SENATE
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NINETY-THIRD SESSION

S.F. No. 49

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01/05/2023	82	Introduction and first reading Referred to Health and Human Services
01/09/2023	117	Authors added Mitchell; Mann
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04/03/2023	2820a	Comm report: To pass as amended and re-refer to Finance
	2846	Joint rule 2.03, referred to Rules and Administration
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A bill for an act

relating to health; establishing an easy enrollment health insurance outreach program; providing for a state-funded cost-sharing reduction program for enrollees of certain health plans through MNsure; establishing the Health Care Affordability Board and Health Care Affordability Advisory Council; requiring monitoring of and recommendations related to health care market trends; requiring reports; providing for civil penalties; modifying premium scale; establishing requirements for a transition to a public option; requiring recommendations for and studies of alternative payment models; appropriating money; amending Minnesota Statutes 2022, sections 62K.15; 62U.04, subdivision 11; 256.962, subdivision 5; 256B.04, by adding a subdivision; 256B.056, subdivision 7; 256B.0631, by adding a subdivision; 256L.04, subdivisions 7a, 10, by adding a subdivision; 256L.07, subdivision 1; 256L.15, subdivision 2; 270B.14, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapters 62J; 62V; 290; repealing Minnesota Statutes 2022, section 256B.0631, subdivisions 1, 2, 3.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1
FACILITATING ENROLLMENT

Section 1. Minnesota Statutes 2022, section 62K.15, is amended to read:

62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT PERIODS.

(a) Health carriers offering individual health plans must limit annual enrollment in the individual market to the annual open enrollment periods for MNsure. Nothing in this section limits the application of special or limited open enrollment periods as defined under the Affordable Care Act.

(b) Health carriers offering individual health plans must inform all applicants at the time of application and enrollees at least annually of the open and special enrollment periods as defined under the Affordable Care Act.

(c) Health carriers offering individual health plans must provide a special enrollment period for enrollment in the individual market by employees of a small employer that offers a qualified small employer health reimbursement arrangement in accordance with United States Code, title 26, section 9831(d). The special enrollment period shall be available only to employees newly hired by a small employer offering a qualified small employer health reimbursement arrangement, and to employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement. For employees newly hired by the small employer, the special enrollment period shall last for 30 days after the employee's first day of employment. For employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement, the special enrollment period shall last for 30 days after the date the arrangement is initially offered to employees.

(d) The commissioner of commerce shall enforce this section.

(e) Health carriers offering individual health plans through MNsure must provide a special enrollment period as required under the easy enrollment health insurance outreach program under section 62V.13.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

Sec. 2. **[62V.13] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM.**

Subdivision 1. **Establishment.** The board, in cooperation with the commissioner of revenue, must establish the easy enrollment health insurance outreach program to:

(1) reduce the number of uninsured Minnesotans and increase access to affordable health insurance coverage;

(2) allow the commissioner of revenue to provide return information, at the request of the taxpayer, to MNsure to provide the taxpayer with information about the potential eligibility for financial assistance and health insurance enrollment options through MNsure;

(3) allow MNsure to estimate taxpayer potential eligibility for financial assistance for health insurance coverage; and

(4) allow MNsure to conduct targeted outreach to assist interested taxpayer households in applying for and enrolling in affordable health insurance options through MNsure, including connecting interested taxpayer households with a navigator or broker for free enrollment assistance.

Subd. 2. **Screening for eligibility for insurance assistance.** Upon receipt of and based on return information received from the commissioner of revenue under section 270B.14, subdivision 22, MNsure may make a projected assessment on whether the interested taxpayer's household may qualify for a financial assistance program for health insurance coverage.

Subd. 3. **Outreach letter and special enrollment period.** (a) MNsure must provide a written letter of the projected assessment under subdivision 2 to a taxpayer who indicates to the commissioner of revenue that the taxpayer is interested in obtaining information on access to health insurance.

(b) MNsure must allow a special enrollment period for taxpayers who receive the outreach letter in paragraph (a) and are determined eligible to enroll in a qualified health plan through MNsure. The triggering event for the special enrollment period is the day the outreach letter under this subdivision is mailed to the taxpayer. An eligible individual, and their dependents, have 65 days from the triggering event to select a qualifying health plan and coverage for the qualifying health plan is effective the first day of the month after plan selection.

(c) Taxpayers who have a member of the taxpayer's household currently enrolled in a qualified health plan through MNsure are not eligible for the special enrollment under paragraph (b).

(d) MNsure must provide information about the easy enrollment health insurance outreach program and the special enrollment period described in this subdivision to the general public.

Subd. 4. **Appeals.** (a) Projected eligibility assessments for financial assistance under this section are not appealable.

(b) Qualification for the special enrollment period under this section is appealable to MNsure under this chapter and Minnesota Rules, chapter 7700.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

Sec. 3. Minnesota Statutes 2022, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations and licensed insurance producers under chapter 60K that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare or medical assistance, the commissioner, within the available appropriation, shall pay the organization or licensed insurance producer a ~~$70~~ $100 application assistance bonus. The organization or licensed insurance producer may provide an applicant a gift certificate or other incentive upon enrollment.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 4. Minnesota Statutes 2022, section 256B.04, is amended by adding a subdivision to read:

Subd. 26. **Disenrollment under medical assistance and MinnesotaCare.** (a) The commissioner shall regularly update mailing addresses and other contact information for medical assistance and MinnesotaCare enrollees in cases of returned mail and nonresponse using information available through managed care and county-based purchasing plans, state health and human services programs, and other sources.

