integrity and confidentiality of any data it

maintains.

(d) Prohibits the commissioner or the commissioner's designee from publishing any analyses or reports that identify or could potentially identify individual patients.

Subd. 5. Pricing data. (a) Requires health plan companies and third-party administrators to submit data on their contract prices with health care providers to a private entity designated by the commissioner, beginning July 1, 2009, and annually on January 1 thereafter, for the purpose of performing the analyses required under this section. Requires the data to be submitted in the form and manner specified by the commissioner.

(b) Limits the commissioner's use of the data submitted to the purpose of carrying out responsibilities under this section.

(c) States that the data collected under this subdivision are nonpublic data as defined in section 13.02. Permits the summary data prepared under this subdivision to be derived from public data. Requires the commissioner to establish procedures and safeguards to protect the integrity and confidentiality of any data it maintains.

Subd. 6. Contracting. Authorizes the commissioner to contract with a private entity or consortium to develop the standards under subdivision 1. Requires the private entity or consortium to be nonprofit and have governance that includes representatives of the various stakeholder groups. States that no stakeholder group may have a majority of the votes on any issue or hold extraordinary powers not granted to any other stakeholder.

Subd. 7. Provider innovation to reduce health care costs and improve quality. States that nothing in this section shall prohibit group purchasers and health care providers, upon mutual agreement, from entering into arrangements that establish package prices for a comprehensive set of services or separately for the cost of care for specific health conditions in addition to the basket of care in section 62U.07. Permits the commissioner to convene working groups to discuss and develop new strategies for reforming health care payment systems.

Subd. 8. Uses of information. (a) States that by January 1, 2011:

- DOER shall use the information and methods developed under subdivision 3, to strengthen incentives for participants of SEGIP to use high quality and low cost providers;

- DHS shall use the information and data to establish a payment system that rewards high- quality and low-cost providers and creates enrollee incentives to receive care from these providers;

- All political subdivisions that offer health benefits to their employees must offer plans that differentiate providers on their cost and quality performance

and create incentives for members to use better performing providers;

- All health plan companies shall use the information and methods to develop products that encourage consumers to use high-quality, low-cost providers; and

- health plan companies that issue health plans in the individual or the small employer markets shall offer at least one health plan that uses the information to establish financial incentives for consumers to choose high-quality and low-cost providers through enrollee cost sharing or selective provider networks.

(b) Requires the commissioner to report to the governor and legislature on recommendations to encourage health plans to promote widespread adoption of products that encourage the use of high-quality, low-cost providers. The recommendations may include tax incentives, pubic reporting of health plan performance, regulatory incentives or changes, and other strategies.

(c) Requires the commissioner of health to work with an advisory group to utilize the cost and provider quality information developed under this section, to develop products that encourage consumers to use high-quality, low-cost providers.

9 Provider pricing for baskets of care. Adds § 62U.07. E stablishes baskets of care.

Subd. 1. Establishment of definitions. Requires the commissioner, in consultation with one or more work groups, to establish uniform definitions for a minimum of 15 baskets of care. In selecting the health conditions, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression. States that the baskets of care must incorporate a patient-directed, decision-making support model. Requires the commissioner to submit recommendations to the Legislative Commission on Health Care Access on establishing a uniform definition of a basket of total cost of care.

Subd. 2. Package prices. (a) Authorizes providers to establish package prices for the baskets of care beginning January 1, 2010 , which can be updated annually.

(b) B eginning January 1, 2010, prohibits providers that have established package prices for baskets of care from varying the payment the provider accepts as full payment for a health care service based upon the identity of the payer, contractual relationship with the payer, the identity of the patient, or whether the patient has coverage through a group purchaser. States that this paragraph applies only to services provided to Minnesota residents or to non-Minnesota residents who obtain health insurance through a Minnesota employer. Exempts Medicare, workers' compensation, no fault insurance, and state health care programs from these requirements. States that this paragraph does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship or the patient or due to the patient being a friend or relative of the provider.

Subd. 3. Quality measurements for baskets of care. (a) Requires the commissioner to establish quality measurements for the defined baskets of care by December 31, 2009. Permits the commissioner to contract with an organization that

works to improve health care quality to make recommendations.

