SEVENTEENTH DAY

St. Paul, Minnesota, Monday, February 25, 1991

The Senate met at 2:00 p.m. and was called to order by the President.

CALL OF THE SENATE

Mr. Luther imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

Prayer was offered by the Chaplain, Rev. Eugene A. Pouliot.

The members of the Senate gave the pledge of allegiance to the flag of the United States of America.

The roll was called, and the following Senators answered to their names:

Adkins	DeCramer	Kelly	Moe, R.D.	Renneke
Beckman	Dicklich	Knaak	Mondale	Riveness
Belanger	Finn	Kroening	Morse	Sams
Benson, D.D.	Flynn	Laidig	Neuville	Samuelson
Benson, J.E.	Frank	Langseth	Novak	Solon
Berg	Frederickson, D.J.	Larson	Olson	Spear
Berglin	Frederickson, D.R.	Lessard	Pappas	Storm
Bernhagen	Halberg	Luther	Pariseau	Stumpf
Bertram	Hottinger	Marty	Piper	Traub
Cohen	Hughes	McGowan	Pogemiller	Vickerman
Dahl	Johnson, D.E.	Mehrkens	Price	Waldorf
Davis	Johnson, D.J.	Merriam	Ranum	
Day	Johnston	Metzen	Reichgott	

The President declared a quorum present.

The reading of the Journal was dispensed with and the Journal, as printed and corrected, was approved.

MEMBERS EXCUSED

Mr. Chmielewski, Mrs. Brataas and Ms. Johnson, J.B. were excused from the Session of today.

EXECUTIVE AND OFFICIAL COMMUNICATIONS

The following communications were received.

February 19, 1991

The Honorable Robert E. Vanasek
Speaker of the House of Representatives

The Honorable Jerome M. Hughes

President of the Senate

I have the honor to inform you that the following enrolled Acts of the 1991 Session of the State Legislature have been received from the Office of the Governor and are deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

S.F. No.	H.F. No.	Session Laws Chapter No.	Time and Date Approved 1991	Date Filed 1991
	152	3	10:00 a.m. February 18	February 19

Sincerely,
Joan Anderson Growe
Secretary of State

February 22, 1991

The Honorable Robert E. Vanasek
Speaker of the House of Representatives

The Honorable Jerome M. Hughes
President of the Senate

I have the honor to inform you that the following enrolled Acts of the 1991 Session of the State Legislature have been received from the Office of the Governor and are deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

S.F. No.	H.F. No.	Session Laws Chapter No.	Time and Date Approved 1991	Date Filed 1991
	14	Res. No. 1	10:00 a.m. February 21	February 22

Sincerely,
Joan Anderson Growe
Secretary of State

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following House File, herewith transmitted: H.F. No. 245.

Edward A. Burdick, Chief Clerk, House of Representatives

Transmitted February 21, 1991

FIRST READING OF HOUSE BILLS

The following bill was read the first time and referred to the committee indicated.

H.F. No. 245: A bill for an act relating to education; providing for school consolidation in Kittson and Marshall counties in certain circumstances.

Referred to the Committee on Education.

REPORTS OF COMMITTEES

Mr. Moe, R.D. moved that the Committee Reports at the Desk be now adopted, with the exception of the report pertaining to appointments. The motion prevailed.

Mrs. Adkins from the Committee on Local Government, to which was referred

S.F. No. 126: A bill for an act relating to Meeker county; authorizing the county board to provide for an addition to the county hospital.

Reports the same back with the recommendation that the bill do pass and be re-referred to the Committee on Health and Human Services. Report adopted.

Mrs. Adkins from the Committee on Local Government, to which was referred

S.F. No. 119: A bill for an act relating to the city of Crookston; permitting the establishment of special service districts in the city of Crookston.

Reports the same back with the recommendation that the bill be amended as follows:

Page 1, line 20, after "*the*" insert "*city of*" and delete "*development authority*"

And when so amended the bill do pass and be re-referred to the Committee on Taxes and Tax Laws. Amendments adopted. Report adopted.

Ms. Berglin from the Committee on Health and Human Services, to which was referred

S.F. No. 148: A bill for an act relating to human services; case management of persons with mental retardation or related conditions; authorizing alternative methods for delivery of services; proposing coding for new law in Minnesota Statutes, chapter 256B.

Reports the same back with the recommendation that the bill be amended as follows:

Page 1, line 9, delete "AND" and insert "OR"

Page 1, line 13, delete "*people*" and insert "*persons*"

Page 1, line 14, delete "*and*" and insert "*or*"

Page 1, line 15, delete "*shall*" and insert "*must meet criteria established by the commissioner and, to the extent possible, must*"

Page 1, line 19, delete "*shall*" and insert "*must*"

Page 1, line 20, after "*following*" insert "*as they relate to the provision of case management*"

Page 2, line 6, before "*self-advocates*" insert "*or*"

Page 2, line 15, delete the first "*and*" and insert "*or*"

Page 2, line 23, before "*human*" insert "*health and*"

Page 2, line 24, delete "*committee*" and insert "*committees*" and delete "*legislature*" and insert "*senate and house of representatives*"

Page 2, line 25, delete "*department of human services*" and insert "*commissioner*"

Page 2, line 27, delete "*this*" and insert "*the*"

Page 2, line 28, delete "*shall*" and insert "*must*" and delete "*rules*" and insert "*Rules*"

Page 2, line 29, delete "*shall*" and insert "*may*"

Page 2, line 30, delete "*civil*" and after "*protections*" insert "*under sections 256.045, subdivision 4a, and 256B.092*"

Page 2, line 31, delete "*of human*"

Page 2, line 32, delete "*services*" and delete "*back*"

Page 2, line 36, delete "*shall expire*" and insert "*expires*"

Page 3, after line 1, insert:

"Sec. 3. [EFFECTIVE DATE.]

Section 1 is effective the day following final enactment."

And when so amended the bill do pass. Amendments adopted. Report adopted.

Mr. Moe, R.D. from the Committee on Rules and Administration, to which was referred under Rule 35, together with the committee report thereon,

S.F. No. 7: A bill for an act relating to liquor; authorizing the possession or use of alcoholic beverages at a private school under certain conditions; amending Minnesota Statutes 1990, section 624.701, subdivision 1a.

Reports the same back with the recommendation that the report from the Committee on Judiciary, shown in the Journal for February 7, 1991, be adopted; that committee recommendation being:

"the bill be amended and when so amended the bill do pass". Amendments adopted. Report adopted.

Mr. Moe, R.D. from the Committee on Rules and Administration, to which were referred for proper reference under Rule 35:

S.F. Nos. 41, 309, 319, 335, 355 and 369 reports the same back with the recommendation that the bills be re-referred as follows:

S.F. No. 41 to the Committee on Governmental Operations.

S.F. Nos. 309, 319, 335 and 355 to the Committee on Veterans and General Legislation.

S.F. No. 369 to the Committee on Judiciary.

Report adopted.

Mr. Waldorf from the Committee on Governmental Operations, to which was referred the following appointment as reported in the Journal for February 4, 1991:

STATE PLANNING AGENCY
COMMISSIONER

Linda Kohl

Reports the same back with the recommendation that the appointment be confirmed.

Mr. Moe, R.D. moved that the foregoing committee report be laid on the table. The motion prevailed.

Ms. Berglin from the Committee on Health and Human Services, to which was referred

S.F. No. 2: A bill for an act relating to health care; establishing the Minnesotans' health care plan to provide health coverage to uninsured and underinsured Minnesotans; requiring all Minnesotans to maintain health coverage; creating a department of health care access; requiring the new commissioner to set overall limits on health care spending and make recommendations regarding health care system reform; requiring an implementation plan and reports; creating a health care analysis unit; requiring data and research initiatives; establishing a rural health advisory committee; requiring joint rural health initiatives; restricting underwriting and premium rating practices; appropriating money; amending Minnesota Statutes 1990, sections 15.06, subdivision 1; and 43A.08, subdivision 1a; proposing coding for new law in Minnesota Statutes, chapters 16B; and 62J; repealing Minnesota Statutes 1990, sections 62E.51 to 62E.55.

Reports the same back with the recommendation that the bill be amended as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

HEALTH CARE ACCESS AGENCY

Section 1. Minnesota Statutes 1990, section 15.06, subdivision 1, is amended to read:

Subdivision 1. [APPLICABILITY.] This section applies to the following departments or agencies: the departments of administration, agriculture, commerce, corrections, jobs and training, education, employee relations, trade and economic development, finance, health, *health care access*, human rights, labor and industry, natural resources, public safety, public service, human services, revenue, transportation, and veterans affairs; the housing finance, state planning, and pollution control agencies; the office of commissioner of iron range resources and rehabilitation; the bureau of mediation services; and their successor departments and agencies. The heads of the foregoing departments or agencies are "commissioners."

Sec. 2. [16B.065] [STATE CONTRACTORS AND VENDORS; HEALTH COVERAGE FOR EMPLOYEES.]

To participate in a state contract or otherwise provide goods or services to a state agency, the contractor, vendor, or service provider must offer health coverage to its employees that meets the terms and conditions for

employer eligibility in the Minnesotans' health care plan in article 2, section 5. The contractor, vendor, or service provider may obtain health coverage through the Minnesotans' health care plan or an alternative source.

Sec. 3. Minnesota Statutes 1990, section 43A.08, subdivision 1a, is amended to read:

Subd. 1a. [ADDITIONAL UNCLASSIFIED POSITIONS.] Appointing authorities for the following agencies may designate additional unclassified positions according to this subdivision: the departments of administration; agriculture; commerce; corrections; jobs and training; education; employee relations; trade and economic development; finance; health; *health care access;* human rights; labor and industry; natural resources; office of administrative hearings; public safety; public service; human services; revenue; transportation; and veterans affairs; the housing finance, state planning, and pollution control agencies; the state board of investment; the office of waste management; the offices of the secretary of state, state auditor, and state treasurer; the state board of technical colleges; the Minnesota center for arts education; and the Minnesota zoological board.

A position designated by an appointing authority according to this subdivision must meet the following standards and criteria:

(1) the designation of the position would not be contrary to other law relating specifically to that agency;

(2) the person occupying the position would report directly to the agency head or deputy agency head and would be designated as part of the agency head's management team;

(3) the duties of the position would involve significant discretion and substantial involvement in the development, interpretation, and implementation of agency policy;

(4) the duties of the position would not require primarily personnel, accounting, or other technical expertise where continuity in the position would be important;

(5) there would be a need for the person occupying the position to be accountable to, loyal to, and compatible with the governor and the agency head, or the employing constitutional officer;

(6) the position would be at the level of division or bureau director or assistant to the agency head; and

(7) the commissioner has approved the designation as being consistent with the standards and criteria in this subdivision.

Sec. 4. [62J.03] [DEFINITIONS.]

Subdivision 1. [SCOPE.] *For purposes of this chapter, the following terms have the meanings given them.*

Subd. 2. [GROUPS; DEFINITIONS.] *The definitions of small group, medium-sized group, large group, and group sponsor in this section are subject to United States Code, title 26, sections 414(b), 414(c), and 414(m), and federal regulations related to those sections, when a group sponsor or sponsors alter, reform, or redefine a group or groups to avoid or to take advantage of community rating. The commissioners of health care access, commerce, and health may adopt rules to supplement those federal statutes and regulations to prevent qualification as a large, medium-sized, or small*

group through the use of separate organizations, multiple organizations, employee leasing, or other arrangements.

Subd. 3. [ADULT.] *"Adult" means a person 18 years of age or older.*

Subd. 4. [CHILD.] *"Child" means a person under 18 years of age.*

Subd. 5. [COMMISSIONER OR COMMISSIONER OF HEALTH CARE ACCESS.] *"Commissioner" or "commissioner of health care access" means the commissioner of health care access or, prior to the existence of that commissioner, the commissioner of human services.*

Subd. 6. [DEPARTMENT.] *"Department" means the department of health care access or, prior to the existence of that department, the bureau of health care access in the department of human services.*

Subd. 7. [GROUP SPONSOR.] *"Group sponsor" means an employer or other entity described in section 62A.10, subdivision 1, as an eligible purchaser of health coverage.*

Subd. 8. [HEALTH COVERAGE.] *"Health coverage" means a policy or contract providing health and accident benefit under chapter 62A, 62C, 62D, 62E, 62H, or 64B; under section 471.617, subdivision 2; or through the state plan. Health coverage does not include a policy or contract designed primarily to provide coverage on a per diem, fixed annuity, or nonexpense-incurred basis, or that provides only accident coverage.*

Subd. 9. [HEALTH PLAN COMPANY.] *"Health plan company" means any entity governed by chapter 62A, 62C, 62D, 62E, 62H, or 64B, or section 471.617, subdivision 2, that offers, sells, issues, or renews health coverage in this state. Health plan company does not include an entity that sells only policies designed primarily to provide coverage on a per diem, fixed annuity, or nonexpense-incurred basis, or policies that provide only accident coverage.*

Subd. 10. [HEALTH PROFESSIONAL.] *In benefit set descriptions, references to services performed by "health professionals" include services performed by any qualified health professionals acting within their licensed, certified, or registered scope of practice.*

Subd. 11. [INDIVIDUAL.] *"Individual" means an individual or family that applies to a health plan company or the state plan for health coverage on an individual or family basis.*

Subd. 12. [INTERMEDIATE BENEFIT SET.] *"Intermediate benefit set" means the health care benefits specified in article 3, sections 1 to 11.*

Subd. 13. [LARGE GROUP.] *"Large group" means a group of 100 or more employees or members of a group sponsor that applies for or obtains health coverage from a health plan company or the state plan. Owners of sole proprietorships, partnerships, and other unincorporated entities are employees for purposes of this definition. Dependents of employees or members do not count for purposes of this definition.*

Subd. 14. [MEDIUM-SIZED GROUP.] *"Medium-sized group" means a group of not fewer than 30 nor more than 99 employees or members of a group sponsor that applies for or obtains health coverage from a health plan company or the state plan. Owners of sole proprietorships, partnerships, and other unincorporated entities are employees for purposes of this definition. Dependents of employees or members do not count for purposes of this definition.*

Subd. 15. [MINIMUM INSURANCE BENEFIT SET.] *"Minimum insurance benefit set" means the health care benefits that must be included in health coverage offered, sold, issued, or renewed by health plan companies, as specified in article 3, section 14.*

Subd. 16. [MINNESOTA RESIDENT.] *"Minnesota resident" means a person whose principal place of residence is Minnesota and who (1) is employed in Minnesota; or (2) has resided in Minnesota for at least 90 consecutive days.*

Subd. 17. [SMALL GROUP.] *"Small group" means a group of not fewer than two nor more than 29 employees or members of a group sponsor that applies for or obtains health coverage from a health plan company or the state plan. Owners of sole proprietorships, partnerships, and other unincorporated entities are employees for purposes of this definition. Dependents of employees or members do not count for purposes of this definition.*

Subd. 18. [STATE PLAN.] *"State plan" means the Minnesotans' health care plan administered by the commissioner of health care access.*

Subd. 19. [SUPPLEMENTAL BENEFIT SET.] *"Supplemental benefit set" means the health care benefits available through the state plan that exceed the intermediate benefit set, as specified in article 3, section 15.*

Subd. 20. [UNIVERSAL BASIC BENEFIT SET.] *"Universal basic benefit set" means the health care benefits specified in article 3, section 12.*

Sec. 5. [62J.04] [BUREAU OF HEALTH CARE ACCESS.]