(b) The commissioner shall not disenroll an individual from medical assistance or MinnesotaCare in cases of returned mail until the commissioner makes at least two attempts by phone, email, or other methods to contact the individual. The commissioner may disenroll the individual after providing no less than 30 days for the individual to respond to the most recent contact attempt.

Sec. 5. Minnesota Statutes 2022, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

(b) Notwithstanding any other law to the contrary:

(1) a child under 21 years of age who is determined eligible for medical assistance must remain eligible for a period of 12 months; and

(2) a child under six years of age who is determined eligible for medical assistance must remain eligible through the month in which the child reaches six years of age.

(c) A child's eligibility under paragraph (b) may be terminated earlier if:

(i) the child or the child's representative requests voluntary termination of eligibility;

(ii) the child ceases to be a resident of this state;

(iii) the child dies;

(iv) the child attains the maximum age; or

(v) the agency determines eligibility was erroneously granted at the most recent eligibility determination due to agency error or fraud, abuse, or perjury attributed to the child or the child's representative.

~~(b)~~ (d) For a person eligible for an insurance affordability program as defined in section 256B.02, subdivision 19, who reports a change that makes the person eligible for medical assistance, eligibility is available for the month the change was reported and for three months prior to the month the change was reported, if the person was eligible in those prior months.

EFFECTIVE DATE. This section is effective July 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2022, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens, with the exception of children under 19 years of age, are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 7. Minnesota Statutes 2022, section 270B.14, is amended by adding a subdivision to read:

Subd. 22. **Disclosure to MNsure board.** The commissioner may disclose a return or return information to the MNsure board if a taxpayer makes the designation under section 290.433 on an income tax return filed with the commissioner. The commissioner must only disclose data necessary to provide the taxpayer with information about the potential eligibility for financial assistance and health insurance enrollment options under section 62V.13.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 8. **[290.433] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM CHECKOFF.**

Subdivision 1. **Taxpayer designation.** Any individual who files an income tax return may designate on their original return a request that the commissioner provide their return information to the MNsure board for purposes of providing the individual with information about potential eligibility for financial assistance and health insurance enrollment options under section 62V.13, to the extent necessary to administer the easy enrollment health insurance outreach program.

Subd. 2. **Form.** The commissioner shall notify filers of their ability to make the designation in subdivision 1 on their income tax return.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023.

Sec. 9. **DIRECTION TO MNSURE BOARD AND COMMISSIONER.**

The MNsure board and the commissioner of the Department of Revenue must develop and implement systems, policies, and procedures that encourage, facilitate, and streamline data sharing, projected eligibility assessments, and notice to taxpayers to achieve the purpose of the easy enrollment health insurance outreach program under Minnesota Statutes, section 62V.13, for operation beginning with tax year 2023.

ARTICLE 2
AFFORDABILITY

Section 1. **[62J.86] DEFINITIONS.**

Subdivision 1. **Definitions.** For the purposes of sections 62J.86 to 62J.92, the following terms have the meanings given.

Subd. 2. **Advisory council.** "Advisory council" means the Health Care Affordability Advisory Council established under section 62J.88.

Subd. 3. **Board.** "Board" means the Health Care Affordability Board established under section 62J.87.

Sec. 2. **[62J.87] HEALTH CARE AFFORDABILITY BOARD.**

Subdivision 1. **Establishment.** The Legislative Coordinating Commission shall establish the Health Care Affordability Board, which shall be governed as a board under section 15.012, paragraph (a), to protect consumers, state and local governments, health plan companies, providers, and other health care system stakeholders from unaffordable health care costs. The board must be operational by January 1, 2024.

Subd. 2. **Membership.** (a) The Health Care Affordability Board consists of 13 members, appointed as follows:

(1) five members appointed by the governor;

(2) two members appointed by the majority leader of the senate;

(3) two members appointed by the minority leader of the senate;

(4) two members appointed by the speaker of the house; and

(5) two members appointed by the minority leader of the house of representatives.

(b) All appointed members must have knowledge and demonstrated expertise in one or more of the following areas: health care finance, health economics, health care management or administration at a senior level, health care consumer advocacy, representing the health care workforce as a leader in a labor organization, purchasing health care insurance as a health benefits administrator, delivery of primary care, health plan company administration, public or population health, and addressing health disparities and structural inequities.

(c) A member may not participate in board proceedings involving an organization, activity, or transaction in which the member has either a direct or indirect financial interest, other than as an individual consumer of health services.

(d) The Legislative Coordinating Commission shall coordinate appointments under this subdivision to ensure that board members are appointed by August 1, 2023, and that board members as a whole meet all of the criteria related to the knowledge and expertise specified in paragraph (b).

Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms. A board member shall not serve more than three consecutive terms.

(b) A board member may resign at any time by giving written notice to the board.

Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from the members appointed by the governor.

