HOUSE RESEARCH

Bill Summary

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Table of Contents

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. Grants to local communities. States that beginning January 1, 2009, the commissioner of health shall award competitive grants to community health boards and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at reducing the rates of obesity and tobacco use.

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

Subd. 3. 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. 4. 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. 5. 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 the first report to include recommendations on sustainable sources of funding.

Subd. 6. 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 standards and other requirements for health care homes, requires payment of care coordination fees, requires the commissioner of human services to implement payment reform for state health care programs, 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, or advanced practice nurse. "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 for the standards.

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

(c) Allows the commissioners to use the expedited rulemaking process in § 14.389, to develop and implement 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. Beginning July 1, 2009 , 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 Health care home reporting requirements. Adds § 256B.0752.

Subd. 1. 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 December 15, 2009 , and each December 15 thereafter.

Subd. 2. 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.

3 Payment restructuring; care coordination fee. Adds § 256B.0753.

Subd. 1. Development. Requires the commissioner of human services, in coordination with the commissioner of health, to develop a payment system that provides per-person care coordination payments to health care homes for providing care coordination services and managing or employing care coordinators. States that the coordination payments are in addition to quality incentive payments. 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. In developing criteria for payments, requires the commissioner to consider the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to care. 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. Requires development of the payment system to be complete by January 1, 2010 .

Subd. 2. Implementation. Requires the commissioner to implement care coordination payments, by July 1, 2010 , or upon federal approval. For enrollees served under fee-for-service, requires the fee to be determined in contracts with health care homes. For enrollees served by managed care or county-based purchasing plans, requires the commissioner's contracts with these plans to require payment of care coordination fees to health care homes.

Subd. 3. 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.

4 Payment reform. Adds § 256B.0754.

Subd. 1. Quality incentive payments. By July 1, 2010 , requires the commissioner of human services to implement quality incentive payments as established under § 62U.02 for all enrollees in state health care programs. States that this section does not limit the ability of the commissioner to establish by contract and monitor, as part of the commissioner's quality assurance obligations, outcome and performance measures for nonmedical services and health issues related to state health care program enrollees.

Subd. 2. Payment reform. By January 1, 2011 , requires the commissioner to use the information and methods developed under § 62U.04 to establish a payment system that: (1) rewards high-quality, low-cost providers; (2) creates enrollee incentives to receive care from such providers; and (3) fosters collaboration among providers to reduce cost shifting.

5 Workforce shortage study. Requires the commissioner of health, in consultation with licensing boards and professional associations, to study changes necessary 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 **Application and renewal forms.** Amends § 256.01, by adding subd. 27. Requires the commissioner to make state health care program applications and renewals available on the department's web site in the most common foreign languages.

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. Allows the bonus to be paid to licensed insurance producers.

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 providing 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 Seamless coverage for MinnesotaCare eligible children. Amends § 256B.057, subd. 2c. States that children receiving MA who become ineligible due to excess income are eligible for "seamless coverage" between MA and MinnesotaCare (this section rephrases and clarifies existing law allowing this coverage). Provides that the child remains eligible under MA for two additional months and is deemed automatically eligible for MinnesotaCare until renewal.

6 Families with children. Amends § 256L.04, subd. 1. Increases the annual income limit for parents on MinnesotaCare, from $50,000 to $57,500. 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 250 percent of FPG, effective July 1, 2009 . (Under current law, this income limit is scheduled to be increased to 215 percent of FPG, effective on that date.)

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 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.

10 General requirements. Amends § 256L.07, subd. 1. Increases the annual income limit for parents on MinnesotaCare from $50,000 to $57,500. Makes conforming changes related to the increase in the program income limit for adults without children. Provides that the change related to the income limit for adults without children is effective January 1, 2009 , or upon federal approval, whichever is later. Provides that the change related to the increase in the income limit for parents is effective July 1, 2010 , or upon federal approval.

11 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 a new sliding premium scale, under which the maximum percentage of gross monthly income that must be contributed is 8.0 percent at 275 percent of FPG. Retains the $4 monthly premiums for children with family incomes that do not exceed 150 percent of FPG. Provides an effective date of January 1, 2009 , or upon federal approval, whichever is later.

12 Automation and coordination for state health care programs. Requires the commissioner of human services to report to the legislature by January 15, 2009 , on ways to improve coordination between state health care programs and social service programs. Specifies criteria for the report.

