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S.F. No. 1459 - School Employee Health Insurance Pool

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Date: March 17, 2005

Section 1 establishes the school employee insurance plan.

Subdivision 1 defines the terms "eligible employee" and "eligible employer." An eligible employer is a school district or a related entity listed in the definition.

Subdivision 2 creates a board to create and administer the health insurance pool. The board would be a public corporation subject to chapter 317A, except as otherwise provided. The state is not liable for the obligations of the corporation. The board expires if coverage is not offered by December 15, 2008.

Subdivision 3 provides that the board has 14 members: seven appointed by school employee unions and seven appointed by the Minnesota School Boards Association. Requires that initial appointments to the board be made by August 1, 2005. Provides that board members are eligible for reimbursement of expenses on the same basis as members of other state-related boards. Requires the board to arrange for ways of resolving disputes within the board to avoid deadlocks. Requires the board to establish governance requirements.

Subdivision 4 requires that the health coverage be available to all eligible employees of eligible employers and that eligible employers provide health coverage only through the pool. Requires the board to offer more than one health plan and allows the board to establish more than one tier of premium rates for a plan. Permits geographic variations. Requires plans to comply with specified health insurance laws and provide the optimal combination of coverage, cost, choice, and stability. The plans offered must be approved by the Commissioner of Commerce. Requires claims reserves, stabilization reserves, reinsurance, and other features to achieve stability and solvency. Permits the board to decide whether the

health plans should be fully insured, self-insured, or some combination. Requires the health plans to include disease management and consumer education, including wellness programs, and measures to encourage wise use of health coverage. Requires health plans providing coverage to employees of eligible employers within two years prior to the effective date of this section to provide to the board, on request, specified aggregate claims data.

Subdivision 5 requires the board to report to the Legislature by January 15, 2007, on final design for the pool. Legislative changes needed to ensure conformance with specified health insurance laws must be included in the report.

Subdivision 6 requires periodic reporting by the board to the Legislature summarizing and evaluating performance of the pool.

Section 2 provides an appropriation of an unspecified amount from the general fund as a loan for start-up costs. Requires that the loan be repaid to the general fund over ten years beginning in the 2008 fiscal year.

CBS:cs

A bill for an act

relating to insurance; creating a statewide health insurance pool for school district employees; appropriating money; amending Minnesota Statutes 2004, sections 62E.02, subdivision 23; 62E.10, subdivision 1; 62E.11, subdivision 5; 297I.05, subdivision 5; proposing coding for new law in Minnesota Statutes, chapter 62A.

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

Section 1. [62A.662] [SCHOOL EMPLOYEE INSURANCE PLAN.]

Subdivision 1. [DEFINITIONS.] For purposes of this section:

(1) "eligible employee" means a person who is insurance eligible under a collective bargaining agreement or under the personnel policy of an eligible employer; and

(2) "eligible employer" means a school district as defined in section 120A.05; a service cooperative as defined in section 123A.21; an intermediate district as defined in section 136D.01; a cooperative center for vocational education as defined in section 123A.22; a regional management information center as defined in section 123A.23; an education unit organized under section 471.59; or a charter school organized under section 124D.10.

Subd. 2. [CREATION OF BOARD.] (a) The Minnesota School Employee Insurance Board is created as a public corporation subject to the provisions of chapter 317A, except as otherwise provided in this section. As provided in section 15.082, the state is not liable for obligations of this public corporation.

(b) The board shall create and administer the Minnesota School Employee Insurance Pool as described in this section.

(c) If the board does not offer coverage by December 15, 2008, the board expires and this section expires on that date.

Subd. 3. [BOARD OF DIRECTORS.] (a) The School Employee Insurance Board consists of:

(1) six members representing exclusive representatives of eligible employees, appointed by exclusive representatives, as provided in paragraph (b);

(2) six members representing eligible employers, appointed by the Minnesota School Boards Association; and

(3) three members appointed by the governor pursuant to section 15.0575.

(b) The six members of the board who represent statewide affiliates of exclusive representatives of eligible employees are appointed as follows: three members appointed by Education Minnesota and one member each appointed by the Service Employees International Union, the Minnesota School Employees Association, and American Federation of State, County, and Municipal Employees.