(b) R equires the commissioner to publish comparative price and quality information on the baskets of care so that it is easily accessible and understandable to the public, beginning July 1, 2010.

10 Coordination; legislative oversight on payment restructuring. Adds § 62U.08.

Subd. 1. Coordination. Requires the commissioner of health, in implementing the responsibilities of this chapter, to ensure that the activities and data collection are implemented in an integrated and coordinated manner, and to streamline data collection to reduce administrative costs.

Subd. 2. Legislative oversight. Beginning December 1, 2008, requires the commissioner of health to submit to the Legislative Commission on Health Care Access periodic progress reports on the implementation of this chapter and sections 256B.0751 to 256B.0753, including but not limited to reports on specified topics.

11 Affordability standard. Adds § 62U.09. E stablishes an affordability standard.

Subd. 1. Definition of affordability. D efines coverage as "affordable" if the sum of premiums, deductibles, and other out-of-pocket costs paid by an individual or family for health coverage does not exceed the applicable percentage of individual or family gross income specified in subdivision 2.

Subd. 2. Affordability standard. S pecifies the affordability standard, which increases to 10 percent of the average gross monthly income for individuals and families with incomes up to 400 percent of FPG.

Subd. 3. Application. States that this section shall only apply to subsidies under the MinnesotaCare program and the employee subsidy program under section 62U.10, and should not be construed to limit or restrict premiums or cost-sharing requirements in the private commercial market.

12 Employee subsidies for health coverage. Adds § 62U.10.

Subd. 1. Development of subsidy program. Requires the commissioner of health, in consultation with the commissioner of human services, to develop a plan and submit recommendations to the legislature by January 15, 2010 , for a subsidy program for eligible employees and dependents with access to employer-subsidized insurance. States that the plan may include direct subsidies or tax credits and deductions, including refundable tax credits, or a combination.

Subd. 2. Eligible employees and dependents; incomes not exceeding 300 percent of the federal poverty guidelines. In order to be eligible for a subsidy under the plan, requires employees or dependents with gross income that does not exceed 300 percent of FPG to:

(1) be covered by employer subsidized coverage that meets the value-based benefit set and design requirements of § 62U.02; and

(2) meet all MinnesotaCare eligibility criteria, except the insurance barriers related to no coverage for four months and no access to employer-subsidized coverage.

Subd. 3. Eligible individuals, employees, and dependents; incomes greater than 300 percent but not exceeding 400 percent of the federal poverty guidelines. In order to be eligible for a subsidy under the plan, requires an individual, employee, or dependent with a gross household income that is greater than 300 percent but does not exceed 400 percent of FPG to:

(1) be covered by health coverage that meets the value-based benefit set and design requirements of § 62U.02; and

(2) meet all MinnesotaCare eligibility requirements, except those related to no access to employer-subsidized coverage, no other health coverage, and gross household income.

Subd. 4. Amount of subsidy. Sets the subsidy amount under the plan at the difference between the cost of health coverage for the employee and any dependents (including premiums, deductibles, and cost-sharing) minus the amount the employee is expected to pay under the affordability standard. Provides that the maximum subsidy cannot exceed the amount of the subsidy that would have been provided under MinnesotaCare.

Subd. 5. Payment of subsidy. Requires the subsidy under the plan to be paid to the employee's health plan company, to be credited first to the employee's share of premium and then to deductibles and cost-sharing.

13 Projected and actual health care spending. Adds § 62U.11. R equires the commissioner to calculate projected and actual health care spending.

(a) Requires the commissioner to calculate the annual projected total health care spending for the state and establish a health care spending baseline for 2008 and the next ten years, based on annual projected spending growth.

(b) Specifies the procedure for establishing the baseline.

(c) Permits the commissioner to adjust the projected baseline as necessary.

(d) States that the baseline must not include Medicare or long-term care spending.

Subd. 2. Actual spending. Requires the commissioner each year, beginning February 15, 2010 , to determine the actual private and public health care spending for the prior calendar year and determine the difference between projected and actual spending. Requires actual spending to be certified by an independent actuarial consultant.