Subdivision 1. [DUTIES.] *The bureau of health care access in the department of human services shall undertake the initial design and implementation of the Minnesotans' health care plan and perform the duties assigned to the commissioner of health care access until the department of health care access has been established. The bureau of health care access is under the supervision of a deputy commissioner appointed by the commissioner of human services.*

Until July 1, 1993, the commissioner of human services has the duties and powers given to the commissioner of health care access. The commissioner of human services may also use any powers granted under other laws to carry out the duties assigned in this chapter.

Subd. 2. [CONTRACTS.] *When entering into contracts with health plans and health care providers, the bureau is not subject to the competitive bidding requirements in section 16B.07.*

Subd. 3. [EMPLOYEES.] *The commissioner of human services shall hire employees to carry out the duties of the department.*

Subd. 4. [RULES.] *The commissioner of human services may adopt permanent and emergency rules as necessary to carry out the duties assigned in this chapter.*

Subd. 5. [CONVERSION TO THE DEPARTMENT OF HEALTH CARE ACCESS.] *Effective July 1, 1993, the staff complement, appropriations, duties, and powers of the bureau of health care access of the department of human services are transferred to the department of health care access according to section 15.039.*

DEPARTMENT OF HEALTH CARE ACCESS

Sec. 6. [62J.05] [DEPARTMENT OF HEALTH CARE ACCESS.]

Subdivision 1. [EXECUTIVE AGENCY.] *The department of health care access is an agency in the executive branch headed by a commissioner of health care access who is appointed by the governor under section 15.06.*

Subd. 2. [GENERAL POWERS AND DUTIES.] *The commissioner of health care access shall:*

(1) administer the Minnesotans' health care plan;

(2) contract with providers, insurers, and health plans to provide coverage or health care to participants in state health programs administered by the commissioner and specify or negotiate the terms of the contracts;

(3) administer the reinsurance pool in article 6, section 12, and the biased selection adjustment in article 6, section 8;

(4) coordinate the health care programs administered by the commissioner with the medical assistance program administered by the commissioner of human services;

(5) have the authority to clarify and refine the terms of the intermediate benefit set, the supplemental benefit set, the minimum insurance benefit set, and the universal basic benefit set, including the authority to waive copayments, or establish a sliding scale copayment schedule that will result in reduced copayments, for enrollees with federal adjusted gross incomes below 185 percent of the federal poverty guideline;

(6) coordinate the mental health benefits of the health care programs administered by the commissioner with county-based mental health programs provided under the community social services act, and recommend changes to the state plan and community social services act programs that will improve the state plan's mental health benefits and minimize duplication with county-based programs;

(7) provide assistance to the commissioner of human services in order to secure waivers of federal requirements for federally subsidized health care programs as necessary to further the state's health care access goals and improve coordination between governmental health care programs;

(8) coordinate the health care programs administered by the commissioner with other state and local health care programs in order to make the most effective use of the state's market leverage and expertise in contracting and working with health plans and health care providers, and recommend to the legislature any changes needed to: (i) improve the effectiveness of public health care purchasing; and (ii) streamline and consolidate government health care programs; and

(9) with the advice of the health care expenditure advisory committee, establish an overall, statewide limit on total public and private health care spending in Minnesota and limits on annual health care spending increases, require compliance of all participants in the health care system with the spending limits, and make recommendations to the governor and the legislature regarding legislation or other actions that are needed to contain health care spending within the limits established by the commissioner. All participants in the health care system are required to take action necessary to ensure that total health care spending and increases in spending remain within the limits established by the commissioner.

Subd. 3. [CONTRACTS.] *When entering into contracts with health plans and health care providers, the commissioner is not subject to the competitive bidding requirements in section 16B.07.*

Subd. 4. [RULES.] *The commissioner may adopt permanent and emergency rules as necessary to carry out the duties assigned in this chapter.*

Subd. 5. [MONITORING OF EMPLOYERS.] *The commissioner shall conduct surveys and other activities to monitor changes over time, if any, in employers' behavior in providing subsidized health coverage. Detailed surveys of employer behavior must be conducted at least annually. After each survey is completed, the findings and an analysis of the positive or negative impact, if any, on the costs of the Minnesotans' health care plan resulting from changes in employers' behavior, and recommendations regarding actions necessary to address changes, must be reported to the commissioners of finance and revenue and to the chairs of the senate finance and house of representatives appropriations committees and the senate and house of representatives tax committees. If the commissioner anticipates that there will be increased state costs associated with a significant decrease in employer-subsidized health coverage, the commissioner of health care access shall submit draft legislation to raise additional revenues through an employer-paid payroll tax to the chairs of the senate finance and house of representatives appropriations committees and the senate and house of representatives tax committees.*

Subd. 6. [CHANGES IN FEDERAL HEALTH CARE PROGRAMS.] *The commissioner, in cooperation with the commissioner of human services, shall identify and pursue changes in federal health care programs that would allow them to be merged or more effectively coordinated with the health care programs administered by the department of health care access. The commissioner of health care access and the commissioner of human services may seek federal waivers, develop partnerships with federal health programs, and seek changes in federal programs.*

Sec. 7. [62J.06] [TECHNOLOGY AND BENEFITS ADVISORY COMMITTEE.]

Subdivision 1. [MEMBERSHIP.] *The commissioner shall convene a technology and benefits advisory committee consisting of consumers, health care providers and payors, a representative of the medical technology industry, and experts in medical ethics. Advisory committee members are appointed by the governor. The governor shall ensure that appointments result in a balance of interests on the committee. The commissioner of health care access shall make recommendations for appointments. The advisory committee is governed by section 15.059 except that it does not expire.*

Subd. 2. [DUTIES.] *The technology and benefits advisory committee is responsible for periodically reviewing, analyzing, and evaluating health care technology, benefits, and coverage and making recommendations to the commissioner and the legislature. The committee's recommendations must be based on the following principles: (1) universal and equitable access to health care procedures and technologies; (2) maintenance of an appropriate balance between expenditures for primary and preventive care, and expenditures for high-cost cases; (3) promotion of high quality and cost-effective health care; and (4) adherence to budget targets. The committee shall solicit comments and recommendations from interested persons during its deliberations. The committee is responsible for reviewing, analyzing, and making recommendations concerning at least the following:*

(i) the universal basic benefit set;

(ii) the intermediate benefit set;

(iii) the supplemental benefit set;

(iv) the minimum insurance benefit set;

(v) coverage for new procedures and technologies;

(vi) state mandated benefits applicable to insurers and other health plan companies;

(vii) benefit levels in other state health coverage programs; and

(viii) coverage and health care standards for cases subject to the reinsurance pool in article 6, section 12, which would be binding on the reinsurance pool.

Sec. 8. [62J.07] [HEALTH CARE EXPENDITURES ADVISORY COMMITTEE.]

Subdivision 1. [MEMBERSHIP.] *The health care expenditures advisory committee is a permanent committee whose members are appointed by the governor. Committee members include representatives of health insurers, health maintenance organizations, and other health plan companies; state agencies that administer government health programs; health care providers; labor; business; and consumer groups. The commissioner of health care access shall make recommendations to the governor regarding appointments to the committee. The governor shall ensure that appointments result in a balance of interests on the committee. The committee is governed by section 15.059, except that it does not expire.*

Subd. 2. [DUTIES.] *The health care expenditures advisory committee shall make recommendations to the commissioner for an overall statewide limit on total public and private health care spending in Minnesota and limits on annual health care spending increases.*

Subd. 3. [STAFF AND SUPPLIES.] *The commissioner of health care access shall provide the advisory committee with staff support and supplies.*

Sec. 9. [62J.08] [IMPLEMENTATION.]

Subdivision 1. [NEW PROGRAM PLANNING AND DEVELOPMENT.] *The commissioner shall begin planning and development for the state plan July 1, 1991. The commissioner shall use an implementation schedule that will lead to enrollment of eligible individuals, families, and employee groups statewide beginning July 1, 1992. Planning and development activities include:*

(1) development of outreach, enrollment, and eligibility determination procedures;

(2) commencement of outreach activities;

(3) planning, development, and acquisition of necessary computer systems, including forms, software, and training;

(4) development of health plan contractor specifications and issuance of requests for proposals;

(5) negotiating and executing health plan contracts;

(6) planning, development, and preparation of systems for direct health

care delivery management by the state or planning for the use of existing administrative systems in the department of human services, as necessary;

(7) preparations, requests for proposals, contract negotiations, and other activities relating to the reinsurance pool; and

(8) other appropriate planning and development activities.

Subd. 2. [TERMS OF PROGRAM CONSOLIDATION.] *In carrying out the merger, transfer, or reconfiguration of existing health care and health coverage programs, as described in this section, the commissioner shall:*

(1) ensure that health care benefits will not be diminished for enrollees and clients of current programs;

(2) assist current program enrollees and clients with the procedures necessary to maintain comparable health care benefits;

(3) ensure that financial obligations for public hospitals and other health care providers that serve the enrollees and clients of current programs will not increase as a result of the merger or transfer; and

(4) ensure coordination between the state plan, local public health departments, public hospitals, and other health care providers that serve the enrollees and clients of current programs in the areas of outreach, patient education, case management, and related services.

Subd. 3. [SHORT-TERM PROGRAM MERGERS.] *By July 1, 1993, or one year after the state plan begins statewide enrollment, whichever is later, the commissioner of health care access, with assistance from the commissioner of human services, shall take action necessary to merge the following programs into the state plan: the children's health plan, and the general assistance medical care program.*

Subd. 4. [SHORT-TERM PROGRAM TRANSFERS.] *By July 1, 1993, or one year after the state plan begins statewide enrollment, whichever is later, the commissioner of health care access, with assistance from the commissioners of human services and health, shall take action necessary to transfer part of the responsibilities and functions of the following programs to the state plan, to the extent that the state plan provides or will provide duplicate services: the services for children with handicaps program, the maternal and child health program, and the consolidated chemical dependency treatment fund. For chemical dependency coverage under the state plan, the commissioner shall:*

(1) adopt the consolidated chemical dependency treatment fund's process for patient evaluation and referral, to the extent possible within the state plan's managed care arrangements; and

(2) coordinate services with the consolidated chemical dependency treatment fund to ensure nonduplication of services and ease of transfer between the programs.

Subd. 5. [MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION.] *Effective July 1, 1992, or when the state plan begins statewide enrollment, whichever is later, no additional enrollments are permitted in the Minnesota comprehensive health association; and current enrollees may remain enrolled in the Minnesota comprehensive health association, may enroll in the state plan, or may obtain health care coverage in the private market. Enrollees in the state plan may choose the intermediate benefit set or both the intermediate and the supplemental benefit sets. The commissioner*

of health care access, with assistance from the commissioner of commerce, shall determine whether or not to include the Minnesota comprehensive health association in longer-term program transfers as stated in subdivision 7, after evaluating the rate of disenrollment from the Minnesota comprehensive health association. If the commissioner recommends merger, transfer, reconfiguration, or other changes to the Minnesota comprehensive health association, the changes must be made consistent with the requirements in subdivision 2.

Subd. 6. [MEDICAL ASSISTANCE.] *By July 1, 1995, the commissioner of health care access, with assistance from the commissioners of human services and health, shall take action necessary to merge all or part of the medical assistance program into the state plan, to the extent that a merger is permitted by federal waivers and will improve the cost-effectiveness of public health care purchasing and streamline and consolidate government health care programs.*

Subd. 7. [LONGER-TERM PROGRAM TRANSFERS.] *By July 1, 1995, the commissioner of health care access, with assistance from the commissioners of employee relations, corrections, and other affected agencies, shall take action necessary to transfer part of the responsibilities and functions of the following programs to the state plan: state and local government employee health benefits programs, corrections system health programs, the health care component of the Minnesota crime victims reparations board program, and other health care and health coverage programs sponsored by state or local government. The transfers must be limited to responsibilities and functions that the state plan provides or will provide, and to transfers that will improve the cost-effectiveness of public health care purchasing and streamline and consolidate government health care programs.*

Subd. 8. [LONGER-TERM PROGRAM RECONFIGURATION.] *By July 1, 1995, the commissioner of health care access, with assistance from the commissioners of labor and industry, commerce, and other affected agencies, shall take action necessary to reconfigure the following programs: the health care component of workers' compensation coverage, and the health care component of motor vehicle and motorcycle coverage. The program reconfigurations must be carried out in a way that significantly improves the cost-effectiveness of public and private health care purchasing and streamlines and consolidates public and private health care programs.*

Subd. 9. [LEGISLATION.] *If the commissioner determines that additional legislation is necessary to fully implement the Minnesotans' health care plan and other activities and requirements established in this chapter, the commissioner shall submit proposed legislation to the legislature by the dates indicated. The proposed legislation must include, but is not limited to, technical changes necessary to:*

(1) merge into the state plan the children's health plan and the general assistance medical care program, to be submitted by January 1, 1992;

(2) transfer to the state plan part of the responsibilities and functions of the services for children with handicaps program, the maternal and child health program, and the consolidated chemical dependency treatment fund, to be submitted by January 1, 1992;

(3) enforce the spending limits established under section 6, subdivision 2, clause (9), to be submitted by January 1, 1992;

(4) transfer to the department of health care access part of the responsibilities and functions of state and local government employee health benefits programs, corrections system health programs, the health care component of the Minnesota crime victims reparations board program, and other health care and health coverage programs sponsored by state and local government, to be submitted by January 1, 1994;

(5) reconfigure the health care components of the workers' compensation coverage and motor vehicle coverage, as described in subdivision 8, to be submitted by January 1, 1994;

(6) transfer to the department of health care access all or part of the responsibilities and functions of the medical assistance program, and to support the state's efforts to secure waivers of federal requirements for federally subsidized health care programs, to be submitted by January 1, 1994; and

(7) establish the content of and procedures for conversion to the universal basic benefit set, to be submitted by January 1, 1994.

Subd. 10. [ASSISTANCE FROM OTHER AGENCIES.] *At the request of the commissioner of health care access, the commissioners of health, commerce, state planning, human services, employee relations, labor and industry, corrections, finance, and other affected agencies shall provide assistance in planning, development, and implementation.*

Sec. 10. [STUDIES AND REPORTS.]