(c) Appointing authorities must make their initial appointments no later than August 1, 2005, by filing a notice of the appointment with the commissioner of commerce. Notices of subsequent appointments must be filed with the board. An entity entitled to appoint a board member may replace the board member at any time.

(d) Board members are eligible for compensation and expense reimbursement under section 15.0575, subdivision 3.

(e) The board shall establish governance requirements, including staggered terms, term limits, quorum, a plan of operation, and audit provisions.

Subd. 4. [DESIGN AND NATURE OF PLAN.] (a) Health coverage offered through the Minnesota School Employee Insurance Pool shall be made available by the board to all eligible employees of eligible employers, as defined in subdivision 1.

(b) If an eligible employer provides health coverage or

money to purchase health coverage to eligible employees, the coverage must be provided or purchased only through the health plans offered by the board.

(c) The board must offer more than one health plan and may establish more than one tier of premium rates for any specific plan. Plans and premium rates may vary across geographic regions established by the board. The health plans must comply with chapters 62A, 62J, 62M, and 62Q, and must provide the optimal combination of coverage, cost, choice, and stability in the judgment of the board. All health plans offered must be approved by the commissioner of commerce.

(d) The board must include claims reserves, stabilization reserves, reinsurance, and other features that, in the judgment of the board, will result in long-term stability and solvency of the health plans offered.

(e) The board may determine whether the health plans should be fully insured through a health carrier licensed in this state, self-insured, or a combination of those two alternatives.

(f) The health plans must include disease management and consumer education, including wellness programs and measures encouraging the wise use of health coverage, to the extent determined to be appropriate by the board. The health plans must use the quality and performance measurements established for use by the state for its employee and public assistance programs.

(g) The board must confer with the service cooperatives and make a recommendation to the legislature on how health insurance reserves currently held by the service cooperatives will be dispensed.

(h) Upon request of the board, health plans that are providing or have provided coverage to employees of eligible employers within two years prior to the effective date of this section, shall provide to the board at no charge nonidentifiable aggregate claims data for that coverage. The information must include data relating to employee group benefit sets, demographics, and claims experience. Notwithstanding section

13.203, Minnesota service cooperatives must also comply with this paragraph.

(i) Effective July 1, 2005, no contract entered into between an eligible employer and an eligible employee or the exclusive representative of an eligible employee shall contain provisions that establish cash payment in lieu of health insurance to an eligible employee if the employee is not receiving such payment on or before June 30, 2005. Nothing in this section shall prevent any eligible employee who otherwise qualifies for payment of cash in lieu of insurance on June 30, 2005, to continue to receive this payment.

Subd. 5. [MCHA MEMBERSHIP AND ASSESSMENTS.] The board is a contributing member of the Minnesota Comprehensive Health Association and must pay assessments made by the association on its premium revenues, as provided in section 62E.11, subdivision 5, paragraph (b).

Subd. 6. [PREMIUM TAX OBLIGATIONS.] The board must pay taxes on premiums as provided in section 297I.05, subdivision 5, paragraph (c).

Subd. 7. [REPORT.] The board shall report to the legislature by January 15, 2007, on a final design for the pool that complies with subdivision 4 and on governance requirements for the board, including staggered terms, term limits, quorum, and a plan of operation and audit provisions. The report must include any legislative changes necessary to ensure conformance with chapters 62A, 62J, 62M, and 62Q.

Subd. 8. [PERIODIC EVALUATION.] (a) Beginning January 15, 2008, and for the next two years, the board must submit an annual report to the commissioner of commerce and the legislature, in compliance with sections 3.195 and 3.197, summarizing and evaluating the performance of the pool during the previous year of operation.

(b) Beginning in 2011 and in each odd-numbered year thereafter, the board must submit to the legislature a biennial report summarizing and evaluating the performance of the pool during the preceding two fiscal years.

Sec. 2. Minnesota Statutes 2004, section 62E.02, subdivision 23, is amended to read:

Subd. 23. [CONTRIBUTING MEMBER.] "Contributing member" means those companies regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; community integrated service networks regulated under chapter 62N; fraternal benefit societies regulated under chapter 64B; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; ~~and~~ joint self-insurance plans regulated under chapter 62H; and the Minnesota School Employee Insurance Board created under section 62A.662. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization ~~or~~, a community integrated service network, or the Minnesota School Employee Insurance Board shall be considered to be accident and health insurance premiums.