(b) The board shall elect a chair to replace the acting chair at the first meeting of the board by a majority of the members. The chair shall serve for two years.

(c) The board shall elect a vice-chair and other officers from its membership as it deems necessary.

Subd. 5. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time executive director and other staff, who shall serve in the unclassified service. The executive director must have significant knowledge and expertise in health economics and demonstrated experience in health policy.

(b) The attorney general shall provide legal services to the board.

(c) The Health Economics Division within the Department of Health shall provide technical assistance to the board in analyzing health care trends and costs and in setting health care spending growth targets.

(d) The board may employ or contract for professional and technical assistance, including actuarial assistance, as the board deems necessary to perform the board's duties.

Subd. 6. **Access to information.** (a) The board may request that a state agency provide the board with any publicly available information in a usable format as requested by the board, at no cost to the board.

(b) The board may request from a state agency unique or custom data sets, and the agency may charge the board for providing the data at the same rate the agency would charge any other public or private entity.

(c) Any information provided to the board by a state agency must be de-identified. For purposes of this subdivision, "de-identification" means the process used to prevent the identity of a person or business from being connected with the information and ensuring all identifiable information has been removed.

(d) Any data submitted to the board shall retain its original classification under the Minnesota Data Practices Act in chapter 13.

Subd. 7. **Compensation.** Board members shall not receive compensation but may receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

Subd. 8. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall meet publicly at least quarterly. The board may meet in closed session when reviewing proprietary information as specified in section 62J.71, subdivision 4.

(b) The board shall announce each public meeting at least two weeks prior to the scheduled date of the meeting. Any materials for the meeting shall be made public at least one week prior to the scheduled date of the meeting.

(c) At each public meeting, the board shall provide the opportunity for comments from the public, including the opportunity for written comments to be submitted to the board prior to a decision by the board.

Sec. 3. **[62J.88] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** The governor shall appoint a Health Care Affordability Advisory Council to provide advice to the board on health care costs and access issues and to represent the views of patients and other stakeholders. Members of the advisory council shall be appointed based on their knowledge and demonstrated expertise in one or more of the following areas: health care delivery, ensuring health care access for diverse populations, public and population health, patient perspectives, health care cost trends and drivers, clinical and health services research, innovation in health care delivery, and health care benefits management.

Subd. 2. **Duties; reports.** (a) The council shall provide technical recommendations to the board on:

(1) the identification of economic indicators and other metrics related to the development and setting of health care spending growth targets;

(2) data sources for measuring health care spending; and

(3) measurement of the impact of health care spending growth targets on diverse communities and populations, including but not limited to those communities and populations adversely affected by health disparities.

(b) The council shall report technical recommendations and a summary of its activities to the board at least annually, and shall submit additional reports on its activities and recommendations to the board, as requested by the board or at the discretion of the council.

Subd. 3. **Terms.** (a) The initial appointed advisory council members shall serve staggered terms of two, three, or four years determined by lot by the secretary of state. Following the initial appointments, advisory council members shall serve four-year terms.

(b) Removal and vacancies of advisory council members shall be governed by section 15.059.

Subd. 4. **Compensation.** Advisory council members may be compensated according to section 15.059.

Subd. 5. **Meetings.** The advisory council shall meet at least quarterly. Meetings of the advisory council are subject to chapter 13D.

Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not expire.

Sec. 4. **[62J.89] DUTIES OF THE BOARD.**

Subdivision 1. **General.** (a) The board shall monitor the administration and reform of the health care delivery and payment systems in the state. The board shall:

(1) set health care spending growth targets for the state, as specified under section 62J.90;

(2) enhance the transparency of provider organizations;

(3) monitor the adoption and effectiveness of alternative payment methodologies;

(4) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care;

(5) monitor and review the impact of changes within the health care marketplace; and

(6) monitor patient access to necessary health care services.

(b) The board shall establish goals to reduce health care disparities in racial and ethnic communities and to ensure access to quality care for persons with disabilities or with chronic or complex health conditions.

Subd. 2. **Market trends.** The board shall monitor efforts to reform the health care delivery and payment system in Minnesota to understand emerging trends in the commercial health insurance market, including large self-insured employers and the state's public health care programs, in order to identify opportunities for state action to achieve:

(1) improved patient experience of care, including quality and satisfaction;

(2) improved health of all populations, including a reduction in health disparities; and

(3) a reduction in the growth of health care costs.

Subd. 3. **Recommendations for reform.** The board shall make recommendations for legislative policy, market, or any other reforms to:

(1) lower the rate of growth in commercial health care costs and public health care program spending in the state;

(2) positively impact the state's rankings in the areas listed in this subdivision and subdivision 2; and

(3) improve the quality and value of care for all Minnesotans, and for specific populations adversely affected by health inequities.

Subd. 4. **Office of Patient Protection.** The board shall establish an Office of Patient Protection, to be operational by January 1, 2025. The office shall assist consumers with issues related to access and quality of health care, and advise the legislature on ways to reduce consumer health care spending and improve consumer experiences by reducing complexity for consumers.

Sec. 5. **[62J.90] HEALTH CARE SPENDING GROWTH TARGETS.**

Subdivision 1. **Establishment and administration.** The board shall establish and administer the health care spending growth target program to limit health care spending growth in the state, and shall report regularly to the legislature and the public on progress toward these targets.