13 Long-term care worker health coverage study. Requires the commissioner of human services to study and report to the legislature by December 15, 2008 , recommendations for a rate increase to long-term care employers for the purchase of employee health insurance in the private market. Specifies requirements for the study and provides a definition of long-term care worker.

14 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) and (d), 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. developing recommendations for an essential benefit set;
3. developing a system of quality incentive payments to providers who meet specified targets;
4. developing a method to calculate providers' relative cost of care and relative quality of care;
5. developing a peer grouping system for providers;
6. establishing uniform definitions for baskets of care, starting with a minimum of seven baskets;
7. requiring certain employers to establish Section 125 Plans;
8. developing a health care affordability proposal for eligible individuals and employees with income not exceeding 300 percent of FPG; and
9. establishing a health care review council.

1 General. Amends § 43A.23, subd. 1. Beginning January 1, 2010 , requires the health benefit plans offered in the commissioner's plan and the managerial plan for state employees to include an option for a high-deductible health plan.

2 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.

3 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. Effective January 1, 2011 , 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 provides that if electronic transmitting is used, it must be done 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.

4 Definitions. Adds § 62U.01. Defines terms for chapter 62U.

5 Payment restructuring; incentive payments based on quality of care. Adds § 62U.02.

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, including providers certified as health care homes. 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 . Specifies criteria for the measures.

Subd. 2. Quality incentive payments. Requires the commissioner, by July 1, 2009 , to develop a quality incentive payment system under which providers are eligible for quality-based payments that are in addition to existing payment levels, based on provider performance against specified targets and improvement over time. To the extent possible, requires the system to adjust for variations in patient population. States that the requirements of § 62Q.101 (evaluation of provider performance measures and disclosure of baselines to providers), 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. (a) 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.

(b) By July 1, 2010 , requires the commissioner of finance to implement the system for participants in the state employees group insurance program (SEGIP).

6 Payment restructuring; care coordination payments. Adds § 62U.03.

(a) R equires health plan companies, by July 1, 2010 , to include health care homes in their provider networks and to pay a care coordination fee for members who choose to enroll in health care homes. Requires health plan companies to develop payment conditions and terms for the care coordination fee that are consistent with the system developed under § 256B.0753. 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. Allows health plan companies to reduce or reallocate payments to other providers to ensure that the implementation of care coordination payments is cost neutral.

(b) By July 1, 2010 , requires the commissioner of finance to implement care coordination payments for SEGIP participants. Allows the commissioner to reallocate payments within the health care system to ensure that implementation is cost neutral.

7 Payment reform to reduce health care costs and improve quality. Adds § 62U.04.

Subd. 1. Development of tools to improve costs and quality outcomes. Requires the commissioner of health to develop a plan to create transparent prices, encourage greater provider innovation and collaboration in cost-effective, high-quality care delivery, reduce administrative burdens, and provide comparative information to consumers on variation in provider health care costs and quality. Requires development to be complete by January 1, 2010 .

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

(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 for final establishment of the peer grouping 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 grouping 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 given 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 this section, 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 § 13.02. Permits summary data prepared under this section to be derived from nonpublic data. Requires the commissioner or designee 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 required analyses. 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 § 13.02. Permits the summary data prepared under this subdivision to be derived from nonpublic data. Requires the commissioner to establish procedures and safeguards to protect the integrity and confidentiality of any data maintained.

Subd. 6. Contracting. Authorizes the commissioner to contract with a private entity or consortium to develop the standards. Requires the private entity or consortium to be nonprofit and have governance that includes representatives of 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. Consumer engagement. Requires the commissioner of health to convene a work group to develop strategies for engaging consumers and to assist consumers in becoming advocates for higher value health care and a more efficient, effective health care system. Requires the commissioner to report to the commissioner and the legislature by January 1, 2010.

Subd. 8. Provider innovation to reduce health care costs and improve quality. (a) 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 baskets of care in § 62U.05.

(b) Allows the commissioner of health to convene working groups of private sector payers and health care providers to discuss and develop new strategies for reforming health care payment systems.

Subd. 9. Uses of information. (a) States that by January 1, 2011:

(1) the commissioner of finance 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;

(2) 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;

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

(4) 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 of health to report to the governor and legislature, by January 1, 2011, 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.

8 Provider pricing for baskets of care. Adds § 62U.05.

Subd. 1. Establishment of definitions. (a) Requires the commissioner of health, by July 1, 2009 , to establish uniform definitions for a minimum of seven baskets of care. In selecting the health conditions, requires the commissioner to consider coronary artery and heart disease, diabetes, asthma, and depression. Also requires the commissioner to consider the prevalence of health conditions, the cost of treatment, and the potential for innovations to reduce cost and improve quality.