Subdivision 1. [HEALTH CARE DELIVERY SYSTEM REFORM.] *The health care expenditures advisory committee shall study and make recommendations regarding further reforms to the health care delivery system in Minnesota. The advisory committee shall solicit the comments, advice, and participation from communities with an interest in accessible, affordable health care. The commissioner shall submit a report on the recommendations of the advisory committee to the legislature by January 1, 1993.*

Subd. 2. [HEALTH PLAN REGULATION.] *The commissioner of health and the commissioner of commerce shall develop a plan for the functional division of regulatory authority over health plans. This plan must be presented to the legislature by January 1, 1992. The plan must allow each commissioner to exercise independent authority to the greatest extent possible and must minimize jurisdictional overlaps. The plan must provide the commissioner of commerce with primary authority for regulating the financial integrity and corporate structure of health plans and must provide the commissioner of health with primary authority for regulating health care delivery and health care quality.*

Subd. 3. [STANDARD CLAIM FORMS AND UTILIZATION REVIEW PROCEDURES.] *The commissioner of health care access shall recommend to the legislature a standard claim form for ambulatory care by January 1, 1993, and standards for certain types of utilization review procedures by January 1, 1994. These recommendations must not have the effect of limiting innovation and improvement in health care delivery management, or compromising the purposes for which information is collected.*

Sec. 11. [APPROPRIATIONS.]

Subdivision 1. [HUMAN SERVICES.] *$ . . . . . is appropriated from the general fund to the commissioner of human services for purposes of sections 1 to 10, to be available until June 30, 1993.*

Subd. 2. [COMMERCE.] *$ . . . . . is appropriated from the general fund to the commissioner of commerce for purposes of section 9 and section 10, subdivision 2, to be available until June 30, 1993.*

Subd. 3. [HEALTH.] *$ . . . . . is appropriated from the general fund to the commissioner of health for purposes of section 9 and section 10, subdivision 2, to be available until June 30, 1993.*

Subd. 4. [LABOR AND INDUSTRY.] *$ . . . . . is appropriated from the general fund to the commissioner of labor and industry for purposes of section 9, to be available until June 30, 1993.*

Sec. 12. [REPEALER.]

Subdivision 1. [CHEPP.] *Minnesota Statutes, sections 62E.51, 62E.52, 62E.53, 62E.531, 62E.54, and 62E.55, relating to the catastrophic health expense protection program, are repealed.*

Subd. 2. [BUREAU OF HEALTH CARE ACCESS.] *Section 5 is repealed effective July 1, 1993.*

Sec. 13. [EFFECTIVE DATES.]

Subdivision 1. [CREATION OF THE BUREAU OF HEALTH CARE ACCESS AND THE HEALTH CARE EXPENDITURES ADVISORY COMMITTEE.] *Sections 5 and 8 are effective July 1, 1991.*

Subd. 2. [CREATION OF THE DEPARTMENT OF HEALTH CARE ACCESS.] *The department of health care access is established effective July 1, 1993.*

Subd. 3. [TECHNOLOGY AND BENEFITS ADVISORY COMMITTEE.] *Section 7 is effective January 1, 1992.*

Subd. 4. [STATE CONTRACTORS.] *Section 2 is effective July 1, 1992, and applies to contracts entered into or renewed, or goods or services provided, after that date.*

ARTICLE 2

MINNESOTANS' HEALTH CARE PLAN

Section 1. [62J.09] [CREATION.]

The Minnesotans' health care plan is created to provide health coverage to individuals, families, and employers who do not have access to other affordable health coverage.

Sec. 2. [62J.10] [COVERAGE REQUIRED FOR MINNESOTA RESIDENTS.]

All Minnesota residents must obtain health coverage equal to or greater than the intermediate benefit set or the minimum insurance benefit set. Coverage may be obtained through the state plan, an employer, an individual policy with a private health plan company, or any other source of coverage. Minnesota residents must provide proof of coverage in the manner required by the commissioner of health care access.

Sec. 3. [62J.11] [ELIGIBILITY OF INDIVIDUALS AND FAMILIES.]

To be eligible to obtain coverage through the state plan, individuals and families must be Minnesota residents and have no other source of health coverage or must have coverage that primarily supplements, rather than duplicates, the intermediate benefit set. A Minnesota resident individual or

family may switch from private health coverage to the state plan provided the transfer does not result in simultaneous coverage under both the state plan and another health care plan. The individual or family must contribute to the cost of health coverage as provided in section 4.

Sec. 4. [62J.12] [INDIVIDUAL AND FAMILY PREMIUMS.]

Subdivision 1. [SLIDING SCALE.] *Each individual and family unit enrolled in the state plan shall pay a premium set in relation to gross income and family size. The commissioner shall establish a sliding scale to determine the amount of the premium each individual or family must pay to obtain health coverage through the state plan. The sliding scale must use the federal poverty guidelines as the primary unit of measurement, and must be based on an individual's or family's federal adjusted gross income as shown on the federal income tax return. If the family files separate returns, the federal adjusted gross income from the returns must be combined for purposes of computing the family's federal adjusted gross income. If coverage provided through the state plan is equivalent to the intermediate benefit set described in article 3, sections 2 to 11, the sliding scale must be designed so that individuals and families with incomes less than 25 percent of the federal poverty level pay 1.08 percent of their gross income, and those with incomes between 250 percent and 275 percent of the federal poverty level pay 6.5 percent of their gross income. Individuals and families with gross incomes over 275 percent of the federal poverty guideline or $40,000, whichever is less, are not eligible for a subsidized premium and must pay 100 percent of the cost of coverage through the state plan. For coverage that differs significantly from the intermediate benefit set, the sliding scale must be adjusted to reflect the differences in coverage. In addition to payments under the sliding scale, enrollees may be required to make greater payments depending on the health plan chosen. The commissioner shall pass differences in premiums between health plans on to enrollees, except that the commissioner may limit differences in charges to enrollees if necessary to prevent enrollment that exceeds the capacity of certain plans.*

Subd. 2. [ADJUSTMENTS TO THE INCOME LIMIT AND SLIDING SCALE.] *The commissioner shall adjust the sliding scale and the maximum income limit for subsidized coverage to reflect changes in prevailing income levels, health coverage costs, and benefit levels.*

Subd. 3. [MUST NOT HAVE ACCESS TO EMPLOYER-SUBSIDIZED COVERAGE.] *To be eligible for subsidized coverage, an individual or family must not have access to subsidized health coverage through an employer, unless the amount of employer subsidy toward the cost of coverage is less than an amount determined by the commissioner of health care access. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans as qualified employer subsidies toward the cost of health coverage for employees for purposes of this section.*

Subd. 4. [NO SUBSIDY AVAILABLE FOR MEDICARE SUPPLEMENT COVERAGE.] *An individual eligible for Medicare benefits must pay 100 percent of the cost of obtaining Medicare supplement coverage through the state plan, regardless of income.*

Subd. 5. [COVERAGE MUST NOT DISPLACE FEDERALLY SUBSIDIZED HEALTH COVERAGE.] *Subsidized state plan coverage must not displace subsidized health coverage through a federally supported health*

program. The commissioner shall establish procedures and requirements to allow coordinated, limited or supplemental participation in the Minnesotans' health care plan, including limited subsidies, of participants in federally supported health programs to the extent necessary to provide coverage comparable to coverage provided to other state plan enrollees without displacing federal benefits.

Subd. 6. [MUST BE A PERMANENT MINNESOTA RESIDENT.] *To be eligible for a subsidy, individuals and families must be permanent residents of Minnesota. A permanent Minnesota resident is a Minnesota resident who considers Minnesota to be the person's principal place of residence and intends to remain in the state permanently or for a long period of time and not as a temporary or short-term resident. An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident and is not entitled to subsidized coverage through the state plan.*

Sec. 5. [62J.13] [ELIGIBILITY OF EMPLOYERS.]

Subdivision 1. [GROUP COVERAGE.] *An employer is eligible to enroll its employees in the state plan as a group in order to offer its employees health coverage under the Minnesotans' health care plan. To be eligible to participate, an employer must pay Minnesota unemployment insurance premiums and have two or more covered employees, including the owner, or, if a sole proprietor, have at least one employee covered by unemployment insurance and include himself/herself in the group for purposes of health coverage. A self-employed person with no employees may not participate as an employer but may participate as an individual or family. The employer must collect employees' share of premiums and remit them to the commissioner along with the employer's contribution. Sliding scale premium subsidies as described in section 4 do not apply to group coverage. The commissioner shall establish conditions for enrollment of employer groups. Conditions may include, but are not limited to, minimum employer contributions toward coverage for employees and their families, minimum standards for employee eligibility, and eligibility waiting periods for new employees. The commissioner may establish special conditions and procedures for employers who are health care providers participating in state health care programs after considering the impact of article 1, section 2, and of different levels of employer contributions toward employee health coverage, on state health care program reimbursement rates and obligations. The commissioner shall make use of administrative systems for group coverage for employers that will identify and enroll enrollees in a manner comparable to individual, nongroup enrollment in order to enhance the portability of coverage to an individual policy or to another employer covered through the state plan, and to minimize administrative costs associated with frequent reissuing of policies.*

Subd. 2. [COVERAGE OF PART-TIME AND SEASONAL EMPLOYEES.] *The commissioner shall establish conditions, procedures, and a special accounting mechanism to allow employers to defray the cost of coverage for part-time and seasonal employees through the state plan without including these employees in the employer's health benefits program. This is the only circumstance under which an employer subsidy toward the cost of employee health coverage and a state subsidy for health coverage through the state plan may be combined. Employers that have terminated health benefits for part-time or seasonal employees within the three years before application are not eligible to participate in the part-time or seasonal*

employee enrollment system. Part-time or seasonal employees on whose behalf employer contributions have been submitted must obtain coverage through the state plan as individuals or families rather than as an employee group. The employer contributions must be used to reduce the premium that the employee would otherwise have owed, and will be in addition to any individual premium subsidy to which the employee would otherwise be entitled. The commissioner shall establish definitions and standards for part-time and seasonal employees as necessary to implement this subdivision.

Sec. 6. [62J.14] [COVERAGE.]

Subdivision 1. [INTERMEDIATE BENEFIT SET.] *Individuals, families, and groups with two to five employees or members may purchase the intermediate benefit set described in article 3, sections 2 to 11, through the state plan.*

Subd. 2. [SUPPLEMENTAL BENEFIT SET.] *Individuals, families, and groups covered by the intermediate benefit set may purchase at their own expense the supplemental benefit set as described in article 3, section 15, through the state plan. Groups with more than five employees or members that participate in the state plan must purchase the supplemental benefit set and the intermediate benefit set.*

PROGRAM ADMINISTRATION

Sec. 7. [62J.15] [PROVISION OF HEALTH CARE SERVICES; MANAGED CARE.]

In areas of the state where managed care health plans operate, the commissioner must deliver health care through contracts with managed care health plans. In order to qualify for participation in the state plan, a managed care health plan must meet the specifications in this section.

(a) The health plan must demonstrate to the satisfaction of the commissioner that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees.

(b) The health plan must have sufficient provider network capacity to adequately serve enrollees and prospective enrollees.

(c) The health plan must have established procedures adequate to manage the delivery of health care. The procedures must incorporate clear standards of practice or protocols where they exist. The procedures must also require enrollees to register with a specific primary care clinic which will coordinate referrals, hospitalizations, and other health care delivery. A plan that has not established these procedures may participate in the program if the plan demonstrates to the satisfaction of the commissioner that an alternative, comparably effective system of case management has been established. A managed care health plan that has not established procedures satisfactory to the commissioner may participate in the program if the plan agrees to implement satisfactory procedures within three years from the date it is accepted for participation by the commissioner.

(d) The health plan must demonstrate a long-term commitment to improving the quality and efficiency of health care.

(e) The health plan must have established programs to educate enrollees about appropriate use of the health care system. The programs may include

self-care education, telephone nurse access, encouragement of healthy lifestyles, and encouragement of conformance to prescribed courses of treatment.

(f) Health plans must notify enrollees by mail when coverage limits under the intermediate benefit set have been reached and explain that payment for future services in excess of the coverage limits are the responsibility of the patient.

(g) The health plan must include appropriate use of non-physician providers within its overall framework of managed care.

Sec. 8. [62J.16] [AREAS WITHOUT SATISFACTORY MANAGED CARE HEALTH PLANS.]

In areas of the state where the commissioner determines satisfactory managed care health plans are not available, the commissioner shall make health care available using one or more of the options specified in this section.

(a) The commissioner may recruit or encourage managed care health plans to serve the area.

(b) The commissioner may establish managed care health plans through direct contracts with existing clinics or other health care providers in the area consistent with the specifications and objectives of the state plan.

(c) The commissioner may pay providers on a fee-for-service basis, using the department of human services claims processing system, health care utilization review system, and other managed care procedures. When developing the payment system, the commissioner shall investigate the proposed Medicare resource-based relative value scale as the basis for a new fee schedule and the possibility of collective bargaining with health care providers. Participating providers must be required to operate under the department's managed care standards and procedures. Payment will be based on a fee schedule to be established by the commissioner with payments established at a level to ensure that program costs in the area are lower than under a managed care system. Providers must be required to accept program enrollees as a condition of serving patients covered by any health coverage program financed by state or local government, including public employee health benefit programs. Providers must be prohibited from billing enrollees for any portion of health care charges not reimbursed by the commissioner, except to collect copayments and deductibles or to charge for services that exceed coverage limits, to the extent these are specified in the state plan.

(d) The commissioner may establish health care clinics to provide services using managed care procedures.

Sec. 9. [62J.17] [ENCOURAGEMENT OF PARTICIPATION OF PROVIDERS SERVING LOW-INCOME PERSONS.]

The commissioner shall encourage expansion or development of health plans that include providers currently serving low-income, uninsured state residents, including nonprofit community clinics, public health departments, and public hospitals. The commissioner's managed care specifications must apply to these providers when serving program enrollees.

Sec. 10. [62J.18] [HEALTH PLAN COMPENSATION; GENERAL.]

The commissioner shall establish health plan payment arrangements in order to create financial incentives to improve the effectiveness and efficiency

of health care delivery. Health plans under contract with the state plan may not vary the benefits included in the intermediate benefit set in order to reduce the cost of premiums. Participating health plans must assume responsibility for health care delivery and must assume financial risk, subject to the limits established through the reinsurance pool. To prevent uncertainty regarding the mix and cost of enrollees from resulting in higher charges in the state plan during the first three years, the commissioner may share risk above or below the health plan's expected costs for state plan enrollees, to the extent that such risk sharing would reduce charges in the state plan. The risk sharing must not alter the community-rated basis for health plans premiums as specified in article 6, section 5. The commissioner shall establish a reserve fund or take other appropriate action to ensure that state funding will be available to fully satisfy the state's payment and risk-sharing obligations in the event the costs of coverage through the state plan are higher than expected. The commissioner is responsible for collecting premium payments from individuals, families, and employers and health plan reimbursement may not be linked to collection of premium payments.

Sec. 11. [62J.19] [OUTREACH ACTIVITIES.]