Subd. 2. **Methodology.** (a) The board shall develop a methodology to establish annual health care spending growth targets and the economic indicators to be used in establishing the initial and subsequent target levels.

(b) The health care spending growth target must:

(1) use a clear and operational definition of total state health care spending;

(2) promote a predictable and sustainable rate of growth for total health care spending as measured by an established economic indicator, such as the rate of increase of the state's economy or of the personal income of residents of this state, or a combination;

(3) define the health care markets and the entities to which the targets apply;

(4) take into consideration the potential for variability in targets across public and private payers;

(5) account for the health status of patients; and

(6) incorporate specific benchmarks related to health equity.

(c) In developing, implementing, and evaluating the growth target program, the board shall:

(1) consider the incorporation of quality of care and primary care spending goals;

(2) ensure that the program does not place a disproportionate burden on communities most impacted by health disparities, the providers who primarily serve communities most impacted by health disparities, or individuals who reside in rural areas or have high health care needs;

(3) explicitly consider payment models that help ensure financial sustainability of rural health care delivery systems and the ability to provide population health;

(4) allow setting growth targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating:

(i) a risk factor adjustment reflecting the health status of the entity's patient mix; and

(ii) an equity adjustment accounting for the social determinants of health and other factors related to health equity for the entity's patient mix;

(5) ensure that growth targets:

(i) do not constrain the Minnesota health care workforce, including the need to provide competitive wages and benefits;

(ii) do not limit the use of collective bargaining or place a floor or ceiling on health care workforce compensation; and

(iii) promote workforce stability and maintain high-quality health care jobs; and

(6) consult with the advisory council and other stakeholders.

Subd. 3. **Data.** The board shall identify data to be used for tracking performance in meeting the growth target and identify methods of data collection necessary for efficient implementation by the board. In identifying data and methods, the board shall:

(1) consider the availability, timeliness, quality, and usefulness of existing data, including the data collected under section 62U.04;

(2) assess the need for additional investments in data collection, data validation, or data analysis capacity to support the board in performing its duties; and

(3) minimize the reporting burden to the extent possible.

Subd. 4. **Setting growth targets; related duties.** (a) The board, by June 15, 2024, and by June 15 of each succeeding calendar year through June 15, 2028, shall establish annual health care spending growth targets for the next calendar year consistent with the requirements of this section. The board shall set annual health care spending growth targets for the five-year period from January 1, 2025, through December 31, 2029.

(b) The board shall periodically review all components of the health care spending growth target program methodology, economic indicators, and other factors. The board may revise the annual spending growth targets after a public hearing, as appropriate. If the board revises a spending growth target, the board must provide public notice at least 60 days before the start of the calendar year to which the revised growth target will apply.

(c) The board, based on an analysis of drivers of health care spending and evidence from public testimony, shall evaluate strategies and new policies, including the establishment of accountability mechanisms, that are able to contribute to meeting growth targets and limiting health care spending growth without increasing disparities in access to health care.

Subd. 5. **Hearings.** At least annually, the board shall hold public hearings to present findings from spending growth target monitoring. The board shall also regularly hold public hearings to take testimony from stakeholders on health care spending growth, setting and revising health care spending growth targets, the impact of spending growth and growth targets on health care access and quality, and as needed to perform the duties assigned under section 62J.89, subdivisions 1, 2, and 3.

Sec. 6. **[62J.91] NOTICE TO HEALTH CARE ENTITIES.**

Subdivision 1. **Notice.** (a) The board shall provide notice to all health care entities that have been identified by the board as exceeding the spending growth target for any given year.

(b) For purposes of this section, "health care entity" shall be defined by the board during the development of the health care spending growth methodology. When developing this methodology, the board shall consider a definition of health care entity that includes clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations, integrated provider and plan systems, and other entities defined by the board, provided that physician organizations with a patient panel of 15,000 or fewer, or which represent providers who collectively receive less than $25,000,000 in annual net patient service revenue from health plan companies and other payers, shall be exempt.

Subd. 2. **Performance improvement plans.** (a) The board shall establish and implement procedures to assist health care entities to improve efficiency and reduce cost growth by requiring some or all health care entities provided notice under subdivision 1 to file and implement a performance improvement plan. The board shall provide written notice of this requirement to health care entities.

(b) Within 45 days of receiving a notice of the requirement to file a performance improvement plan, a health care entity shall:

(1) file a performance improvement plan with the board; or

(2) file an application with the board to waive the requirement to file a performance improvement plan or extend the timeline for filing a performance improvement plan.

(c) The health care entity may file any documentation or supporting evidence with the board to support the health care entity's application to waive or extend the timeline to file a performance improvement plan. The board shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application, provided that this information shall be made public at the discretion of the board. The board may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request in light of all information received from the health care entity, based on a consideration of the following factors:

(1) the costs, price, and utilization trends of the health care entity over time, and any demonstrated improvement in reducing per capita medical expenses adjusted by health status;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth;

(3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity. These factors may include but shall not be limited to age and other health status adjusted factors and other cost inputs such as pharmaceutical expenses and medical device expenses;

(4) the overall financial condition of the health care entity; and

(5) any other factors the board considers relevant. If the board declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the board shall provide written notice to the health care entity that its application for a waiver

or extension was denied and the health care entity shall file a performance improvement plan.