Sec. 3. Minnesota Statutes 2004, section 62E.10, subdivision 1, is amended to read:

Subdivision 1. [CREATION; TAX EXEMPTION.] There is established a Comprehensive Health Association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers; self-insurers; fraternals; joint self-insurance plans regulated under chapter 62H; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; the Minnesota School Employee Insurance Board created under section 62A.662; health maintenance organizations; and community integrated service networks licensed or authorized to do business in this state. The Comprehensive Health Association is exempt from the taxes imposed under chapter 297I and any other laws of this state and all property owned by the association is exempt from taxation.

Sec. 4. Minnesota Statutes 2004, section 62E.11,

subdivision 5, is amended to read:

Subd. 5. [ALLOCATION OF LOSSES.] (a) Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contributing member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner. Payments made by the state to a contributing member for medical assistance, MinnesotaCare, or general assistance medical care services according to chapters 256, 256B, and 256D shall be excluded when determining a contributing member's total premium.

(b) In making the allocation of losses provided in paragraph (a), the association's assessment against the Minnesota School Employee Insurance Board must equal the product of (1) the percentage of premiums assessed against other association members; (2) .3885; and (3) premiums received by the Minnesota School Employee Insurance Board. For purposes of this calculation, premiums of the board used must be net of rate credits and retroactive rate refunds on the same basis as the premiums of other association members.

Sec. 5. Minnesota Statutes 2004, section 297I.05, subdivision 5, is amended to read:

Subd. 5. [HEALTH MAINTENANCE ORGANIZATIONS, NONPROFIT HEALTH SERVICE PLAN CORPORATIONS, ~~AND~~ COMMUNITY INTEGRATED SERVICE NETWORKS, AND THE MINNESOTA SCHOOL EMPLOYEE INSURANCE

BOARD.] (a) Health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations are exempt from the tax imposed under this section for premiums received in calendar years 2001 to 2003.

(b) For calendar years after 2003, a tax is imposed on health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations. The rate of tax is equal to one percent of gross premiums less return premiums received in the calendar year.

(c) A tax is imposed on the Minnesota School Employee Insurance Board under section 62A.662. The rate of tax is equal to .36 percent of gross premiums less return premiums received in the calendar year.

(d) In approving the premium rates as required in sections 62L.08, subdivision 8, and 62A.65, subdivision 3, the commissioners of health and commerce shall ensure that any exemption from tax as described in paragraph (a) is reflected in the premium rate.

~~(d)~~ (e) The commissioner shall deposit all revenues, including penalties and interest, collected under this chapter from health maintenance organizations, community integrated service networks, ~~and~~ nonprofit health service plan corporations , and the Minnesota School Employee Insurance Board in the health care access fund. Refunds of overpayments of tax imposed by this subdivision must be paid from the health care access fund. There is annually appropriated from the health care access fund to the commissioner the amount necessary to make any refunds of the tax imposed under this subdivision.

Sec. 6. [APPROPRIATION; LOAN.]

$..... is appropriated from the general fund to the commissioner of commerce as a loan for start-up costs to the Minnesota School Employee Insurance Board. The Minnesota School Employee Insurance Board must repay the loan to the general fund in ten equal installments paid at the end of each fiscal year, beginning with the 2008 fiscal year.

STATEWIDE HEALTH INSURANCE FOR SCHOOL EMPLOYEES

Why is it important?

School districts are finding it impossible to continue to offer reasonable health insurance coverage to employees. Double-digit increases in health insurance costs will continue without reforming the system, and will only expand this problem.

Statewide health insurance for school employees, HF 517 and SF 1459, is smart public policy that will bring about reform and efficiency in how school districts offer health insurance coverage to employees. It will:

- Save millions of dollars, while providing a long-term, locally-controlled solution to the health insurance crisis confronting school districts;
- Curtail the skyrocketing growth in health-insurance premiums; and
- Allow school districts to continue to offer cost-effective, quality health care coverage to employees.

Statewide Health Insurance for School Employees is supported by AFSCME, AFL-CIO, MSEA and SEIU.

Contact Jan Alswager, manager of government relations, at 651-292-4890 or jan.alswager@educationminnesota.org for more information.

