..... moves to amend H.F. No. 1843 as follows:

Delete everything after the enacting clause and insert:

"Section 1. **ANALYSIS OF BENEFITS AND COSTS OF A UNIVERSAL HEALTH CARE SYSTEM.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "All necessary care" means the full range of services listed in the proposed Minnesota Health Plan legislation, including medical, dental, vision and hearing, mental health, chemical dependency treatment, reproductive and sexual health, prescription drugs, medical equipment and supplies, long-term care, home care, and coordination of care.

(c) "Total public and private health care spending" means:

(1) spending on all medical care including but not limited to dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care, whether paid through premiums, co-pays and deductibles, other out-of-pocket payments, or other funding from government, employers, or other sources; and

(2) the costs associated with administering, delivering, and paying for the care. The costs of administering, delivering, and paying for the care includes all expenses by insurers, providers, employers, individuals, and government to select, negotiate, purchase, and administer insurance and care including but not limited to coverage for health care, dental, long-term care, prescription drugs, and the medical expense portions of workers compensation and automobile insurance, and the cost of administering and paying for all health care products and services that are not covered by insurance.

Subd. 2. **Initial assumptions.** (a) When calculating administrative savings under the universal health proposal, the analysts shall recognize that simple, direct payment of medical services avoids the need for provider networks, eliminates prior authorization requirements, and eliminates administrative complexity of other payment schemes along with the need for creating risk adjustment mechanisms, and measuring, tracking, and paying under those risk adjusted or nonrisk adjusted payment schemes by both providers and payors.

(b) The analysts shall assume that, while gross provider payments may be reduced to reflect reduced administrative costs, net provider income would remain similar to the current system. However, they shall not assume that payment rate negotiations will track current Medicaid, Medicare, or market payment rates or a combination of those rates, because provider compensation, after adjusting for reduced administrative costs, would not be universally raised or lowered but would be negotiated based on market needs, so provider compensation might be raised in an underserved area such as mental health but lowered in other areas.

Subd. 3. **Contract for analysis of proposal.** The commissioner of health shall contract with one or more independent entities to conduct an analysis of the benefits and costs of a legislative proposal for a universal health care financing system and a similar analysis of the current health care financing system to assist the state in comparing the proposal to the current system. The contractor or contractors must strive to produce estimates for all elements in subdivision 5.

Subd. 4. **Proposal.** The commissioner of health, with input from the commissioners of human services and commerce, shall submit to the contractor for analysis the legislative proposal known as the Minnesota Health Plan (Senate File No. 2740/House File No. 2798) that would offer a universal health care plan designed to meet a set of principles, including to:

(1) ensure all Minnesotans are covered;

(2) cover all necessary care; and

(3) allow patients to choose their doctors, hospitals, and other providers.

Subd. 5. **Proposal analysis.** (a) The analysis must measure the performance of both the proposed Minnesota Health Plan and the current public and private health care financing system over a ten-year period to contrast the impact on:

(1) coverage: the number of people who are uninsured versus the number of people who are insured;

(2) benefit completeness: adequacy of coverage measured by the completeness of the coverage and the number of people lacking coverage for key necessary care elements such as dental, long-term care, medical equipment or supplies, vision and hearing, or other health services that are not covered, if any. The analysis must take into account the vast variety of benefit designs in the commercial market and report the extent of coverage in each area;

(3) underinsurance: whether people with coverage can afford the care they need or whether cost prevents them from accessing care. This includes affordability in terms of premiums, deductibles, and out-of-pocket expenses;

(4) system capacity: the timeliness and appropriateness of the care received and whether people turn to inappropriate care such as emergency rooms because of a lack of proper care in accordance with clinical guidelines; and

(5) health care spending: total public and private health care spending in Minnesota under the current system versus under the Minnesota Health Plan legislative proposal, including all spending by individuals, businesses, and government. Where relevant, the analysis shall be broken out by key necessary care areas, such as medical, dental, and mental health. The analysis of total health care spending shall examine whether there are savings or additional costs under the legislative proposal compared to the existing system due to:

(i) changes in cost of insurance, billing, underwriting, marketing, evaluation, and other administrative functions for all entities involved in the health care system, including savings from global budgeting for hospitals and institutional care instead of billing for individual services provided;

(ii) changed prices on medical services and products, including pharmaceuticals, due to price negotiations under the proposal;

(iii) impact on utilization, health outcomes, and workplace absenteeism due to prevention, early intervention, and health-promoting activities;

(iv) shortages or excess capacity of medical facilities, equipment, and personnel, including caregivers and staff, under either the current system or the proposal, including capacity of clinics, hospitals, and other appropriate care sites versus inappropriate emergency room usage. The analysis shall break down capacity by geographic differences such as rural versus metro, and disparate access by population group;

(v) the impact on state, local, and federal government non-health-care expenditures. This may include areas such as reduced crime and out-of-home placement costs due to

mental health or chemical dependency coverage. Additional definition may further develop hypotheses for other impacts that warrant analysis;

(vi) job losses or gains within the health care system; specifically, in health care delivery, health billing, and insurance administration;

(vii) job losses or gains elsewhere in the economy under the proposal due to implementation of the resulting reduction of insurance and administrative burdens on businesses; and

(viii) impacts on disparities in health care access and outcomes.

(b) The contractor or contractors shall propose an iterative process for designing and conducting the analysis. Steps shall be reviewed with and approved by the commissioner of health and lead house and senate authors of the legislative proposal, and shall include but not be limited to:

(1) clarification of the specifics of the proposal. The analysis shall assume that the provisions in the proposal are not preempted by federal law or that the federal government gives a waiver to the preemptions;

(2) additional data elements needed to accomplish goals of the analysis;

(3) assumptions analysts are using in their analysis and the quality of the evidence behind those assumptions;

(4) timing of each stage of the project with agreed-upon decision points;

(5) approaches to address any services currently provided in the existing health care system that may not be provided for within the Minnesota Health Plan as proposed; and

(6) optional scenarios provided by the contractor or contractors with minor alterations in the proposed plan related to services covered or cost-sharing if those scenarios might be helpful to the legislature.

(c) The commissioner shall issue a final report on the analysis by January 15, 2026, and may provide interim reports and status updates to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance aligned with the iterative process defined above.

(d) The contractor may offer a modeling tool as deliverable with a line-item cost provided.

Sec. 2. **APPROPRIATION.**

$..... in fiscal year 2024 is appropriated from the general fund to the commissioner of health to conduct an economic analysis of the benefits and costs of the health care system proposal specified in section 1 and to contract with contractors as necessary to complete the analysis. This is a onetime appropriation and is available until June 30, 2026."

Amend the title accordingly