(d) A health care entity shall file a performance improvement plan with the board:

(1) within 45 days of receipt of an initial notice;

(2) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or

(3) if the health care entity is granted an extension, on the date given on the extension.

The performance improvement plan shall identify the causes of the entity's cost growth and shall include but not be limited to specific strategies, adjustments, and action steps the entity proposes to implement to improve cost performance. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan must not exceed 18 months.

(e) The board shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation. If the board determines that the performance improvement plan is unacceptable or incomplete, the board may provide consultation on the criteria that have not been met and may allow an additional time period of up to 30 calendar days for resubmission. Upon approval of the proposed performance improvement plan, the board shall notify the health care entity to begin immediate implementation of the performance improvement plan. Public notice shall be provided by the board on its website, identifying that the health care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the board. The board shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

(f) All health care entities shall in good faith work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan, the health care entity may file amendments to the performance improvement plan, subject to approval of the board. At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the board regarding the outcome of the performance improvement plan. If the board determines the performance improvement plan was not implemented successfully, the board shall:

(1) extend the implementation timetable of the existing performance improvement plan;

(2) approve amendments to the performance improvement plan as proposed by the health care entity;

(3) require the health care entity to submit a new performance improvement plan; or

(4) waive or delay the requirement to file any additional performance improvement plans.

Upon the successful completion of the performance improvement plan, the board shall remove the identity of the health care entity from the board's website. The board may assist health care entities with implementing the performance improvement plans or otherwise ensure compliance with this subdivision.

(g) If the board determines that a health care entity has:

(1) willfully neglected to file a performance improvement plan with the board within 45 days as required;

(2) failed to file an acceptable performance improvement plan in good faith with the board;

(3) failed to implement the performance improvement plan in good faith; or

(4) knowingly failed to provide information required by this subdivision to the board or knowingly provided false information, the board may assess a civil penalty to the health care entity of not more than $500,000. The board shall only impose a civil penalty as a last resort.

Sec. 7. **[62J.92] REPORTING REQUIREMENTS.**

Subdivision 1. **General requirement.** (a) The board shall present the reports required by this section to the chairs and ranking members of the legislative committees with primary jurisdiction over health care finance and policy. The board shall also make these reports available to the public on the board's website.

(b) The board may contract with a third-party vendor for technical assistance in preparing the reports.

Subd. 2. **Progress reports.** The board shall submit written progress updates about the development and implementation of the health care spending growth target program by February 15, 2025, and February 15, 2026. The updates must include reporting on board membership and activities, program design decisions, planned timelines for implementation

of the program, and the progress of implementation. The reports must include the methodological details underlying program design decisions.

Subd. 3. **Health care spending trends.** By December 15, 2025, and every December 15 thereafter, the board shall submit a report on health care spending trends and the health care spending growth target program that includes:

(1) spending growth in aggregate and for entities subject to health care spending growth targets relative to established target levels;

(2) findings from analyses of drivers of health care spending growth;

(3) estimates of the impact of health care spending growth on Minnesota residents, including for communities most impacted by health disparities, related to their access to insurance and care, value of health care, and the ability to pursue other spending priorities;

(4) the potential and observed impact of the health care growth targets on the financial viability of the rural delivery system;

(5) changes under consideration for revising the methodology to monitor or set growth targets;

(6) recommendations for initiatives to assist health care entities in meeting health care spending growth targets, including broader and more transparent adoption of value-based payment arrangements; and

(7) the number of health care entities whose spending growth exceeded growth targets, information on performance improvement plans and the extent to which the plans were completed, and any civil penalties imposed on health care entities related to noncompliance with performance improvement plans and related requirements.

Sec. 8. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for the following purposes:

(1) to evaluate the performance of the health care home program as authorized under section 62U.03, subdivision 7;

(2) to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations;

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities; ~~and~~

(5) to compile one or more public use files of summary data or tables that must:

(i) be available to the public for no or minimal cost by March 1, 2016, and available by web-based electronic data download by June 30, 2019;

(ii) not identify individual patients, payers, or providers;

(iii) be updated by the commissioner, at least annually, with the most current data available;

(iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

(v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015~~.~~; and

(6) to provide technical assistance to the Health Care Affordability Board to implement sections 62J.86 to 62J.92.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, 2023.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

Sec. 9. **[62V.12] STATE-FUNDED COST-SHARING REDUCTIONS.**

Subdivision 1. **Establishment.** (a) The board must develop and administer a state-funded cost-sharing reduction program for eligible persons who enroll in a silver level qualified health plan through MNsure. The board must implement the cost-sharing reduction program for plan years beginning on or after January 1, 2024.

(b) For purposes of this section, an "eligible person" is an individual who meets the eligibility criteria to receive a cost-sharing reduction under Code of Federal Regulations, title 45, section 155.305(g).