Subdivision 1. [OUTREACH TO INDIVIDUALS.] *The commissioner shall establish outreach activities to inform state residents about public and private sources of health coverage and to assist them in obtaining coverage. Outreach activities must include the following:*

(1) health coverage information and counseling services provided throughout the state and through a toll-free telephone number; and

(2) ongoing publicity and advertising activities.

Subd. 2. [OUTREACH TO EMPLOYERS.] *The commissioner shall establish outreach activities to inform employers about the Minnesotans' health care plan and other sources of health care coverage and to assist them to obtain or expand coverage for their employees. Outreach activities must be directed at the types of employers determined by the commissioner to be most interested in joining the state plan.*

Sec. 12. [62J.20] [ENROLLMENT EDUCATION AND ASSISTANCE.]

The commissioner shall provide enrollment education and assistance to state residents. The assistance may include written materials, workshops, and individual assistance. Educational programs and assistance must be designed to serve persons who are not proficient in English or who have special communication needs. The program must provide information on the following topics in addition to information provided at the discretion of the commissioner:

(1) basic and supplemental coverage offered by the state plan;

(2) features of specific health plans offered by the state plan, including information on obtaining health care within health plans and descriptions of provider networks;

(3) differences between individual and group coverage;

(4) premiums associated with each plan and premium payment procedures and obligations; and

(5) actions enrollees must take if eligibility status changes.

Sec. 13. [62J.21] [APPLICATION FORMS AND PROCEDURES.]

Subdivision 1. [PROCEDURES.] *The commissioner shall accept application forms submitted by mail or in person. Applicants must include payment equal to one month of premium costs with the completed application. Applicants who are employed full-time by an employer who participates in the state plan must apply through the employer. Part-time and seasonal employees of an employer who participates in the state plan may participate on an individual basis as provided in section 5, subdivision 2.*

Subd. 2. [FORMS.] *Application must be made on forms supplied by the commissioner. The commissioner shall design the form in order to collect the minimum amount of information necessary to administer the program. A more detailed form may be designed for use by applicants potentially eligible for federally subsidized health care programs and other state programs.*

Subd. 3. [AVAILABILITY OF FORMS.] *The commissioner shall make application forms available throughout Minnesota at state government offices; at hospitals, clinics, and other health care provider offices, especially where large numbers of low-income persons are served; with individual income tax forms; with applications for a driver's license, state identification card, or motor vehicle registration; with school and college registration materials; at food shelves; at the offices of insurers, health maintenance organizations, and other health plan companies; at school district offices; at public and private elementary schools; at community health offices; and at women, infants, and children (WIC) program sites.*

Sec. 14. [62J.22] [ELIGIBILITY DETERMINATION.]

Subdivision 1. [ELIGIBILITY VERIFICATION.] *The emphasis of eligibility verification procedures must be on achieving enrollment and coverage as soon after application as possible. To this end, confirmation of income and other information provided by the applicant shall occur primarily through use of personal data that the state gathers, such as income tax records, for other purposes. The commissioner may use individuals' social security numbers as identifiers for purposes of administering the plan.*

Subd. 2. [APPLICANT INFORMATION.] *Applicants shall submit evidence of family income, earned and unearned, for use in determining the amount of the premium and eligibility for a subsidy. Enrollees shall report changes in eligibility status as they occur.*

Subd. 3. [FRAUD.] *If subsequent to enrollment an enrollee in the state plan is found to have provided fraudulent information, the commissioner may disenroll the enrollee if the enrollee has sufficient, alternate coverage, but must maintain enrollment for those without alternate coverage. In all cases, the commissioner may recover premiums not paid due to fraud through the means listed in section 20, subdivision 3.*

Subd. 4. [REVERIFICATION.] *Eligibility for the state plan must be redetermined annually. The commissioner must use mail and other, simple means of obtaining information from enrollees, then engage in random checkups of the accuracy of information provided.*

Sec. 15. [62J.23] [ENROLLMENT.]

Subdivision 1. [COVERAGE EFFECTIVE DATE.] *Coverage becomes effective on the next first or 15th of a month, whichever comes first, after the commissioner transfers enrollment information to the health plan selected by the applicant. The transfer to the health plan must occur no later than*

two weeks after the commissioner receives a completed application and payment of one month of premium costs.

Subd. 2. [ENROLLMENT CONFIRMATION.] *No more than two weeks shall elapse between the time the commissioner receives a completed application and the applicant is notified of acceptance, rejection, or unusual delay and the reasons why. Refusal to provide a health history will not disqualify an applicant from the state plan. The commissioner shall operate a toll-free telephone service to confirm individual enrollment in the state plan. The service must be available to assist enrollees, health plans, and providers.*

Sec. 16. [62J.24] [OPEN ENROLLMENT.]

The commissioner shall establish an annual open enrollment period during which enrollees must be allowed to transfer between health plans. Enrollees may not transfer between plans during other periods unless their place of residence changes and their current plan does not provide coverage in the new location.

Sec. 17. [62J.25] [PREMIUM PAYMENTS; APPLICATION.]

The premium payment procedures established in sections 18 and 19 apply to coverage purchased through the Minnesotans' health care plan by an individual or an employer.

Sec. 18. [62J.26] [PAYMENTS FROM INDIVIDUALS.]

Subdivision 1. [AUTOMATIC PAYMENTS.] *The commissioner shall establish an automatic premium payment system and shall require enrollees not receiving group coverage through an employer to make payments through the automatic system whenever practical. The system may include automatic payment through:*

(1) automatic bank account debiting;

(2) automatic income withholding for employees, modeled after the system used for child support enforcement;

(3) automatic collections through the state income tax system, including automatic deductions for employees and estimated payments for self-employed enrollees;

(4) automatic deductions from unemployment compensation benefits; or

(5) other methods developed by the commissioner.

Subd. 2. [MANUAL PAYMENTS.] *The commissioner may allow manual payments directly from enrollees to the commissioner for enrollees:*

(1) making their initial premium payment with their application form;

(2) expected to remain on the program for a short period of time; or

(3) for whom automatic payments are impractical.

Subd. 3. [PAYMENT PERIODS.] *Premiums shall be paid on a monthly basis. The commissioner shall encourage enrollees to make premium payments covering longer periods of time whenever practical.*

Sec. 19. [62J.27] [EMPLOYER ENROLLMENT.]

Subdivision 1. [ENROLLMENT OF EMPLOYEES.] *Employers seeking to participate in the state plan must apply to the commissioner to enroll*

their employees. A person enrolled under this method ceases to be covered as a member of the employer's group when employment with the employer is discontinued. The commissioner shall establish procedures to convert enrollees from group coverage to individual coverage when they cease employment with an employer who participates in the program unless the enrollee can provide evidence of coverage through a new employer or through some other plan.

Subd. 2. [COLLECTION OF PREMIUMS.] *The commissioner shall require employers participating in the state plan to collect the employees' share of premiums and pay the employees' share and the employers' share directly to the commissioner.*

Subd. 3. [TECHNICAL ASSISTANCE TO EMPLOYERS.] *The commissioner must provide technical assistance to employers participating in the state plan. Technical assistance must be targeted to employers who do not currently offer employee health benefits or for whom technical assistance services are not readily available. The assistance must be provided at cost and may include assistance on the following:*

(1) designing and establishing a health benefit program;

(2) administering state and federal continuation coverage requirements; and

(3) establishing tax-sheltered premium accounts for employees.

Sec. 20. [62J.28] [ENFORCEMENT PROCEDURES.]

Subdivision 1. [EVIDENCE OF COVERAGE REQUIRED.] *The commissioner shall enforce the requirement that all state residents must maintain and show evidence of health insurance coverage.*

Subd. 2. [RESTRICTION ON TERMINATING COVERAGE.] *The commissioner shall prohibit an enrollee from terminating coverage in the Minnesotans' health care plan except when the enrollee provides evidence of alternative coverage.*

Subd. 3. [NONPAYMENT OF PREMIUM.] *The commissioner may not cancel an enrollee's participation in the state plan for failure to pay premiums. The commissioner shall attempt to collect unpaid premiums through the following methods:*

(1) automatic income withholding, modeled after the child support enforcement system;

(2) automatic payroll deductions; or

(3) other methods identified or developed by the commissioner.

Subd. 4. [IDENTIFICATION OF UNINSURED PERSONS.] *The commissioner shall develop and implement a system to identify state residents who have not obtained health care coverage. The system may include a survey question added to driver's license applications, income tax forms, school registration forms, and other similar forms. The system may include additional methods developed by the commissioner.*

Subd. 5. [PROVISION OF COVERAGE.] *The commissioner shall enroll state residents identified under subdivision 4 in the state plan and collect the appropriate premium from them.*

Subd. 6. [IMPLEMENTATION.] *In developing procedures to implement*

this section, the commissioner shall consult with the attorney general.

Sec. 21. [EFFECTIVE DATE FOR MANDATORY UNIVERSAL COVERAGE.]

Section 2 is effective July 1, 1993, or one year after the state plan becomes available statewide, whichever occurs later.

Sec. 22. [APPROPRIATION.]

$ . . . . . is appropriated from the general fund to the commissioner of human services for the purposes of section 9, to be available until June 30, 1993.

ARTICLE 3

COVERED SERVICES

THE INTERMEDIATE BENEFIT SET

Section 1. [62J.29] [AUTHORITY TO OFFER COVERAGE.]

Health plan companies participating in the state plan are authorized to offer, sell, issue, and renew the intermediate benefit set and the supplemental benefit set subject to the terms established by the commissioner of health care access, notwithstanding any contrary provisions of chapter 62A, 62C, 62D, 62E, 62J, or other laws governing health coverage.

Sec. 2. [62J.30] [COVERED SERVICES: PREVENTIVE CARE.]

(a) The intermediate benefit set covers expenses for the following preventive care services for all intermediate benefit set enrollees:

(1) prenatal and postnatal care;

(2) well baby exams for children under one year of age;

(3) immunizations; and

(4) selected tests, screenings, and examinations that are demonstrated to be cost-effective components of a preventive care program, including but not limited to: Pap tests for women age 18 and older at intervals recommended by the American Cancer Society; and mammograms for women age 50 and older at intervals recommended by the American Cancer Society.

(b) The intermediate benefit set covers the following services for children, if the services are provided as part of an early and periodic screening, diagnosis, and treatment (EPSDT) regimen:

(1) routine physical exams and well child exams, including the cost of laboratory and X-ray services associated with the exam;

(2) eye exams conducted by a licensed ophthalmologist or optometrist;

(3) hearing exams; and

(4) speech exams.

Sec. 3. [62J.31] [COVERED SERVICES: PRIMARY CARE; PRESCRIPTION DRUGS; INJECTIONS; SUPPLIES.]

Subdivision 1. [PRIMARY CARE.] *The intermediate benefit set covers a total of up to eight visits per year provided by primary care physicians, nurse practitioners, and physician assistants. "Visits" include office visits, home visits, and visits in a custodial facility. For the purpose of this benefit, "primary care physicians" include only general and family practitioners,*

internists, pediatricians, obstetricians, and gynecologists, when serving in a primary care, rather than a consultative, capacity. Additional visits are covered when they are an alternative to inpatient care. The limit on visits does not apply to children.

Subd. 2. [PRESCRIPTION DRUGS.] *The intermediate benefit set covers outpatient prescription drugs ordered by an authorized prescriber, including the dispensing fee, from a formulary specified by the commissioner. Adult prescriptions are subject to a $5 copayment. The commissioner shall establish a broader formulary for children. There is no copayment for prescriptions for children.*

Subd. 3. [THERAPEUTIC INJECTIONS.] *The intermediate benefit set covers therapeutic injections administered by a qualified health professional from a formulary specified by the commissioner. Therapeutic injections administered to adults are subject to a $5 copayment. The commissioner shall establish a broader formulary for children. There is no copayment for therapeutic injections administered to children.*

Subd. 4. [MEDICAL EQUIPMENT AND SUPPLIES FOR CHILDREN.] *The intermediate benefit set covers the following medical equipment and supplies for children:*

(1) appliances and equipment, including but not limited to orthotics, canes, crutches, glucosan, glucometers, intermittent positive pressure machines, rib belts for the treatment of an accident or illness, walkers, and wheelchairs;

(2) prosthetics and artificial parts that replace missing body parts or improve body function;

(3) one pair of eyeglasses every two years, unless more often if recommended by a qualified health professional. Contact lenses are not covered; and

(4) hearing aids.

Sec. 4. [62J.32] [COVERED SERVICES: ADDITIONAL OUTPATIENT SERVICES.]

Subdivision 1. [OUTPATIENT SPECIALIST AND THERAPY SERVICES.] *The intermediate benefit set covers a total of up to eight visits and consultations per year, excluding visits as defined in section 3, subdivision 1, provided by qualified health professionals. Additional visits are covered when they are an alternative to inpatient care. The limit on visits and consultations does not apply to children.*

Subd. 2. [OUTPATIENT SURGICAL SERVICES.] *The intermediate benefit set covers health professional and institutional outpatient surgical services, including surgery performed in a hospital outpatient department, physician's office, or freestanding surgical facility. This benefit includes services by an anesthesiologist or anesthetist for outpatient surgeries.*

Subd. 3. [RADIOLOGY AND PATHOLOGY SERVICES.] *The intermediate benefit set covers radiology and pathology services performed by a hospital outpatient department or a freestanding surgical facility. This benefit also provides for professional services provided by a qualified health professional when X-rays and laboratory procedures are performed in a physician's office, hospital outpatient department, or freestanding surgical facility.*

Subd. 4. [CARDIOVASCULAR TESTS AND PROCEDURES.] *The intermediate benefit set covers therapeutic services, cardiography, cardiac catheterization, and other cardiovascular services performed or ordered by a qualified health professional.*

Subd. 5. [ALLERGY TESTING AND IMMUNOTHERAPY FOR CHILDREN.] *The intermediate benefit set covers professional services and materials associated with allergy testing and immunotherapy provided to children, when administered by a qualified health professional.*

Subd. 6. [DIALYSIS PROCEDURES.] *The intermediate benefit set covers services by a qualified health professional for dialysis treatment, including hemodialysis, peritoneal dialysis, and miscellaneous dialysis procedures.*

Subd. 7. [MISCELLANEOUS TESTS AND PROCEDURES.] *The intermediate benefit set covers the following additional professional services: biofeedback services, gastroenterology services, otorhinolaryngology services, vestibular functions tests, noninvasive peripheral vascular diagnostic studies, pulmonary services, neurology services, chemotherapy services, and dermatology services.*

Sec. 5. [62J.33] [COVERED SERVICES: MENTAL HEALTH AND ALCOHOL OR DRUG DEPENDENCY CARE; INPATIENT AND OUTPATIENT.]