(b) Requires the commissioner to convene work groups to assist in establishing definitions. Requires work groups to include members appointed by statewide associations representing health care providers, health plan companies, and organizations that work to improve health care quality.

(c) Requires baskets of care to incorporate a patient-directed, decision-making model, to the extent possible.

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

(b) B eginning January 1, 2010, prohibits providers that have established package prices for baskets of care from varying the amount the provider accepts as full

payment for a health care service based upon the identity of the payer, a 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 automobile 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 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 about existing and new measures.

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

9 Coordination; legislative oversight on payment restructuring. Adds § 62U.06.

Subd. 1. Coordination. Requires the commissioner of health, in carrying out the responsibilities of this chapter, to ensure that the activities and data collection are implemented in an integrated and coordinated manner. Also requires the commissioner to use existing data sources and implement methods to streamline data collection to reduce administrative costs.

Subd. 2. Legislative oversight. Beginning January 15, 2009, 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.0754.

Subd. 3. Rulemaking. Allows the commissioner to use the expedited rulemaking process under section 14.389, for purposes of this chapter.

10 Section 125 plans. Adds § 62U.07.

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 coverage with pretax dollars. States that this does not require an employer to offer or purchase group health coverage for 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.

(b) Allows employers to opt out of the requirement to establish a Section 125 plan by sending a form to the commissioner of commerce. Requires the commissioner to create a check-box form for employers

to opt out, and to make this form available on the web by April 1, 2009 .

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 purchased by employees under a Section 125 Plan.

Subd. 4. Section 125 Plan employer incentives. (a) Requires the commissioner of employment and economic development to award grants to eligible employers that establish Section 125 Plans.

(b) In order to be eligible for a grant, requires small employers to:

(1) not have offered health insurance to employees through a group or self-insured plan in the 12 months prior to applying for a grant;

(2) have established a Section 125 Plan within 90 days prior to applying for grant funding, and not have offered such a plan for at least the nine-month period prior to establishment of a plan under this section; and

(3) certify to the commissioner that Section 125 Plan has been established that meets the requirements of subdivision 3.

(c) Sets the amount of the grant award at $350 per employer.

11 Essential benefit set. Adds § 62U.08.

Subd. 1. Work group created. Requires the commissioner of health to convene a work group to make recommendations on the design of a health benefit set that provides coverage for a broad range of services and technologies, is based on scientific evidence that the services and technologies are clinically effective and cost-effective, and requires lower enrollee cost-sharing for services and technologies determined to be cost-effective. Specifies requirements for work group membership, and requires the work group to meet at least once per year and at other times as necessary to ensure that the benefit set continues to be safe, effective, and scientifically based.

Subd. 2. Duties. Requires the work group to submit to the commissioner by October 15, 2009 , an initial essential benefit set and design that meets specified criteria. Allows the work group to consult with the Institute for Clinical Systems Improvement to assemble existing scientifically based practice standards.

Subd. 3. Report. By January 15, 2010 , requires the commissioner to report the recommendations

of the work group to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance.

12 Health care reform review council. Adds § 62U.09.

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.0754.

Subd. 2. (a) Provides that the council consists of 14 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;

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

(9) one member appointed by the Minnesota Council of Health Plans;

(10) one member appointed by the Smart Buy Alliance;

(11) one member appointed by the Minnesota Medical Group Management Association; and

(12) one consumer member appointed by AARP Minnesota.

(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

13 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 .

14 Health care affordability proposal. Requires the commissioner of health, in coordination with the commissioner of human services, to develop a health care affordability proposal for eligible individuals and employees with access to employer-subsidized insurance and with gross family incomes not exceeding 300 percent of FPG. Requires the commissioner to evaluate and report on direct payments to individuals, tax credits, including refundable tax credits, tax deductions and a combination of direct payments, and tax deductions. Requires the proposal to be designed so that individuals and families have access to affordable coverage. Defines coverage as "affordable" if the sum of premiums, deductibles, and other out-of-pocket costs does not exceed the applicable percentage of gross monthly income required under the new MinnesotaCare sliding premium scale established in § 256L.15, subd. 2, paragraph (d). Requires the commissioner to submit a report and recommendations to the legislature by January 15, 2009 .

Article 5: Appropriations

See Spreadsheet