Subd. 2. **Reduction in cost-sharing.** (a) The cost-sharing reduction program must use state funds to reduce enrollee cost-sharing by increasing the actuarial value of silver level health plans for eligible persons beyond the 73 percent value established in Code of Federal Regulations, title 45, section 156.420(a)(3)(ii), to an actuarial value of 87 percent.

(b) Paragraph (a) applies beginning for plan year 2024 for eligible individuals expected to have a household income above 200 percent of the federal poverty level but that does not exceed 250 percent of the federal poverty level, for the benefit year for which coverage is requested.

(c) Beginning for plan year 2026, the cost-sharing reduction program applies for eligible individuals expected to have a household income above 250 percent of the federal poverty level but that does not exceed 300 percent of the federal poverty level, for the benefit year for which coverage is requested. Under this paragraph, the cost-sharing reduction program applies by increasing the actuarial value of silver level health plans for eligible persons to the 73 percent actuarial value established in Code of Federal Regulations, title 45, section 156.420(a)(3)(ii).

Subd. 3. **Administration.** The board, when administering the program, must:

(1) allow eligible persons to enroll in a silver level health plan with a state-funded cost-sharing reduction;

(2) modify the MNsure shopping tool to display the total cost-sharing reduction benefit available to individuals eligible under this section; and

(3) reimburse health carriers on a quarterly basis for the cost to the health plan providing the state-funded cost-sharing reductions.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 10. Minnesota Statutes 2022, section 256B.0631, is amended by adding a subdivision to read:

Subd. 1a. **Prohibition on cost-sharing and deductibles.** The medical assistance benefit plan must not include cost-sharing or deductibles for any medical assistance recipient or benefit.

EFFECTIVE DATE. This section is effective July 1, 2025, and applies to all medical assistance benefit plans offered, issued, or renewed on or after that date.

Sec. 11. **RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

(a) The commissioners of human services, health, and commerce and the MNsure board shall submit to the health care affordability board and the chairs and ranking minority members of the legislative committees with primary jurisdiction over health and human services finance and policy and commerce by January 15, 2024, a report on the organization and duties of the Office of Patient Protection, to be established under Minnesota Statutes, section 62J.89, subdivision 4. The report must include recommendations on how the office shall:

(1) coordinate or consolidate within the office existing state agency patient protection activities, including but not limited to the activities of ombudsman offices and the MNsure board;

(2) enforce standards and procedures under Minnesota Statutes, chapter 62M, for utilization review organizations;

(3) work with private sector and state agency consumer assistance programs to assist consumers with questions or concerns relating to public programs and private insurance coverage;

(4) establish and implement procedures to assist consumers aggrieved by restrictions on patient choice, denials of services, and reductions in quality of care resulting from any final action by a payer or provider; and

(5) make health plan company quality of care and patient satisfaction information and other information collected by the office readily accessible to consumers on the board's website.

(b) The commissioners and the MNsure board shall consult with stakeholders as they develop the recommendations. The stakeholders consulted must include but are not limited to organizations and individuals representing: underserved communities; persons with

disabilities; low-income Minnesotans; senior citizens; and public and private sector health plan enrollees, including persons who purchase coverage through MNsure, health plan companies, and public and private sector purchasers of health coverage.

(c) The commissioners and the MNsure board may contract with a third party to develop the report and recommendations.

Sec. 12. **REPEALER.**

Minnesota Statutes 2022, section 256B.0631, subdivisions 1, 2, and 3, are repealed.

EFFECTIVE DATE. This section is effective July 1, 2025.

ARTICLE 3
PUBLIC OPTION

Section 1. Minnesota Statutes 2022, section 256L.04, subdivision 7a, is amended to read:

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program, except as provided in subdivision 15.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 7. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 2. Minnesota Statutes 2022, section 256L.04, is amended by adding a subdivision to read:

Subd. 15. **Persons eligible for public option.** (a) Families and individuals with income above the maximum income eligibility limit specified in subdivision 1 or 7 but who meet all other MinnesotaCare eligibility requirements are eligible for MinnesotaCare. All other provisions of this chapter apply unless otherwise specified.

(b) Families and individuals may enroll in MinnesotaCare under this subdivision only during an annual open enrollment period or special enrollment period, as designated by MNsure in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 7. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2022, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines~~,~~ are no longer eligible for the program and ~~shall~~ must be disenrolled by the commissioner, unless the individuals continue MinnesotaCare enrollment through the public option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month in which the commissioner sends advance notice according to Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 7. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2022, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

~~(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).~~

~~(c)~~ (b) Paragraph ~~(b)~~ (a) does not apply to~~:~~

~~(1)~~ children 20 years of age or younger~~; and~~

~~(2) individuals with household incomes below 35 percent of the federal poverty guidelines~~.