Subdivision 1. [INPATIENT MENTAL HEALTH.] *The intermediate benefit set covers 80 percent of the cost of inpatient hospitalization for treatment of mental disorders. After a family's total copayment for all covered inpatient benefits, including mental health and all other categories of covered inpatient care, except maternity, exceeds $2,500 in one calendar year, the intermediate benefit set covers 100 percent of additional services. After the intermediate benefit set has paid $70,000 in inpatient benefits of any kind except maternity for a person within a calendar year, the intermediate benefit set will cover no further inpatient benefits, except maternity, of any kind for that person for that calendar year.*

Subd. 2. [INPATIENT HEALTH PROFESSIONAL SERVICES; VISITS AND CONSULTATIONS.] *The intermediate benefit set covers, subject to subdivision 1, physician services for visits, consultations, and other care provided for treatment of mental disorders on an inpatient basis at a hospital or approved extended care facility. This benefit also provides for the care of critically ill patients in a variety of settings that require the constant attention of a qualified health professional. Consultations by nonphysicians are covered if provided by appropriate health professionals.*

Subd. 3. [INPATIENT ALCOHOL AND DRUG DEPENDENCY TREATMENT NOT COVERED.] *The intermediate benefit set does not cover inpatient hospital treatment of alcohol or drug dependency.*

Subd. 4. [OUTPATIENT MENTAL HEALTH.] *The intermediate benefit set covers up to ten hours per year of outpatient mental health therapy by a qualified professional. Two hours of group therapy count as one hour of individual therapy. Additional hours are covered when they are an alternative to inpatient care.*

Subd. 5. [OUTPATIENT ALCOHOL AND DRUG DEPENDENCY TREATMENT.] *The intermediate benefit set covers up to ten hours per year of outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient treatment program. Two hours of group treatment*

count as one hour of individual treatment.

Sec. 6. [62J.34] [COVERED SERVICES: MATERNITY.]

Subdivision 1. [INPATIENT MATERNITY; HOSPITAL SERVICES.] *The intermediate benefit set covers 80 percent of the cost of maternity inpatient care, consisting of room, board, and ancillary services. After a patient's total copayment for covered hospital services for inpatient maternity care reaches $500 per pregnancy, the intermediate benefit set covers 100 percent of additional services. This copayment is separate from the copayment for nonmaternity inpatient care. This benefit covers vaginal and caesarean deliveries, complications of pregnancy, miscarriages, and other medically necessary services. This subdivision includes only hospital inpatient services. This subdivision does not cover neonatal care or services associated with premature birth.*

Subd. 2. [OUTPATIENT MATERNITY; HOSPITAL SERVICES.] *The intermediate benefit set covers outpatient treatment of miscarriages, testing procedures such as amniocentesis and ultrasound, and other medically necessary procedures. This subdivision covers only use of hospital facilities and services by hospital employees.*

Subd. 3. [HEALTH PROFESSIONALS; OBSTETRICAL CARE.] *The intermediate benefit set covers health professional services for vaginal and caesarean deliveries, complications of pregnancy, miscarriages, and other medically necessary procedures. This benefit includes delivery care, surgical care, and anesthesia. This benefit does not include standard prenatal and postnatal visits, which the intermediate benefit set covers as preventive care in section 2.*

Sec. 7. [62J.35] [COVERED SERVICES: EMERGENCY CARE.]

Subdivision 1. [HOSPITAL EMERGENCY ROOM.] *After a $50 copayment paid by the insured, the intermediate benefit set covers hospital services for outpatient emergency medical care performed on an emergency basis in the emergency area of a hospital outpatient department or urgent care center. The $50 copayment is waived if the person is admitted to a hospital within 24 hours for a condition related to the emergency care. This subdivision does not include health professional services, which are covered in subdivision 2.*

Subd. 2. [HEALTH PROFESSIONALS; EMERGENCY ROOM CARE.] *The intermediate benefit set covers emergency services by qualified health professionals performed in the emergency area of a hospital outpatient department or urgent care center.*

Subd. 3. [AMBULANCE.] *The intermediate benefit set covers 80 percent of the cost of licensed ambulance service. Ambulance service for maternity care is not covered except when medically necessary.*

Sec. 8. [62J.36] [COVERED SERVICES: HOSPITAL INPATIENT AND HOME HEALTH CARE.]

Subdivision 1. [GENERAL COPAYMENT AND BENEFIT LIMIT; HOSPITALIZATION.] *The intermediate benefit set covers 80 percent of the cost of general inpatient hospitalization. After a family's total copayment for all covered inpatient benefits, including mental health and all other categories of covered inpatient care, except maternity, exceeds $2,500 in one calendar year, the intermediate benefit set covers 100 percent of additional services. After the intermediate benefit set has paid $70,000 in inpatient benefits of*

any kind except maternity for a person within a calendar year, the intermediate benefit set will cover no further inpatient benefits, except maternity, of any kind for that person for that calendar year.

Subd. 2. [HOSPITAL INPATIENT SERVICES.] *The intermediate benefit set covers, subject to subdivision 1, hospital services, including inpatient room, board, and ancillary services. The covered room charges are for a semiprivate room, except as otherwise provided in section 62E.06, subdivision 1, paragraph (c), clause (4). Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs, supplies, physical therapy, and other services normally provided by hospitals. Ancillary services do not include care by health professionals, whether or not employed by the hospital. This subdivision does not include maternity and related neonatal care, alcohol and drug abuse treatment, or inpatient confinement for nursing or custodial care.*

Subd. 3. [INPATIENT HEALTH PROFESSIONAL SURGERY.] *The intermediate benefit set covers, subject to subdivision 1, services by surgeons, assistant surgeons, anesthesiologists, anesthetists, and other qualified health professionals for surgery and related procedures, including normal presurgical and postsurgical examinations, for inpatient nonmaternity surgery.*

Subd. 4. [INPATIENT HEALTH PROFESSIONAL RADIOLOGY AND PATHOLOGY.] *The intermediate benefit set covers, subject to subdivision 1, services by physicians for radiology and pathology evaluation performed on an inpatient basis.*

Subd. 5. [INPATIENT HEALTH PROFESSIONAL SERVICES; VISITS AND CONSULTATIONS.] *The intermediate benefit set covers, subject to subdivision 1, physician services for visits, consultations, and other care provided on an inpatient basis at a hospital or approved extended care facility. This benefit also provides for the care of critically ill patients in a variety of settings that require the constant attention of the physician. Consultations by nonphysicians are covered if provided by appropriate health professionals.*

Subd. 6. [EXTENDED CARE FACILITIES.] *The intermediate benefit set covers, subject to subdivision 1, room, board, and ancillary services at an approved extended care facility that is the extended care unit of a hospital or an independent skilled nursing facility. This benefit covers only noncustodial care.*

Subd. 7. [PRIVATE DUTY NURSING; HOME HEALTH CARE.] *The intermediate benefit set covers, subject to subdivision 1, private duty nursing and home health visits by a home health professional if prescribed by the attending physician. Custodial care is not covered.*

Sec. 9. [62J.37] [COVERED SERVICES: CHILDREN'S DENTAL CARE.]

This benefit provides for preventive and nonpreventive services for children.

(a) The intermediate benefit set covers preventive services which include oral examinations, X-rays, fluoride applications, teeth cleaning, and other laboratory and diagnostic tests.

(b) The intermediate benefit set covers 80 percent of the cost of basic

nonpreventive services which include emergency treatment, space maintainers, simple extractions, surgical extractions, oral surgery, anesthesia services, restorations, periodontics, and endodontics.

(c) The intermediate benefit set covers 50 percent of the cost of major nonpreventive services which include inlays and crowns, dentures and other removable prosthetics, bridges and other fixed prosthetics, denture and bridge repair, and other prosthetics.

Sec. 10. [62J.38] [EXCLUDED SERVICES.]

Subdivision 1. [MEDICAL NECESSITY.] *The intermediate benefit set does not cover services that are not medically necessary.*

Subd. 2. [OTHER EXCLUDED SERVICES.] *Regardless of medical necessity, the intermediate benefit set does not cover the following services:*

(1) expenses listed under section 62E.06, subdivision 1, paragraph (c);

(2) inpatient treatment of alcoholism, chemical dependency, or drug addiction;

(3) treatment of temporomandibular joint disorder;

(4) treatment of craniomandibular disorder;

(5) orthodontia care;

(6) experimental procedures;

(7) custodial care;

(8) personal comfort or beautification;

(9) treatment for obesity;

(10) in vitro fertilization;

(11) artificial insemination;

(12) reversal of voluntary sterilization; and

(13) transsexual surgery.

Sec. 11. [62J.39] [INPATIENT CHEMICAL DEPENDENCY COVERAGE.]

Notwithstanding section 5, subdivision 2, and section 10, subdivision 2, clause (2), if there is insufficient money available to provide treatment through the consolidated chemical dependency treatment fund for all persons potentially eligible under section 254B.04, subdivision 1, the intermediate benefit set must cover medically necessary residential and inpatient treatment of alcoholism, chemical dependency, or drug addiction on the same basis that the intermediate benefit set covers general inpatient care and inpatient mental health care. The commissioner shall establish procedures for coordinating the intermediate benefit set with the consolidated chemical dependency treatment fund, including a mechanism for increasing payments to health plans or providers under article 2, sections 7 and 8, in the event the intermediate benefit set must be expanded to include inpatient and residential treatment.

UNIVERSAL BASIC BENEFIT PLAN

Sec. 12. [62J.40] [UNIVERSAL BASIC BENEFIT SET.]

Subdivision 1. [CONTENT OF THE UNIVERSAL BASIC BENEFIT

SET.] *The universal basic benefit set is a uniform standard of health coverage that will be available to all Minnesotans. The commissioner shall determine the content of the universal basic benefit set, with the advice of the technology and benefits advisory committee. The universal basic benefit set must include:*

(1) the benefits contained in the intermediate benefit set, including but not limited to full coverage for prenatal care, immunizations, and other preventive care as currently mandated for health maintenance organizations; and

(2) all or part of the mandated benefits currently required under chapters 60A, 62A, 62C, 62D, and 62E, as appropriate, based on an analysis of the requirements using the principles stated in article 1, section 7, subdivision 2.

Subd. 2. [CONVERSION TO THE UNIVERSAL BASIC BENEFIT SET.] *The following changes will occur on July 1, 1995:*

(1) the universal basic benefit set will replace the intermediate benefit set as the benefit set made available on a subsidized basis through the state plan;

(2) the supplemental benefit set will no longer be available through the state plan;

(3) the state plan may make available optional coverage that exceeds the universal basic benefit set;

(4) the intermediate benefit set will no longer be available in the private market;

(5) the universal basic benefit set will replace the mandated benefits currently required under chapters 60A, 62A, 62C, 62D, and 62E; and

(6) any health coverage programs sponsored by state or local government will be required to provide benefits equal to or better than the universal basic benefit set.

Sec. 13. [62J.41] [AVAILABILITY OF INTERMEDIATE BENEFIT SET.]

The intermediate benefit set is available only to individuals and to small groups containing no more than five employees or members. The intermediate benefit set may be offered through the state plan, and through the private market only by health plan companies participating in the state plan.

Sec. 14. [62J.42] [MINIMUM INSURANCE BENEFIT SET.]

For all health plan companies except those governed by chapter 62D, the minimum insurance benefit set is a number two qualified plan, as defined in section 62E.06, subdivision 2. For the purposes of this requirement, actuarial equivalence must not be used. For health plan companies governed by chapter 62D, the minimum insurance benefit set is the set of benefits required under chapter 62D. Except as provided in section 13, no health coverage may be offered, sold, issued, or renewed to any Minnesota resident or to any group in Minnesota unless the coverage meets or exceeds the requirements of the minimum insurance benefit set.

Sec. 15. [62J.43] [SUPPLEMENTAL BENEFIT SET.]

The supplemental benefit set includes the benefits commonly included in

group health coverage offered by health maintenance organizations operating under chapter 62D that are not included in the intermediate benefit set. The commissioner of health care access shall establish, by rule, uniform provisions for the supplemental benefit set. The state plan and health plan companies participating in the state plan must make the supplemental benefit set available as an option to any individual or group covered by the intermediate benefit set. For groups too large to qualify for the intermediate benefit set, the intermediate benefit set combined with the supplemental benefit set will be the only benefit set available through the state plan.

Sec. 16. [EFFECTIVE DATE.]

Sections 1 to 15 are effective on July 1, 1992.

ARTICLE 4

RESEARCH AND DATA COLLECTION

Section 1. [62J.44] [HEALTH CARE ANALYSIS UNIT.]

Subdivision 1. [ESTABLISHMENT.] *The commissioner shall establish a health care analysis unit to conduct data and research initiatives in order to improve the efficiency and effectiveness of health care in Minnesota.*

Subd. 2. [GENERAL DUTIES; IMPLEMENTATION DATE.] *The commissioner, through the health care analysis unit, shall:*

(1) conduct applied research using existing and newly established health care data bases, and promote applications based on existing research;

(2) establish the condition-specific data base required under section 2;

(3) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plans;

(4) work closely with health plans and health care providers under contract with the commissioner of health care access to promote improvements in health care efficiency and effectiveness;

(5) periodically evaluate the state's existing health care financing and delivery programs, and the health programs created or administered by the commissioner of health care access;

(6) regularly prepare estimates, specific to Minnesota, of total health service expenditures and sources of payment;

(7) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management;

(8) conduct periodic surveys, including those required by section 4; and

(9) provide technical assistance to health plan and health care purchasers, as required by section 5.

The commissioner shall begin implementation of these data collection and research initiatives by July 1, 1992.

Subd. 3. [CRITERIA FOR UNIT INITIATIVES.] *Data and research initiatives by the health care analysis unit must:*

(1) serve the needs of the general public, public sector health care programs, employers and other purchasers of health care, health care providers, including providers serving large numbers of low-income people, and health

plan companies;

(2) promote a significantly accelerated pace of publicly disseminated, applied research on health care delivery, outcomes, costs, quality, and management;

(3) conduct research and promote health care applications based on scientifically sound and statistically valid methods;

(4) be statewide in scope, in order to benefit health care purchasers and providers in all parts of Minnesota and to ensure a broad and representative data base for research, comparisons, and applications;

(5) emphasize data that is useful, relevant, and nonredundant of existing data. The initiatives may duplicate existing private activities, if this is necessary to ensure that the data collected will be in the public domain;

(6) be structured to minimize the administrative burden on health plans, health care providers, and the health care delivery system; and

(7) promote continuous improvement in the efficiency and effectiveness of health care delivery.

Subd. 4. [CRITERIA FOR PUBLIC SECTOR HEALTH CARE PROGRAMS.] *Data and research initiatives related to public sector health care programs must:*

(1) assist the state's current health care financing and delivery programs, and the state plan, to deliver and purchase health care in a manner that promotes improvements in health care efficiency and effectiveness;

(2) assist the state in its public health activities, including the analysis of disease prevalence and trends and the development of public health responses;

(3) assist the state in developing and refining its overall health policy, including policy related to health care costs, quality, and access; and

(4) provide a data source that allows the evaluation of state health care financing and delivery programs.