An organization of 70,000 educators doing what it takes to help students succeed.

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Education Minnesota is an affiliate of the American Federation of Teachers, National Education Association and AFL-CIO.

Statewide Health Insurance for School Employees

Smart public policy that will:

- Reform health insurance coverage for school employees
- Provide more efficient use of tax dollars

What is the problem?

- School districts and their employees are confronted with double-digit increases in health care coverage.
- Runaway costs are consuming school districts' revenues and employees' incomes.
- School districts and employees are bei[illegible]rced to re[illegible] or even eliminate insurance coverage.
- Without the necessary reforms in this [illegible]ll of these [illegible]lems will continue to get worse.

HF 517 & SF 1459

STATEWIDE HEALTH INSURANCE FOR SCHOOL EMPLOYEES

What is it?

HF 517 and SF 1459 are bills designed to create a statewide health insurance program for all school district employees and their families. The legislation is built on the state's own feasibility study that established the viability of the concept and estimated cost savings of approximately $223 million over the first six years of implementation.

The authors are Rep. Greg Davids (R-Preston) and Sen. Don Betzold (D-Fridley).

STATEWIDE HEALTH INSURANCE FOR SCHOOL EMPLOYEES

What does the leg[illegible]slat[illegible]n do?

In short, the statewide health-insurance legislation would:

- Establish a risk pool of about 200,000 individuals, which would reform the current approach to health care coverage for school employees and generate significant cost savings. This will:
  - o Spread the costs of catastrophic claims across a much larger population;
  - o Reduce the likelihood of spikes in insurance premiums.
- Create a labor-management committee, with equal representation between labor and management, to develop and oversee all aspects of the program. This will:
  - o Provide continued local control through district and union negotiations. Individual school districts and the union will still determine which plan to offer, how much the district will contribute toward the premiums, and who is eligible for insurance.

Comments on SF 1459, School District Statewide Health Plan

Keith Carlson
Executive Director
Metropolitan Inter-County Association

Just like School Districts, Counties Provide Employee Health Care Benefits in a Variety of Manners

- Some Self Insure
- Some Purchase Traditional Insurance Products
- Some Purchase Some or All of Their Coverage Through the Service Coops
- <u>This Third Option Will Disappear As the Coops Go Out of Business or Become Uncompetitive</u>
  - **This Will Raise Affected Counties (and Their Taxpayers') Costs for Health Insurance**

The Premise that Pooling or a Statewide Plan Will Generate Substantial Savings Is Very Questionable

- This and Similar Proposals Have Been Studied on Four Different Occasions.
- Only Once - under the Education Minnesota-funded Study - Has It Been Concluded That Statewide Pooling Bears the Potential for Significant Savings
  - With the amendments made in prior committees, a substantial portion of those savings have disappeared.
    - 37% or $80 million of "savings" came from assumption that plan would be self insured and exempt form MCHA
    - Further "savings" were lost with the requirement that the plan must pay insurance gross premiums taxes

Metropolitan Inter-County Association 3

If Pooling Generates Substantial Savings, Why Aren't the Statewide Local Government Organizations Already Doing It