~~(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:~~

~~**Federal Poverty Guideline Greater than or Equal to**~~	~~**Less than**~~	~~**Individual Premium Amount**~~
~~35%~~	~~55%~~	~~$4~~
~~55%~~	~~80%~~	~~$6~~
~~80%~~	~~90%~~	~~$8~~

~~90%~~	~~100%~~	~~$10~~
~~100%~~	~~110%~~	~~$12~~
~~110%~~	~~120%~~	~~$14~~
~~120%~~	~~130%~~	~~$15~~
~~130%~~	~~140%~~	~~$16~~
~~140%~~	~~150%~~	~~$25~~
~~150%~~	~~160%~~	~~$37~~
~~160%~~	~~170%~~	~~$44~~
~~170%~~	~~180%~~	~~$52~~
~~180%~~	~~190%~~	~~$61~~
~~190%~~	~~200%~~	~~$71~~
~~200%~~		~~$80~~

~~(e)~~ (c) Beginning January 1, ~~2021~~ 2024, the commissioner shall continue to charge premiums in accordance with the simplified premium scale established to comply with the American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31, 2025, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The commissioner shall adjust the premium scale ~~established under paragraph (d)~~ as needed to ensure that premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with the Code of Federal Regulations, title 42, section 600.505 (a)(1).

(d) The commissioner shall establish a sliding premium scale for persons eligible through the public option under section 256L.04, subdivision 15. Beginning January 1, 2027, persons eligible through the public option shall pay premiums according to this premium scale. Persons eligible through the public option who are 20 years of age or younger are exempt from paying premiums.

EFFECTIVE DATE. This section is effective January 1, 2024, and certification under section 7 is not required, except that paragraph (d) is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 7. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. **TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

(a) The commissioner of human services must continue to administer MinnesotaCare as a basic health program in accordance with Minnesota Statutes, section 256L.02,

subdivision 5, and must seek federal waivers, approvals, and law changes as required under section 6.

(b) The commissioner must present an implementation plan for the MinnesotaCare public option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by December 15, 2024. The plan must include:

(1) recommendations for any changes to the MinnesotaCare public option necessary to continue federal basic health program funding or to receive other federal funding;

(2) recommendations for ensuring sufficient provider participation in MinnesotaCare;

(3) estimates of state costs related to the MinnesotaCare public option;

(4) a description of the proposed premium scale for persons eligible through the public option, including an analysis of the extent to which the proposed premium scale:

(i) ensures affordable premiums for persons across the income spectrum enrolled under the public option; and

(ii) avoids premium cliffs for persons transitioning to and enrolled under the public option; and

(5) draft legislation that includes any additional policy and conforming changes necessary to implement the MinnesotaCare public option and the implementation plan recommendations.

(c) The commissioner shall present to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, by January 15, 2025, a report comparing service delivery and payment system models for delivering services to MinnesotaCare enrollees eligible under Minnesota Statutes, section 256L.04, subdivisions 1, 7, and 15. The report must compare the current delivery model with at least two alternative models. The alternative models must include a state-based model in which the state holds the plan risk as the insurer and may contract with a third-party administrator for claims processing and plan administration. The alternative models may include but are not limited to:

(1) expanding the use of integrated health partnerships under Minnesota Statutes, section 256B.0755;

(2) delivering care under fee-for-service through a primary care case management system; and

(3) continuing to contract with managed care and county-based purchasing plans for some or all enrollees under modified contracts.

(d) The report must also include:

(1) a description of how each model would address:

(i) racial inequities in the delivery of health care and health care outcomes;

(ii) geographic inequities in the delivery of health care;

(iii) incentives for preventive care and other best practices; and

(iv) reimbursement of providers for high-quality, value-based care at levels sufficient to sustain or increase enrollee access to care;

(2) a comparison of the projected cost of each model; and

(3) an implementation timeline for each model that includes the earliest date by which each model could be implemented if authorized during the 2025 legislative session.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 6. **REQUEST FOR FEDERAL APPROVAL.**

(a) The commissioner of human services must seek all federal waivers, approvals, and law changes necessary to implement article 3, including but not limited to those waivers, approvals, and law changes necessary to allow the state to:

(1) continue receiving federal basic health program payments for basic health program-eligible MinnesotaCare enrollees and to receive other federal funding for the MinnesotaCare public option;

(2) receive federal payments equal to the value of premium tax credits and cost-sharing reductions that MinnesotaCare enrollees with household incomes greater than 200 percent of the federal poverty guidelines would otherwise have received; and

(3) receive federal payments equal to the value of emergency medical assistance that would otherwise have been paid to the state for covered services provided to eligible enrollees.

(b) In implementing this section, the commissioner of human services must contract with one or more independent entities to conduct an actuarial analysis of the implementation, administration, and effects of the provisions of article 3, including but not limited to benefits, costs, impacts on coverage, and affordability to the state and eligible enrollees, impacts on

the state's individual market, and compliance with federal law, at a minimum as necessary to obtain any waivers, approvals, and law changes sought under this section.

(c) In implementing this section, the commissioner of human services must consult with the commissioner of commerce and the Board of Directors of MNsure and may contract for technical assistance.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 7. **CONTINGENT EFFECTIVE DATE.**

Sections 1, 2, and 3, and the specified portion of section 4, are effective January 1, 2027, or upon federal approval, whichever is later, but only if the commissioner of human services certifies to the legislature the following:

(1) that implementation of those sections will not result in substantial reduction in federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of the federal poverty guidelines;

(2) premiums necessary to operationalize the program are deemed affordable in accordance with applicable federal law;

(3) the actuarial value of benefit does not fall below 94 percent and the benefit set is equal to or greater than that historically available in MinnesotaCare;

(4) the 1332 waiver was approved consistent, or without substantial deviation, from the implementation plan;

(5) the commissioner of commerce certifies that the public option would expand plan options available for individuals purchasing coverage;

(6) the state receives a substantially similar pass-through funding amount from the federal government that would have otherwise gone to enrollees' advanced premium tax credits;

(7) individuals currently served by the MinnesotaCare program are not disproportionally or substantively negatively impacted in order to make the public option affordable or implementable; and

(8) individuals currently served by the Medical Assistance program are not disproportionally or substantively negatively impacted in order to make the public option affordable or implementable.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 4
HEALTH CARE MODEL STUDIES

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

Subdivision 1. **Definitions.** (a) "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, 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.