Subd. 5. [DATA COLLECTION PROCEDURES.] *The health care analysis unit shall collect data from health care providers, health plan companies, and individuals in the most cost-effective manner. The unit may require health care providers and health plan companies to collect and provide patient health data, provide mailing lists of patients, and cooperate in other ways with the data collection process. All patient-identifying information is classified as private data. The health care analysis unit may assign, or require health care providers and health plan companies to assign, a unique identification number to each patient to safeguard patient identity.*

Subd. 6. [DATA IN PUBLIC DOMAIN.] *Data collected through the research initiatives and activities of the health care analysis unit are classified as public data under section 13.03, except that any patient-identifying information is private data. When appropriate, the unit shall allow health care providers and health plan companies an opportunity to respond to findings prior to public dissemination of data. Initial findings shall be made available to the public by January 1, 1994.*

Sec. 2. [62J.45] [LARGE-SCALE DATA BASES.]

The health care analysis unit shall establish a large-scale data base for

a limited number of health conditions. This initiative must meet the following requirements:

(1) the data collected must be for specific health conditions, rather than specific procedures, types of health care providers, or services;

(2) the data collected must include information on health outcomes, including information on mortality, patient functional status and quality of life, symptoms, and patient satisfaction;

(3) the data collected must include information necessary to measure and make adjustments for differences in severity of patient condition across different health care providers, and may include data obtained directly from the patient or from patient medical records;

(4) the initiative must emphasize conditions that account for significant total costs, when considering both the frequency of a condition and the unit cost of treatment. The initial emphasis must be on the study of conditions commonly treated in hospitals on an inpatient or outpatient basis, or in freestanding outpatient surgical centers. As improved data collection and evaluation techniques are incorporated, this emphasis shall be expanded to include entire episodes of care for a given condition, whether or not treatment includes use of a hospital or a freestanding outpatient surgical center;

(5) the data must be collected in a manner that allows comparisons to be made between providers, health plan companies, public programs, and other entities; and

(6) data collection for any one condition must continue for a sufficient time to permit adequate analysis, feedback to providers, and monitoring for changes in practice patterns.

Sec. 3. [62J.46] [USE OF EXISTING PUBLIC SECTOR DATA BASES.]

The health care analysis unit shall use existing public sector data bases, such as those existing for medical assistance and Medicare, to the greatest extent possible. The unit shall establish linkages between existing public sector data bases, and consider and implement methods to streamline public sector data collection in order to reduce public and private sector administrative costs.

Sec. 4. [62J.47] [SURVEY RESEARCH.]

The health care analysis unit shall conduct periodic surveys to accomplish the data and research goals listed in section 1. These surveys shall include, but are not limited to:

(1) surveys of enrollee satisfaction with health plans and health care providers;

(2) surveys to monitor changes over time in financial and geographic access and sources of health coverage;

(3) surveys of health service prices, especially for services less commonly covered by health insurance, or for which patients commonly face significant out-of-pocket expenses;

(4) surveys of health plan prices, especially for health plans sold on a community-rated or table-rated basis; and

(5) surveys of new procedures and treatments performed by health care providers, as a basis for considering changes in the benefits provided by state health coverage programs.

Sec. 5. [62J.48] [TECHNICAL ASSISTANCE FOR PURCHASERS.]

The health care analysis unit shall provide technical assistance to health plan and health care purchasers. The unit shall collect information about:

(1) premiums, benefit levels, managed care procedures, health care outcomes, and other features of popular health plans and health plan companies; and

(2) prices, outcomes, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses.

The commissioner shall publicize this information in an easily understandable format.

Sec. 6. [STUDY OF ADMINISTRATIVE COSTS.]

The health care analysis unit shall study costs and requirements incurred by health plan companies and health care providers that are related to the collection and submission of information to the state and federal government, insurers, and other third parties. The unit shall recommend to the commissioner by January 1, 1993, any reforms that may reduce these costs without compromising the purposes for which the information is collected.

Sec. 7. [APPROPRIATION.]

$ . . . . . is appropriated from the general fund to the commissioner of human services to establish a health care analysis unit and implement the initiative required by sections 1 to 6.

ARTICLE 5

RURAL HEALTH CARE

Section 1. [62J.49] [RURAL HEALTH ADVISORY COMMITTEE.]

Subdivision 1. [ESTABLISHMENT; MEMBERSHIP.] *The commissioner shall establish a 15-member rural health advisory committee. The committee shall consist of consumers, rural health care providers, experts on rural health, and community leaders from rural Minnesota. The department of health care access will make recommendations for committee membership. Committee members will be appointed by the governor. The terms, compensation, and removal of members are governed by section 15.059. The advisory committee does not expire as provided in section 15.059, subdivision 5.*

Subd. 2. [DUTIES.] *The advisory committee shall:*

(1) advise the commissioner of health care access, the commissioner of health, and other state agencies on rural health issues;

(2) provide a systematic and cohesive approach toward rural health issues and rural health care planning, at both a local and statewide level;

(3) develop and evaluate mechanisms to encourage greater cooperation among rural communities and among providers;

(4) recommend and evaluate approaches to rural health issues that are sensitive to the needs of local communities;

(5) develop methods for identifying individuals who are underserved by the rural health care system; and

(6) evaluate the Minnesotans' health care plan and recommend program changes needed to better address problems and needs in rural health care.

Subd. 3. [STAFFING; OFFICE SPACE; EQUIPMENT.] *The commissioner shall provide the advisory committee with staff support, office space, and access to office equipment and services.*

Sec. 2. [62J.50] [RURAL HEALTH INITIATIVES.]

The commissioner of health care access, consulting as necessary with the commissioner of health and other state agencies, shall:

(1) study and develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services. Where possible, this plan will guide the department of health care access in contracting for health care delivery throughout Minnesota;

(2) develop and administer a planning and transition grant program for rural hospitals, health care providers, and communities. Grants may be used for planning regarding the use of facilities, recruitment of health personnel, and coordination of health services;

(3) develop and administer a program of financial assistance for rural hospitals in isolated areas of the state that are in danger of closing without financial assistance, and that have exhausted local sources of support;

(4) develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

(5) develop a statewide, coordinated recruitment strategy for health care personnel;

(6) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

(7) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages;

(8) develop recommendations for establishing telecommunication systems to improve rural health education and health care delivery;

(9) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas;

(10) support efforts to secure higher reimbursement for rural health care providers from the Medicare program; and

(11) carry out other activities necessary to address rural health problems.

Sec. 3. [62J.51] [DATA BASE ON HEALTH PERSONNEL.]

The health care analysis unit established under article 4, section 1, shall develop and maintain a data base on health services personnel. The health care analysis unit shall use this information to assist local communities and units of state government to develop plans for the recruitment and retention of health personnel. Information collected in the data base must include, but is not limited to, data on levels of educational preparation, specialty, and place of employment. The unit is authorized to collect information through the health professions registration and licensure systems, with the cooperation of the state health licensing boards.

Sec. 4. [APPROPRIATION.]

(a) $ . . . . . is appropriated from the general fund to the commissioner of health for the biennium ending June 30, 1993, to implement the initiatives required under section 2.

(b) $ . . . . . is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 1993, to implement the initiatives required under section 2.

(c) $ . . . . . is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 1993, to establish a rural health advisory committee.

Sec. 5. [EFFECTIVE DATE.]

Subdivision 1. [CREATION OF THE RURAL HEALTH ADVISORY COMMITTEE.] *Section 1 is effective January 1, 1992.*

Subd. 2. [RURAL HEALTH INITIATIVES.] *Sections 2 and 3 are effective July 1, 1991.*

ARTICLE 6

HEALTH COVERAGE; UNDERWRITING AND PREMIUMS; REINSURANCE POOL

Section 1. [62J.52] [PROVISION OF COVERAGE.]

No health plan company may deny an application for health coverage submitted to it by an individual, small group, or medium-sized group, if the health plan company offers, sells, issues, or renews health coverage to entities of the same category as the entity that submitted the application.

Sec. 2. [62J.53] [CANCELLATION.]

No health plan company may cancel or fail to renew health coverage that it provides to an individual, small group, or medium-sized group, except for nonpayment of a legally permitted premium or copayment, fraud or misrepresentation, noncompliance with plan provisions, or failure to maintain legally permitted participation requirements.

Sec. 3. [62J.54] [PREEXISTING CONDITIONS.]

Subdivision 1. [BASIC COVERAGE.] *No health plan company may limit basic coverage provided to an individual, small group, or medium-sized group on the basis of the past or present health status, disability, health care utilization, occupation, or any other characteristic of any person, except as allowed in this section. Limitations on coverage include, but are not limited to, waiting periods, excluded or restricted conditions or types of coverage, and similar restrictions. For the purposes of this requirement,*

"basic coverage" means the minimum insurance benefit set or the intermediate benefit set.

Subd. 2. [OPTIONAL COVERAGE.] *For optional coverage, a health plan company may require a waiting period of up to 12 months for coverage of preexisting health conditions. This waiting period may not be used for optional coverage purchased at the time of an individual's initial enrollment in the state plan or when an individual's or group's optional coverage is substantially similar to coverage currently in force with another health plan company. For the purposes of this requirement, "optional coverage" means any coverage in excess of the minimum insurance benefit set or the intermediate benefit set.*

Subd. 3. [RECENT ARRIVALS IN MINNESOTA.] *A health plan company may require a waiting period of up to 12 months for coverage of preexisting health conditions for persons who recently relocated to the state. The waiting period cannot exceed 12 months from the time the person became a permanent Minnesota resident, except that if the individual or family moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition, the health plan may exclude coverage of that preexisting condition for up to 36 months.*

Sec. 4. [62J.55] [LEVEL COMMISSIONS.]

No health plan company may pay commissions or other compensation to an agent or broker, with respect to the sale of health coverage, unless payment of the commissions is spread evenly over a period of at least five years from the date of purchase of the coverage.

Sec. 5. [62J.56] [COMMUNITY RATING REQUIRED.]

Subdivision 1. [COMMUNITY RATING.] *No health plan company may offer, sell, issue, or renew health coverage to any individual or small group, unless the premium charged for the coverage is community rated. If the health plan company participates in the state plan, the community rate charged in the private market must equal the rate charged in the state plan. For individual and small group health coverage, health plan companies must use the following three rate cells only: (1) one person; (2) a two-person family; and (3) a family of three or more persons.*

Subd. 2. [LIMITATIONS.] *The community rating may not take into account the age, sex, health status, disability, occupation, geographical location, or any other factors except the following:*

(1) differences in benefit levels;

(2) differences in family size, except that family members in excess of three must be disregarded;

(3) actual differences in acquisition and administration costs between individuals as a whole and small groups as a whole; and

(4) premium reductions of no more than four percent for individuals or small groups that engage in activities or practices intended to promote the health of the covered persons.

Sec. 6. [62J.57] [COMPENSATION OF AGENTS.]

Subdivision 1. [COMPENSATION; PRIVATE MARKET.] *No health plan company shall, with respect to health coverage provided in the private market:*

(1) make the amount of its compensation of an agent, broker, or employee depend in any way, directly or indirectly, upon the loss ratio or any other underwriting performance of health coverage written through the agent, broker, or employee; or

(2) cancel, terminate, or fail to renew an agency, brokerage, or employment contract or arrangement, or reduce or restrict underwriting authority on the basis of the loss ratio, or any other underwriting performance of health coverage written through an agent, broker, or employee.

Subd. 2. [COMPENSATION; STATE PLAN.] *No health plan company shall, with respect to health coverage provided through the state plan, pay agent commissions.*

Sec. 7. [62J.58] [COMMUNITY RATING; MEDICARE SUPPLEMENTAL.]

Health plan companies that sell Medicare supplemental coverage must establish a separate community rate, as described in section 5, for that coverage. The community rate must be the same in the private market as in the state plan, for health plan companies that sell that coverage through the state plan.

Sec. 8. [62J.59] [BIASED SELECTION ADJUSTMENT.]

Subdivision 1. [REPORT.] *Each health plan company must annually provide the commissioner of health care access with a report of the number of males and females that it insured in the individual and small group market for the past calendar year, together with data showing the age distribution of the insureds, separately for males and females. A person insured by that company for only a portion of the year counts on a pro rata basis, based upon the closest whole number of months during which that person was covered. For each age-sex combination, the total cost incurred must be shown. Data must be shown separately for Medicare supplemental coverage and for coverage provided through the state plan and through the private market. The commissioner may also require the report to contain other information necessary to administration of the biased selection adjustment, including but not limited to: (1) coverage levels; (2) reinsurance pool premiums; and (3) managed care activities that affect costs.*

Subd. 2. [ASSESSMENTS AND PAYMENTS.] *Each company must pay an assessment or receive a reimbursement, based upon the extent to which that company's age-sex distribution of insureds differs from the statewide average for the entire individual and small group market. The commissioner of health care access shall adopt rules specifying a procedure for determining the amount of the reimbursement or assessment with respect to individual companies. The rules for determining the amounts of reimbursements to and assessments on individual health plan companies must take into account differences in coverage levels, reinsurance pool premiums, and managed care activities that affect costs. Health plan companies whose inefficient managed care activities result in higher costs must not be compensated for those higher costs by this biased selection adjustment, to the extent possible given the information available to the commissioner about the characteristics and activities of different companies that affect their efficiency.*

Subd. 3. [TRUST FUND.] *Payment of assessments must be made to the commissioner of health care access and maintained in a separate trust fund, out of which the reimbursements required by this section will be paid.*

Reimbursements will be made only out of this trust fund and only to the extent of assessments received. Any shortfall in assessment payments received result in pro rata adjustments in reimbursements made to health plan companies.

Sec. 9. [62J.60] [MEDIUM-SIZED GROUPS.]

Each health plan company that offers, sells, issues, or renews health coverage for medium-sized groups in this state must determine a single base community rate for medium-sized groups, to be used both in the private market and in the state plan if the health plan company participates in the state plan. The base community rate may be adjusted to reflect differences in benefit levels or other product differences. Each health plan company participating in the medium-sized group market may offer premium rates to particular medium-sized groups that are no more than 30 percent above and no more than 30 percent below that base community rate. These premium differences may be based upon any underwriting criteria permitted by law. No health plan company may increase the premium it charges to a medium-sized group for which it provides coverage if the increase would exceed the increase in that health plan company's base community rate plus 15 percent per year. Each health plan company must provide the commissioner of commerce with a detailed description of its rating methodology, including actuarial justifications for its base community rate and for premiums that deviate from it, except that health plan companies operating under chapter 62D must provide the descriptions and justifications to the commissioner of health.

Sec. 10. [62J.61] [MINIMUM LOSS RATIOS.]

All health coverage sold by health plan companies in this state must have loss ratios no lower than those specified by rule by the commissioner of health for health plan companies operating under chapter 62D and by the commissioner of commerce for all other health plan companies. The minimum loss ratios may differ between the individual, small group, medium-sized group, and large group market. The commissioner of commerce and the commissioner of health shall coordinate their efforts to ensure consistency between their respective loss ratio standards. The commissioner of commerce and the commissioner of health shall take action to ensure that loss ratio rules are in force by January 1, 1993, including adoption of emergency rules, if necessary.