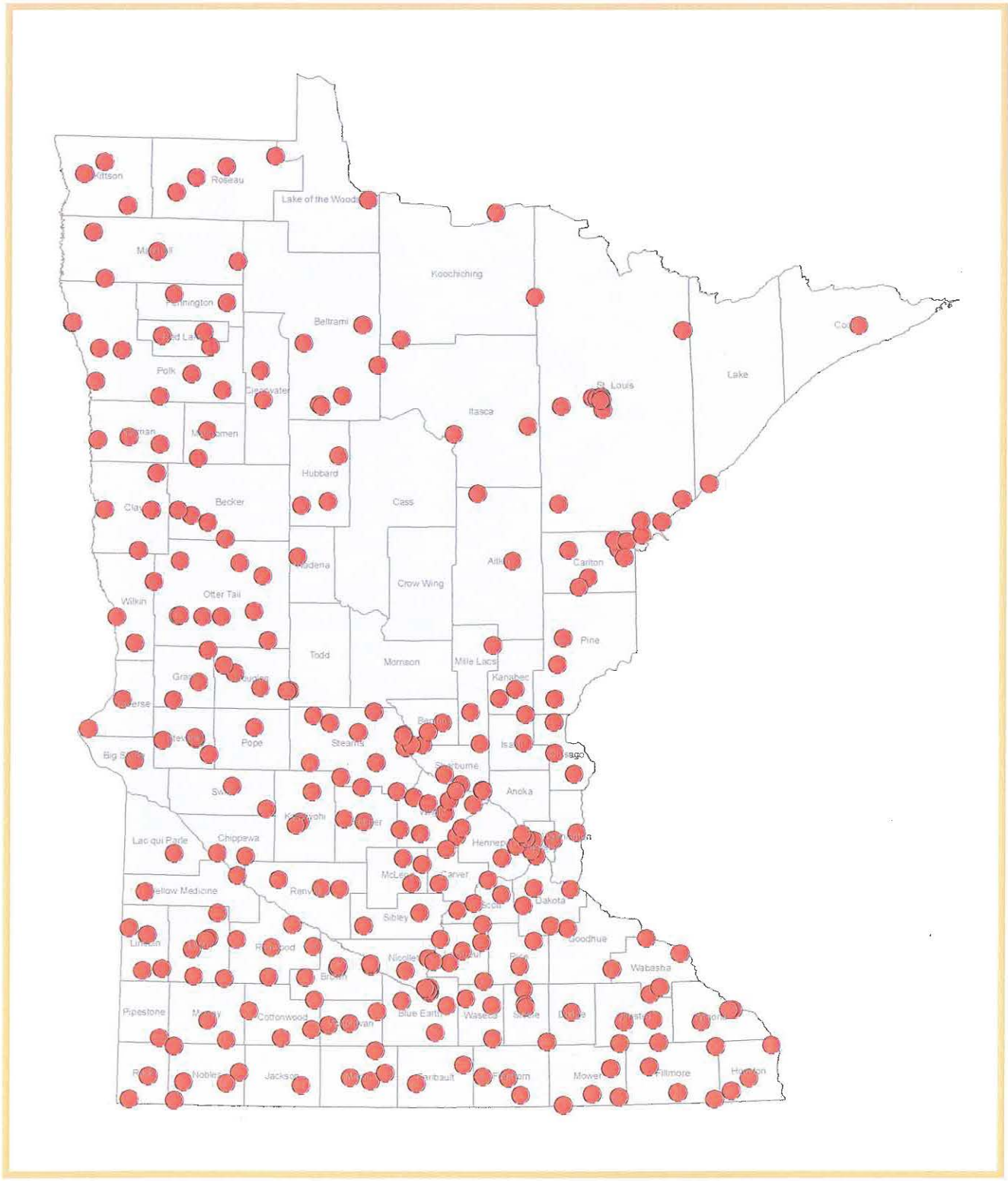
- All the Local Government Statewide Associations – MSBA, LMC and AMC – "Pool" for Casualty and Workers Comp Purposes
- Since the Infrastructure Is Already There to "Pool" for Health Care Benefits, Why Aren't the Statewide Organizations Doing It?
- **Answer: Savings for <u>All Members</u> Simply Aren't There**

Metropolitan Inter-County Association 4

What's the Financial Exposure and Who Bears It If the Statewide Plan Doesn't Work

- Of Greatest Concern to Counties Is the Financial Implications for the State and the Funding of Other Programs
  - If Actuary Is Wrong and/or Actual Plan Design Is Not Consistent with the Study (e.g. 100% mandatory participation), There Maybe a Shortfall that School Districts Will Initially Have to Bear Particularly with Stabilization Reserves Set at 9.8%, Less Than Half the Level Recommended by Assoc. Of Insurance Commissioners
- **Our Fear is that the State Will Ultimately Be Asked to Bear Some or All of that Tab Particularly Since the State Assumed Funding of General Ed in 2001**
- Worse, There Will Be a Political Liability That Will Likely Be Converted into a Financial One in Terms of Making "Whole" Those School District Employees Who Lose Health Insurance Benefits and/or Suffer Premium Increases
- Both would Be to the Detriment of Funding for Other Programs