(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.

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.

Sec. 2. **BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM PROPOSAL.**

Subdivision 1. **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 contract must strive to produce estimates for all elements in subdivision 3.

Subd. 2. **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, proposed in 2023 Senate File No. 2740; House File No. 2798, if enacted, that would offer a universal health care plan designed to meet a set of principles, including:

(1) ensure all Minnesotans are covered;

(2) cover all necessary care; and

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

Subd. 3. **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) impact 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 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 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. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 5
APPROPRIATIONS

Section 1. **COMMISSIONER OF HUMAN SERVICES.**

(a) $505,000 in fiscal year 2024 and $579,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of human services for easy enrollment.

(b) $5,293,000 in fiscal year 2024 and $25,574,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of human services for medical assistance.

(c) $72,000 in fiscal year 2024 and $84,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of human services for responsibilities under the health care affordability board.

(d) $9,255,000 in fiscal year 2024 and $8,167,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of human services for the MinnesotaCare public option. The base for this appropriation is $3,417,000 in fiscal year 2026 and $7,960,000 in fiscal year 2027.

(e) $15,000 in fiscal year 2024 and $3,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of human services for system costs.

(f) $1,470,000 in fiscal year 2024 and $1,470,000 in fiscal year 2025 are appropriated from the health care access fund to the commissioner of human services for incentive payments to navigators.

(g) $1,077,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for MinnesotaCare.

Sec. 2. **BOARD OF DIRECTORS OF MNSURE.**

(a) $15,000,000 in fiscal year 2024 and $30,000,000 in fiscal year 2025 are appropriated from the general fund to the Board of Directors of MNsure to implement the cost-sharing reduction program under Minnesota Statutes, section 62V.12. The base for this appropriation is $32,500,000 in fiscal year 2026 and $35,000,000 in fiscal year 2027.

(b) $3,000,000 in fiscal year 2024 is appropriated from the general fund to the Board of Directors of MNsure to modernize MNsure's information technology infrastructure and expand service capacities to implement the cost-sharing reduction program under Minnesota Statutes, section 62V.12. This is a onetime appropriation.

(c) $313,000 in fiscal year 2024 and $514,000 in fiscal year 2025 are appropriated from the general fund to the Board of Directors of MNsure for administrative costs for the cost-sharing reduction program under Minnesota Statutes, section 62V.12.

(d) $70,000 in fiscal year 2024 and $70,000 in fiscal year 2025 are appropriated from the general fund to the Board of Directors of MNsure for easy enrollment.

(e) $39,000 in fiscal year 2024 and $16,000 in fiscal year 2025 are appropriated from the general fund to the Board of Directors of MNsure for responsibilities under the health care affordability board.

(f) $4,200,000 in fiscal year 2025 is appropriated from the general fund to the Board of Directors of MNsure to implement the MinnesotaCare public option. This is a onetime appropriation.

Sec. 3. **COMMISSIONER OF HEALTH.**

(a) $2,795,000 in fiscal year 2024 and $3,046,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of health to fund activities of the health economics division necessary to implement article 2, sections 1 to 8. The general fund base for this appropriation is $2,994,000 in fiscal year 2026 and $2,994,000 in fiscal year 2027.

(b) $1,200,000 is appropriated in fiscal year 2024 from the general fund to the commissioner of health to conduct an economic analysis of benefits and costs of the health care system proposal in section 1 and to contract as necessary to complete the analysis. This is a onetime appropriation and is available until June 30, 2026.

Sec. 4. **COMMISSIONER OF REVENUE.**

$40,000 in fiscal year 2024 and $4,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of revenue for easy enrollment.

Sec. 5. **COMMISSIONER OF COMMERCE.**

$42,000 in fiscal year 2024 and $17,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of commerce for responsibilities under the health care affordability board.

Sec. 6. **HEALTH CARE AFFORDABILITY BOARD.**

$1,336,000 in fiscal year 2024 and $1,727,000 in fiscal year 2025 are appropriated from the general fund to the Health Care Affordability Board to implement article 2, sections 1 to 8. The general fund base for this appropriation is $1,793,000 in fiscal year 2026 and $1,790,000 in fiscal year 2027.

256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room;

(10) services, fee-for-service payments subject to volume purchase through competitive bidding;

(11) American Indians who meet the requirements in Code of Federal Regulations, title 42, sections 447.51 and 447.56;

(12) persons needing treatment for breast or cervical cancer as described under section 256B.057, subdivision 10; and

(13) services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130.

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum for prescription drug co-payments; or

(2) for a recipient who has met their monthly five percent cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.