Sec. 11. [62J.62] [ENFORCEMENT AUTHORITY.]

The commissioner of commerce and commissioner of health have the responsibility and authority to enforce sections 1 to 7, 9, 10, and 16, with respect to the health plan companies that they respectively regulate, and have all of the powers otherwise granted to them by statute for use in carrying out their respective responsibilities under this chapter.

Sec. 12. [62J.63] [REINSURANCE POOL.]

(a) All health plan companies selling health coverage to individuals, small groups, or medium-sized groups in this state, including coverage provided through the state plan, must participate in the Minnesota health reinsurance pool, which the commissioner of health care access shall administer. This reinsurance pool must provide reinsurance to participating health plan companies for:

(1) 85 percent of costs incurred for any case, to the extent that the costs

of care exceed $30,000;

(2) 85 percent of the cost of cases assigned to the reinsurance pool pursuant to section 15; and

(3) 100 percent of that portion of the costs incurred for any case that exceeds $100,000.

(b) For the purposes of sections 12 to 15, a "case" qualifies for reinsurance coverage if a specific patient receives $30,000 or more in covered services for a specific cause or spell of illness in a period of 12 or fewer consecutive months. The reinsurance benefit period continues until the end of 12 consecutive months in which the patient receives less than $10,000 in covered services for that cause or spell of illness.

Sec. 13. [62J.64] [ASSIGNMENT OF HIGH-RISK CASES.]

The commissioner shall establish procedures to identify cases and medical conditions that involve a high probability that health care costs in excess of $30,000 will be incurred for a specific cause or spell of illness during a 12-month period. For these cases and conditions, the commissioner may require a determination by a qualified health professional as to whether a particular case is likely to exceed the $30,000 threshold. If the qualified health professional certifies that the case is likely to exceed the $30,000 threshold, the commissioner shall assign the case to the reinsurance pool. If the condition exists at the time of initial enrollment, financial responsibility for the case must be assigned to the reinsurance pool by the commissioner upon receipt of a request from the health plan company providing coverage for the person, along with any documentation reasonably required by the commissioner.

Sec. 14. [62J.65] [CASE MANAGEMENT.]

The commissioner of health care access shall contract for case management services designed to provide cost-effective treatment of cases assigned to the reinsurance pool.

Sec. 15. [62J.66] [REINSURANCE POOL PREMIUMS.]

Each health plan company participating in the Minnesota health reinsurance pool must pay premiums for the reinsurance coverage in the amounts and at the times specified by the commissioner of health care access. The reinsurance premiums must be determined on a community-rated basis, except that adjustments may be made to reflect differences in managed care systems.

Sec. 16. [APPROPRIATION.]

Subdivision 1. [COMMERCE.] *$ . . . . . is appropriated from the general fund to the commissioner of commerce for purposes of sections 10 and 11, to be available until June 30, 1993.*

Subd. 2. [HEALTH.] *$ . . . . . is appropriated from the general fund to the commissioner of health for purposes of sections 10 and 11, to be available until June 30, 1993.*

Subd. 3. [HEALTH CARE ACCESS.] *$ . . . . . is appropriated from the general fund to the commissioner of health care access for the purposes of sections 8 and 12 to 15, to be available until June 30, 1993.*

Sec. 17. [EFFECTIVE DATE.]

Sections 1 to 15 are effective July 1, 1992, except that all rulemaking authority granted in sections 1 to 15 is effective the day following final enactment."

Delete the title and insert:

"A bill for an act relating to health care; establishing the Minnesotans' health care plan to provide health coverage to uninsured and underinsured Minnesotans; requiring all Minnesotans to maintain health coverage; creating a department of health care access; requiring the new commissioner to set overall limits on health care spending and make recommendations regarding health care system reform; creating a technology and benefits advisory committee; creating a health care expenditures advisory committee; requiring an implementation plan and reports; creating a health care analysis unit; requiring data and research initiatives; establishing a rural health advisory committee; requiring joint rural health initiatives; restricting underwriting and premium rating practices; appropriating money; amending Minnesota Statutes 1990, sections 15.06, subdivision 1; and 43A.08, subdivision 1a; proposing coding for new law in Minnesota Statutes, chapters 16B; and 62J; repealing Minnesota Statutes 1990, sections 62E.51 to 62E.55."

And when so amended the bill do pass and be re-referred to the Committee on Commerce. Amendments adopted. Report adopted.

SECOND READING OF SENATE BILLS

S.F. Nos. 148 and 7 were read the second time.

MOTIONS AND RESOLUTIONS

Ms. Johnson, J.B. moved that the name of Ms. Olson be added as a co-author to S.F. No. 132. The motion prevailed.

Mr. Marty moved that the name of Ms. Johnson, J.B. be added as a co-author to S.F. No. 137. The motion prevailed.

Mr. Waldorf moved that the name of Ms. Johnson, J.B. be added as a co-author to S.F. No. 158. The motion prevailed.

Mr. Merriam moved that the name of Ms. Johnson, J.B. be added as a co-author to S.F. No. 256. The motion prevailed.

Mr. Merriam moved that the name of Ms. Johnson, J.B. be added as a co-author to S.F. No. 257. The motion prevailed.

Mr. Langseth moved that his name be stricken as a co-author to S.F. No. 275. The motion prevailed.

Mr. Pogemiller moved that the name of Mr. Luther be added as a co-author to S.F. No. 351. The motion prevailed.

Ms. Berglin moved that the name of Mr. Frederickson, D.J. be added as a co-author to S.F. No. 374. The motion prevailed.

Mr. Bertram moved that the name of Mr. Vickerman be added as a co-author to S.F. No. 391. The motion prevailed.

Mr. Kelly moved that the name of Mr. Marty be added as a co-author to S.F. No. 404. The motion prevailed.

Mr. Merriam moved that the name of Mr. Marty be added as a co-author to S.F. No. 408. The motion prevailed.

Mr. Moe, R.D. moved that H.F. No. 82 be taken from the table and referred to the Committee on Governmental Operations. The motion prevailed.

Mr. Samuelson moved that S.F. No. 144 be withdrawn from the Committee on Rules and Administration and re-referred to the Committee on Finance. The motion prevailed.

Mr. Solon moved that S.F. No. 398 be withdrawn from the Committee on Judiciary and re-referred to the Committee on Veterans and General Legislation. The motion prevailed.

Mr. Berg moved that S.F. No. 168 be withdrawn from the Committee on Judiciary and re-referred to the Committee on Veterans and General Legislation. The motion prevailed.

Mr. Vickerman moved that S.F. No. 190 be withdrawn from the Committee on Judiciary and re-referred to the Committee on Veterans and General Legislation. The motion prevailed.

GENERAL ORDERS

The Senate resolved itself into a Committee of the Whole, with Mr. Hughes in the chair.

After some time spent therein, the committee arose, and Mr. Hughes reported that the committee had considered the following:

S.F. No. 90, which the committee reports progress, subject to the following motion:

Mr. Morse moved to amend S.F. No. 90 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [FEDERAL SAVINGS BANK ACQUISITION.]

Any bank doing business in this state that directly or indirectly on or before December 17, 1990: (1) acquired a federal savings bank, or (2) assumed the liability to pay the deposits of any branch thereof, may, notwithstanding the numerical and distance limitations and consent requirements of Minnesota Statutes, section 47.52, retain and operate the main office or any branch office of the federal savings bank as a detached facility of the acquiring bank or establish and operate any former branch office as a detached facility of the acquiring bank if the branch was closed because banks whose principal office is located in a municipality with a population of 10,000 persons or less failed to consent to the retention or establishment of the branch as a detached facility of the acquiring bank.

Sec. 2. [EFFECTIVE DATE.]

Section 1 is effective the day following final enactment."

Delete the title and insert:

"A bill for an act relating to financial institutions; authorizing certain banks to acquire federal savings banks and operate them as detached facilities."

The motion prevailed. So the amendment was adopted.

S.F. No. 90 was then progressed.

On motion of Mr. Moe, R.D., the report of the Committee of the Whole, as kept by the Secretary, was adopted.

INTRODUCTION AND FIRST READING OF SENATE BILLS

The following bills were read the first time and referred to the committees indicated.

Mr. Dicklich introduced—

S.F. No. 415: A bill for an act relating to the Minnesota board on aging; authorizing supplemental funds for congregate and home-delivered meals; appropriating money; amending Minnesota Statutes 1990, section 256.975, by adding a subdivision.

Referred to the Committee on Health and Human Services.

Mr. Dicklich introduced—

S.F. No. 416: A bill for an act relating to intoxicating liquor; specifying the number of on-sale licenses which may be issued in the city of Virginia; repealing Laws 1974, chapter 501, section 1.

Referred to the Committee on Commerce.

Messrs. Dicklich, Dahl, Mondale, Hottinger and Ms. Traub introduced—

S.F. No. 417: A bill for an act relating to education; making technical corrections to certain statutes and laws; amending Minnesota Statutes 1990, sections 120.06, subdivision 1; 120.062, subdivision 8a, and by adding a subdivision; 120.0752, subdivision 2; 120.101, subdivision 4; 120.17, subdivision 3b; 121.612, subdivisions 2 and 5; 123.3514, subdivisions 6 and 6b; 123.932, subdivisions 3 and 4; 124.14, subdivision 1; 124.195, subdivisions 10 and 11; 124.214, subdivisions 2 and 3; 124.225; 124.244, subdivision 3; 124.83, subdivisions 1 and 5; 124A.036, subdivision 5; 124A.24; 124B.03, subdivision 2; 125.60, subdivision 3; 127.27, subdivisions 2, 4, 5, and 10; 127.29; 127.30, subdivisions 1 and 3; 127.31, subdivision 2; 275.065, subdivision 6; 275.125, subdivisions 5b, 5c, 18, and 20; and 275.16; proposing coding for new law in Minnesota Statutes, chapter 121; repealing Minnesota Statutes 1990, section 124.225, subdivisions 3, 4b, 7c, 8b, 8i, and 8j.

Referred to the Committee on Education.

Messrs. Waldorf, Pogemiller, Renneke and Morse introduced—

S.F. No. 418: A bill for an act relating to state government; providing certain investment options for the state deferred compensation plan; amending Minnesota Statutes 1990, section 352.96, subdivisions 2 and 3.

Referred to the Committee on Governmental Operations.

Ms. Reichgott, Messrs. Pogemiller, Belanger, Ms. Berglin and Mr. Johnson, D.J. introduced—

S.F. No. 419: A bill for an act relating to taxation; allowing counties to make special levies for the unreimbursed costs of family-based services;

amending Minnesota Statutes 1990, section 275.50, subdivision 2.

Referred to the Committee on Taxes and Tax Laws.

Messrs. Finn, Samuelson and Lessard introduced—

S.F. No. 420: A bill for an act relating to state lands; authorizing sale of certain tax-forfeited lands that border public water in Cass county.

Referred to the Committee on Environment and Natural Resources.

Messrs. Frank, Dahl and Novak introduced—

S.F. No. 421: A bill for an act relating to education; increasing the cooperation and combination revenue limit; amending Minnesota Statutes 1990, section 124.2725, subdivision 10.

Referred to the Committee on Education.

Messrs. Solon, Samuelson, Storm, Ms. Berglin and Mr. Pogemiller introduced—

S.F. No. 422: A bill for an act relating to human services; establishing a board of chemical dependency counselors; licensing and regulating chemical dependency counselors; providing penalties; appropriating money; amending Minnesota Statutes 1990, section 595.02, subdivision 1; proposing coding for new law as Minnesota Statutes, chapter 148C.

Referred to the Committee on Health and Human Services.

Messrs. Dicklich and Lessard introduced—

S.F. No. 423: A bill for an act relating to corrections; requiring one counselor or other staff person for every 20 juveniles confined in state juvenile correctional facilities; proposing coding for new law in Minnesota Statutes, chapter 242.

Referred to the Committee on Health and Human Services.

Messrs. Bertram and Pogemiller introduced—

S.F. No. 424: A bill for an act relating to public contracts; requiring preference for resident bidders against nonresident bidders from other countries in certain circumstances; defining resident bidder; denying the privilege of transacting business with the department of transportation or local road authorities to persons who have committed contract offenses; defining contract offenses; amending Minnesota Statutes 1990, sections 16B.102, and 161.315, subdivisions 1 and 2.

Referred to the Committee on Governmental Operations.

Messrs. Laidig, Solon, Belanger, Mrs. Brataas and Mr. Luther introduced—

S.F. No. 425: A bill for an act relating to unclaimed property; providing for payment of certain expenses for claims made in other states; proposing coding for new law in Minnesota Statutes, chapter 345.

Referred to the Committee on Commerce.

Ms. Johnston, Mrs. Brataas, Ms. Pappas, Messrs. Hottinger and Belanger introduced—

S.F. No. 426: A bill for an act relating to occupations and professions; increasing minimum insurance coverage required for abstracters; abolishing requirement of seals by impression; repealing an obsolete provision; amending Minnesota Statutes 1990, sections 386.66 and 386.67; repealing Minnesota Statutes 1990, section 386.65, subdivision 3.

Referred to the Committee on Commerce.

Messrs. Renneke and Hughes introduced—

S.F. No. 427: A bill for an act relating to gambling; specifying that bets made in certain card games are not bets under laws relating to unlawful gambling; amending Minnesota Statutes 1990, section 609.75, subdivision 3.

Referred to the Committee on Gaming Regulation.

Messrs. Solon, Gustafson, Dicklich and Johnson, D.J. introduced—

S.F. No. 428: A bill for an act relating to state government; providing for a study of decentralization of state government; providing for a report to the legislature; appropriating money.

Referred to the Committee on Governmental Operations.

Ms. Flynn, Messrs. Marty; Johnson, D.E.; Ms. Berglin and Mr. Storm introduced—

S.F. No. 429: A bill for an act relating to health; amending the clean indoor air act; amending Minnesota Statutes 1990, sections 144.413, subdivision 2, and by adding subdivisions; 144.414, subdivisions 1, 3, and by adding a subdivision; 144.415; 144.416; and 144.417, subdivision 2.

Referred to the Committee on Health and Human Services.

Messrs. Morse; Renneke; Moe, R.D.; Solon and Frederickson, D.J. introduced—

S.F. No. 430: A bill for an act relating to retirement; police state aid program; requiring payments equivalent to automobile insurance premium taxes by self-insurers; expanding the permissible use of police state aid; amending Minnesota Statutes 1990, sections 69.021, subdivisions 5 and 6; and 69.031, subdivision 5; proposing coding for new law in Minnesota Statutes, chapter 60A.

Referred to the Committee on Governmental Operations.

Mr. Stumpf introduced—

S.F. No. 431: A bill for an act relating to local government; permitting Pennington county and Thief River Falls to construct, finance, and own student housing.

Referred to the Committee on Economic Development and Housing.