Subd. 3. Publication of spending. R equires the commissioner to annually publish projected and actual spending in the State Register, beginning February 15, 2010 .

14 Health care reform review council. Adds § 62U.12.

Subd. 1. Establishment. Establishes the Health Care Reform Review Council to periodically review the progress of implementation of this chapter and sections 256B.0751 to 256B.0753.

Subd. 2. (a) Provides that the council consists of ten members, appointed as follows:

(1) two members appointed by the Minnesota Medical Association, at least one of whom must represent rural physicians;

(2) one member appointed by the Minnesota Nurses Association;

(3) two members appointed by the Minnesota Hospital Association, at least one of whom must be a rural hospital administrator;

(4) one member appointed by the Minnesota Academy of Physician Assistants;

(5) one member appointed by the Minnesota Business Partnership;

(6) one member appointed by the Minnesota Chamber of Commerce;

(7) one member appointed by the SEIU Minnesota State Council; and

(8) one member appointed by the AFL-CIO.

(b) If a member is not able or eligible to participate, requires a new member to be appointed by the entity that appointed the outgoing member.

Subd. 3. Operations of council. (a) Requires the commissioner of health to convene the first meeting of the council by January 15, 2009, and requires the council to meet at least quarterly.

(b) Provides that the council is governed by section 15.059, except that members shall not receive per diems and the council does not expire.

(c) Requires the commissioner of health to provide staff, administrative support, and office space to the council.

Subd. 4. Responsibilities of the council. Requires the council to periodically review the implementation of this chapter and sections 256B.0751 to 256B.0753, including but not limited to: (1) the development and implementation of certification, process, outcome, and quality standards for health care homes; (2) development and implementation of payment restructuring and payment reform; and (3) development of the plan and recommendations for providing health coverage subsidies for employees.

15 Section 125 plans. Adds § 62U.13. R equires certain employers to establish Section 125 Plans with an opt-out option.

Subd. 1. Definitions. Defines terms.

Subd. 2. Section 125 plan requirement. (a) R equires by July 1, 2009 , all employers with 11 or more current full-time-equivalent employees to establish a Section 125 Plan to allow their employees to purchase individual market or employer-based health plan coverage with pretax dollars. States that this does not require an employer to offer or purchase coverage for its employees. Exempts from this requirement employers:

(1) that offer a group health insurance plan;

(2) that are self-insured; and

(3) with no employees who are eligible to participate in a Section 125 Plan.

Paragraph (b) permits employers that have been certified by a licensed insurance agent as having received education and information on the benefits of offering Section 125 Plans to opt out of doing so by filing an opt-out notice with the commissioner of commerce.

Subd. 3. Employer requirements. (a) S tates that employers that do not offer a group health plan and are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase an individual market health plan;

(2) allow employees to choose any licensed insurance agent to assist them in purchasing the plan;

(3) deduct premiums from the employee's wages on a pretax basis upon an employee's request, in an amount not to exceed the employee's wages, and remit these premiums to the health plan company; and

(4) provide notice to employees that individual market health plans purchased by employees through payroll deduction are not employer sponsored or administered.

(b) States that employers are to be held harmless from any and all claims related to individual market health plans.

16 Payment reform. Adds § 256B.0751.

Subd. 1. Quality incentive payments. Requires the commissioner of human services to implement quality incentive payments as required under section 62U.04. States that this does not limit the ability of the commissioner to establish by contract and monitor outcome and performance measures related to state health care program enrollees.

Subd. 2. Payment reform. Requires the commissioner of human services to establish a payment system to reduce health care costs and improve quality as required under section 62U.06.

17 High-deductible health plan option. Requires the commissioner of finance to consider including, in the health insurance benefit plans offered under the managerial plan to state employees, an option that is compatible with the definition of a high-deductible plan in the Internal Revenue Code.

18 Study of uniform claims review process. Requires the commissioner of health to establish a work group to make recommendations on the potential for reducing claims adjudication costs of health care providers and health plan companies by adopting more uniform payment methods, and the potential impact of establishing uniform prices that would replace prices negotiated individually by providers with separate payers. Requires the work group to report recommendations and action steps to the commissioner by January 1, 2010 .

Article 5: Appropriations

See Spreadsheet