Paul Brinkman



N

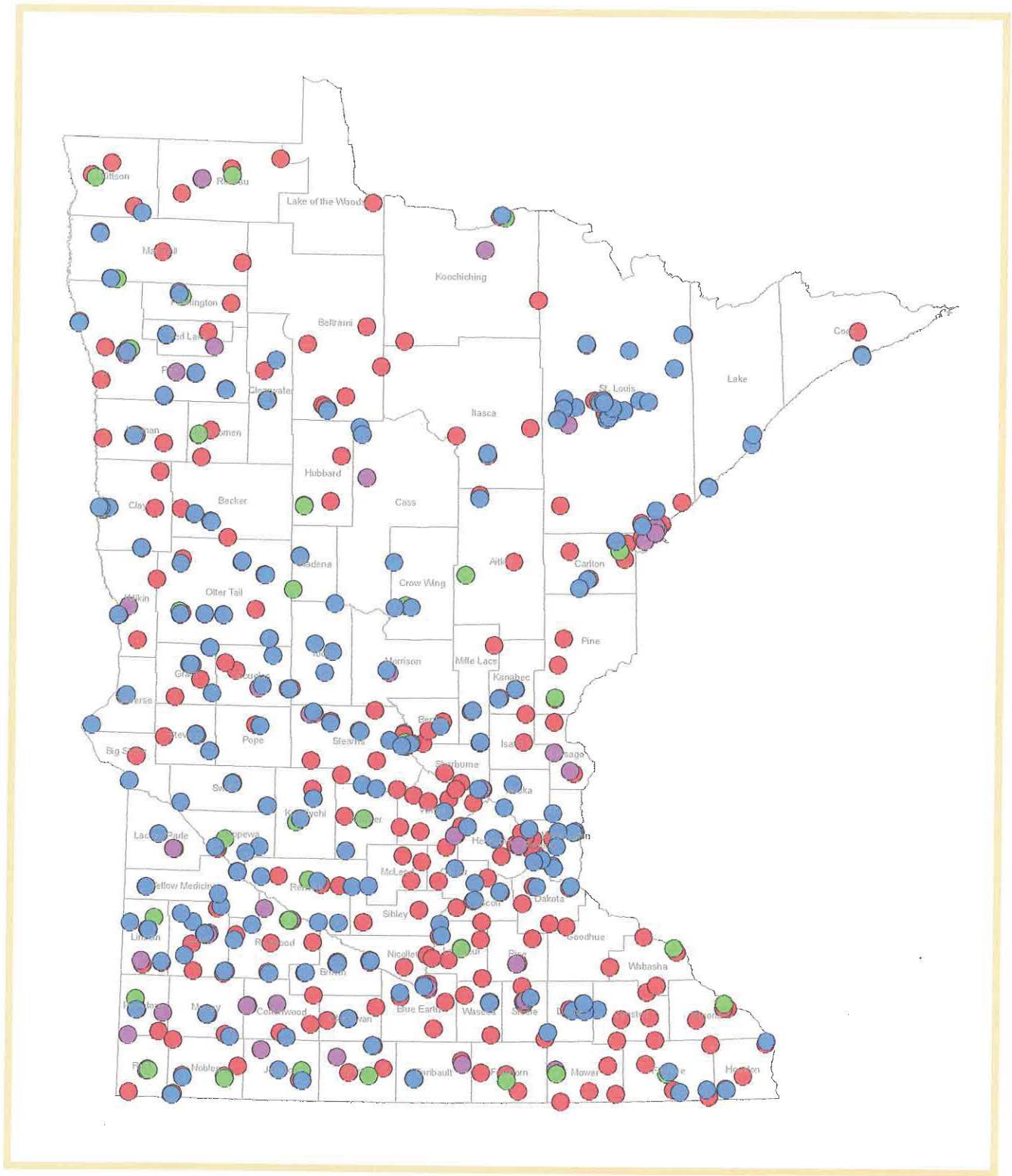
Legend

- County Boundary
- Schools

Service Cooperative Groups Schools, MN, March 2005

Map created on 3/18/2005 by Health-care Informatics. Data source, Marketing

healthcare informatics



N

Legend

- County Boundary
- Schools
- Government Agencies
- Counties
- Cities

Service Cooperative Groups Minnesota, March 2005

Map created on 3/18/2005 by Healthcare Informatics. Data source, Marketing

healthcare informatics

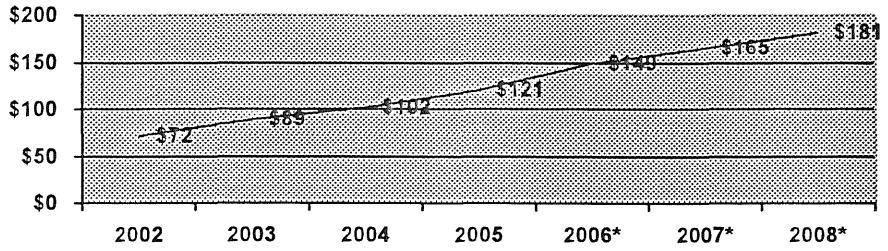
H.F. 517/S.F. 1459 School Health Care Purchasing Pool

The Minnesota Chamber of Commerce opposes H.F.517/S.F.1459 which creates a mandatory statewide teacher health care pool. The Chamber has several concerns with this legislation.

1. Under this plan, schools would no longer pay health care taxes. This shifts costs of the Minnesota Comprehensive Health Association (MCHA) and premium taxes to the 30% of small employers, individuals and farmers who purchase insurance in the fully insured private market. According to the Milliman report, 36 percent of the projected savings in this pool are the direct result of this cost shift.

   MCHA: The MCHA assessment is growing significantly while the base of payers is shrinking. This bill intensifies this problem. In 1997, the MCHA assessment was $37 million dollars with 35% of the market paying into the program. In 2004, the assessment was $102 million with 30% of the market paying the bill. H.F. 517/S.F. 1459 would reduce the number paying into the MCHA program to 24 percent. According to projections from the Milliman report, this bill would lower the collections of MCHA by $7.3 million in school year 2006/2007 and $7.9 million in 2007/2008. As the following chart indicates, the MCHA program is projected to continue its significant growth. In 2004, the MCHA assessment overtook the provider tax as the largest of the health care taxes, accounting for 2.1 percent of premium.

   Growth in MCHA Assessment (in millions)



   * projected

   Premium Taxes: The projected savings to the school health plan in HMO and indemnity premium taxes is estimated to be $6.5 million in school year 2006/2007 and $7.1 million in 2007/2008. The indemnity portion of the premium taxes is paid into the general fund, thus creating a hole in the general fund. The HMO portion of the premium tax is paid into the Health Care Access Fund, thus creating a shortage in this account.