Messrs. Samuelson, Kroening, Frank and Metzen introduced—

S.F. No. 432: A bill for an act relating to employment; regulating certain construction bids; providing penalties; proposing coding for new law in Minnesota Statutes, chapter 181.

Referred to the Committee on Employment.

Mses. Reichgott, Ranum, Messrs. Marty and Spear introduced—

S.F. No. 433: A bill for an act relating to sexual abuse; extending the statute of limitations for intentional torts involving the sexual abuse of a minor; eliminating the statute of limitations in criminal sexual conduct cases involving a minor victim; amending Minnesota Statutes 1990, sections 541.073; and 628.26.

Referred to the Committee on Judiciary.

Mr. Marty, Ms. Ranum, Messrs. Knaak, Neuville and Cohen introduced—

S.F. No. 434: A bill for an act relating to government data practices; prohibiting the release of motor vehicle or driver's license data lists for commercial purposes; amending Minnesota Statutes 1990, section 13.69, by adding a subdivision.

Referred to the Committee on Judiciary.

Mr. Mehrkens introduced—

S.F. No. 435: A bill for an act relating to education; approving a maximum effort school loan program capital loan.

Referred to the Committee on Education.

Messrs. Luther; Moe, R.D.; Benson, D.D.; Bertram and McGowan introduced—

S.F. No. 436: A resolution memorializing the International Special Olympics Committee in support of the 1991 International Special Olympics Games.

Referred to the Committee on Veterans and General Legislation.

Messrs. Bernhagen; Dahl; Day; Frederickson, D.R. and Davis introduced—

S.F. No. 437: A bill for an act relating to agriculture; changing the shade tree disease and wood use programs; amending Minnesota Statutes 1990, sections 18.023, subdivisions 10a and 11; and 18.024, subdivision 1.

Referred to the Committee on Agriculture and Rural Development.

Messrs. Belanger, Riveness, Ms. Reichgott, Messrs. Kelly and Neuville introduced—

S.F. No. 438: A bill for an act relating to torts; providing immunity against tort liability for any school district which is unable to obtain insurance for claims relating to asbestos or hazardous waste; amending Minnesota Statutes 1990, section 466.06.

Referred to the Committee on Judiciary.

Messrs. Frederickson, D.R.; Frederickson, D.J.; Renneke and Stumpf introduced—

S.F. No. 439: A bill for an act relating to education; authorizing school districts to use up to 50 percent of current or anticipated capital expenditure facility revenue as debt service revenue for bonds they may issue for certain capital projects; amending Minnesota Statutes 1990, section 124.243, by adding a subdivision.

Referred to the Committee on Education.

Messrs. Marty, Luther and Merriam introduced—

S.F. No. 440: A bill for an act relating to insurance; requiring insurers to permit their insureds to inspect medical records obtained in connection with a claim; requiring health care providers to permit access to medical records by persons examined for certain medical review purposes; amending Minnesota Statutes 1990, sections 72A.491, subdivision 19; 144.335, subdivision 1; and 145.64.

Referred to the Committee on Commerce.

Messrs. Lessard, Solon, Finn and Frederickson, D.R. introduced—

S.F. No. 441: A bill for an act relating to commerce; modifying provisions relating to certain motor vehicle accident prevention courses; appropriating money; amending Minnesota Statutes 1990, sections 65B.28, subdivisions 1, 2, and by adding subdivisions.

Referred to the Committee on Commerce.

Messrs. Lessard, Price, Finn and Ms. Traub introduced—

S.F. No. 442: A bill for an act relating to watercraft; regulating the use and operation of personal watercraft; amending Minnesota Statutes 1990, section 86B.005, by adding subdivisions; proposing coding for new law in Minnesota Statutes, chapter 86B.

Referred to the Committee on Environment and Natural Resources.

Messrs. Mondale, Kelly, Ms. Ranum, Messrs. Hottinger and Neuville introduced—

S.F. No. 443: A bill for an act relating to civil procedure; providing for security for costs in certiorari matters; amending Minnesota Statutes 1990, section 606.03.

Referred to the Committee on Judiciary.

Messrs. Price, Dicklich, Metzen, Bertram and Finn introduced—

S.F. No. 444: A bill for an act relating to education; providing a two-year tuition exemption to Minnesota veterans of the Persian Gulf war; proposing coding for new law in Minnesota Statutes, chapter 135A.

Referred to the Committee on Veterans and General Legislation.

Messrs. Hottinger, Renneke, Vickerman, Riveness and Day introduced—

S.F. No. 445: A bill for an act relating to interscholastic athletics; providing that persons who assault a sports official may be excluded from certain events; proposing coding for new law in Minnesota Statutes, chapter 128C.

Referred to the Committee on Education.

Messrs. Beckman; Frederickson, D.J.; Johnson, D.J.; Bernhagen and Pogemiller introduced—

S.F. No. 446: A bill for an act relating to economic development; authorizing the establishment of rural development zones; proposing coding for new law in Minnesota Statutes, chapter 469.

Referred to the Committee on Economic Development and Housing.

Messrs. Pogemiller, DeCramer, Mondale and Ms. Pappas introduced—

S.F. No. 447: A bill for an act relating to the University of Minnesota; changing the structure of certain bargaining units; amending Minnesota Statutes 1990, section 179A.11, subdivision 1.

Referred to the Committee on Governmental Operations.

Messrs. Morse, Waldorf, Mrs. Adkins, Ms. Flynn and Mr. Benson, D.D. introduced—

S.F. No. 448: A bill for an act relating to local government; regulating the development, imposition, and management of state mandates upon local political subdivisions; amending Minnesota Statutes 1990, section 14.11, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 3 and 14; repealing Minnesota Statutes 1990, section 3.982.

Referred to the Committee on Local Government.

Messrs. Solon, Gustafson and Kelly introduced—

S.F. No. 449: A bill for an act relating to retirement; Duluth teachers retirement fund association and St. Paul teachers retirement fund association; proposing coding for new law in Minnesota Statutes, chapter 354A; repealing Laws 1985, chapter 259, sections 2 and 3; and Laws 1990, chapter 570, article 7, section 4.

Referred to the Committee on Governmental Operations.

Ms. Flynn, Mrs. Brataas, Messrs. Luther, Dicklich and Mondale introduced—

S.F. No. 450: A bill for an act relating to education; requiring junior and senior high schools to establish school-based health clinics; establishing standards for school-based health clinics; authorizing grants; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 123.

Referred to the Committee on Education.

Mses. Flynn, Pappas, Messrs. Waldorf, Merriam and Kelly introduced—

S.F. No. 451: A bill for an act relating to government operations; requiring a study of the feasibility of consolidating counties and rationalizing other internal boundaries; appropriating money.

Referred to the Committee on Local Government.

Messrs. Marty, Finn, Spear and Johnson, D.E. introduced—

S.F. No. 452: A bill for an act relating to gambling; requiring posting of the compulsive gambling hotline number; imposing surcharges on gambling permits and licenses; appropriating money; amending Minnesota Statutes 1990, sections 240.13, subdivision 2; 349.172; and 349A.06, subdivision 5.

Referred to the Committee on Gaming Regulation.

Messrs. McGowan; Spear; Johnson, D.E.; Merriam and Knaak introduced—

S.F. No. 453: A bill for an act relating to corrections; establishing a juvenile detention services subsidy program; appropriating money; amending Minnesota Statutes 1990, section 241.022; proposing coding for new law in Minnesota Statutes, chapter 241.

Referred to the Committee on Health and Human Services.

Messrs. Dicklich; Johnson, D.J.; Moe, R.D. and Novak introduced—

S.F. No. 454: A bill for an act relating to commerce; restraint of trade; prohibiting the charging of unconscionable prices for critical petroleum products; prohibiting fuel suppliers from requiring certain minimum deliveries; providing for investigations and enforcement; establishing a volunteer corps to aid in enforcement; proposing coding for new law in Minnesota Statutes, chapter 325D.

Referred to the Committee on Commerce.

Mr. Benson, D.D. introduced—

S.F. No. 455: A bill for an act relating to taxation; updating references to the Internal Revenue Code; amending Minnesota Statutes 1990, sections 290.01, subdivisions 19, 19a, and 19d; 290.067, subdivision 1; and 290.92, subdivision 1.

Referred to the Committee on Taxes and Tax Laws.

Mr. Benson, D.D. introduced—

S.F. No. 456: A bill for an act relating to taxation; increasing the taxes on cigarettes; changing the computation of alcoholic beverage taxes; amending Minnesota Statutes 1990, sections 297.02, subdivision 1; 297.03, subdivision 5; 297C.01, by adding subdivisions; and 297C.02.

Referred to the Committee on Taxes and Tax Laws.

Mr. Berg introduced—

S.F. No. 457: A bill for an act relating to game and fish; setting conditions under which a hunter may take two deer; amending Minnesota Statutes 1990, section 97B.301, subdivision 4.

Referred to the Committee on Environment and Natural Resources.

Mr. Metzen introduced—

S.F. No. 458: A bill for an act relating to health care; establishing the Minnesotans' health care plan to provide health coverage to uninsured and underinsured Minnesotans; requiring all Minnesotans to maintain health coverage; creating a department of health care access; requiring the new commissioner to set overall limits on health care spending and make recommendations regarding health care system reform; requiring an implementation plan and reports; creating a health care analysis unit; requiring data and research initiatives; establishing a rural health advisory committee; requiring joint rural health initiatives; restricting underwriting and premium rating practices; appropriating money; amending Minnesota Statutes 1990, sections 15.06, subdivision 1; and 43A.08, subdivision 1a; proposing coding for new law in Minnesota Statutes, chapters 16B; and 62J; repealing Minnesota Statutes 1990, sections 62E.51 to 62E.55.

Referred to the Committee on Health and Human Services.

Messrs. Hottinger and Finn introduced—

S.F. No. 459: A bill for an act relating to consumer protection; prohibiting certain uses of consumer identification information; prohibiting the use of certain credit card information; providing penalties; proposing coding for new law in Minnesota Statutes, chapter 325F.

Referred to the Committee on Commerce.

Messrs. Beckman, Larson, Bertram, Ms. Johnson, J.B. and Mr. Frederickson, D.J. introduced—

S.F. No. 460: A bill for an act relating to veterans; changing certain requirements for appointment of county veterans service officers; amending Minnesota Statutes 1990, section 197.60, subdivision 2, and by adding a subdivision.

Referred to the Committee on Veterans and General Legislation.

Messrs. Luther, Pogemiller, Riveness and DeCramer introduced—

S.F. No. 461: A bill for an act relating to state employees; allowing state employees to donate accrued sick leave for the benefit of another state employee; amending Minnesota Statutes 1990, section 43A.181.

Referred to the Committee on Governmental Operations.

Messrs. Riveness, Cohen, Mondale, Lessard and Luther introduced—

S.F. No. 462: A bill for an act relating to the environment; establishing an environmental enforcement account; establishing a field citation pilot project for unauthorized disposal of solid waste; amending Minnesota Statutes 1990, sections 115.072; and 116.07, subdivision 4d; proposing coding

for new law in Minnesota Statutes, chapter 115.

Referred to the Committee on Environment and Natural Resources.

Mr. Dicklich introduced—

S.F. No. 463: A bill for an act relating to occupations and professions; requiring crane operators to be licensed by the state; requiring rulemaking; establishing a crane operators examining board; providing penalties; amending Minnesota Statutes 1990, section 214.01, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 326.

Referred to the Committee on Employment.

Messrs. Merriam and Spear introduced—

S.F. No. 464: A bill for an act relating to crimes; providing that a claimant in a forfeiture proceeding does not have to pay a filing fee; providing for appointment of qualified interpreters in forfeiture proceedings; amending Minnesota Statutes 1990, sections 609.5314, subdivision 3; and 611.32.

Referred to the Committee on Judiciary.

Mr. Cohen introduced—

S.F. No. 465: A bill for an act relating to motor vehicles; allowing personalized license plates for classic, pioneer, collector, and street rod vehicles; amending Minnesota Statutes 1990, sections 168.10, subdivisions 1a, 1b, 1c, and 1d; 168.105, subdivisions 2 and 3; and 168.12, subdivision 2a.

Referred to the Committee on Transportation.

Ms. Olson, Messrs. Mehrkens, Dicklich and Knaak introduced—

S.F. No. 466: A bill for an act relating to education; presenting the governor's programs for the prekindergarten through grade 12 education system; appropriating money; amending Minnesota Statutes 1990, sections 62A.047; 121.88, subdivisions 9, 10, and by adding a subdivision; 121.904, subdivisions 4a and 4e; 121.912, subdivision 1b; 123.707, subdivisions 2, 3, and by adding a subdivision; 124.17, subdivisions 1, 1b, and by adding a subdivision; 124.195, subdivision 12; 124.223; 124.225; 124.261; 124.2711, subdivisions 1 and 3; 124.2713, subdivisions 3, 4, 5, and 6; 124.2721, subdivisions 2 and 4; 124.2725, subdivisions 2, 3, and 6; 124.273, subdivision 1b; 124.32, subdivisions 1b, 5, and 10; 124.46, subdivision 3; 124.573, subdivisions 2b and 3a; 124.574, subdivision 2b; 125.575, subdivisions 1, 2, 3, and 4; 124.83, subdivision 4; 124A.02, subdivisions 16 and 23; 124A.03; 124A.04; 124A.22, subdivisions 2, 3, 4, 8, and 9; 124A.23, subdivisions 1, 4, and 5; 124A.24; 124A.26, subdivision 1; 126.22, subdivisions 2, 3, and 4; 136D.27, subdivision 1; 136D.74, subdivision 2; 136D.87, subdivision 1; and 275.125, subdivisions 5, 5c, 6e, 6i, and 8b; proposing coding for new law in Minnesota Statutes, chapters 124; 124A; 124C; and 125; repealing Minnesota Statutes 1990, sections 123.351, subdivision 10; 124.195, subdivision 12; 124.223, subdivisions 3, 9, and 10; 124.252; 124.575; 124A.02, subdivision 19; and 275.125, subdivisions 8c and 8e; Laws 1989, chapter 222, section 10.

Referred to the Committee on Education.

Mr. Dicklich introduced—

S.F. No. 467: A bill for an act relating to education; providing for supplemental revenue and minimum allowance revenue in certain cases; amending Minnesota Statutes 1990, section 122.531, by adding a subdivision; repealing Minnesota Statutes 1990, section 122.531, subdivision 5.

Referred to the Committee on Education.

Messrs. Luther, Spear and Mehrkens introduced—

S.F. No. 468: A bill for an act relating to employment; changing the date for submission of recommendations by the compensation council; amending Minnesota Statutes 1990, section 15A.082, subdivision 3.

Referred to the Committee on Governmental Operations.

ADJOURNMENT

Mr. Moe, R.D. moved that the Senate do now adjourn until 2:00 p.m., Thursday, February 28, 1991. The motion prevailed.

Patrick E. Flahaven, Secretary of the Senate