2. Several of the assumptions that are used to arrive at this pool producing savings are flawed and are not available to other types of pooling or other arrangements in the market. The attachment point of $500,000 for stop loss is unrealistically high. Similar attachment points for pools for small and medium sized employers are around $75,000. The reserve requirements proposed are significantly less that what would be approved in a private purchasing pool. Such assumptions could affect the stability of the pool and could open the state to issues of liability if this pool were to fail.

Prepared by the Minnesota Chamber of Commerce

Senate Counsel, Research, and Fiscal Analysis

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S.F. No. 1440 - Uniform Standards for Identification Documents

Author: Senator Steve Kelley

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: March 24, 2005

S.F. No. 1440 requires the Commissioner of Health to establish uniform standards for birth certificates and other vital statistics documents.

Section 1 (144.05, subdivision 5) requires the Commissioner of Health to, by rule, provide uniform standards for the creation of birth certificates and other vital statistics documents. In preparing these standards the commissioner shall consult with the Commissioner of Public Safety and other affected departments and local authorities and shall consider security requirements, the practices of other states, proposals of state associations, and federal recommendations. Documents and replacement of documents issued in 2008 and thereafter must conform to these standards.

Section 2 (144.227, subdivision 2) states that a public employee who willfully and knowingly issues a counterfeited or altered certificate, vital record, report, or a copy of one of these is guilty of a gross misdemeanor. The section also states that a person who willfully and knowingly provides a blank document or other material to use in a counterfeited or altered document, vital record, or report is guilty of a gross misdemeanor.

Section 3 (171.07, subdivision 9) states that the Commissioner of Public Safety must consider when developing driver licenses and identification cards the standards for documents established by the commissioner of health as well as security requirements, the practices of other states, the proposals of state associations, and federal recommendations.

Section 4 (171.07, subdivision 9a) states that in 2009 and thereafter any birth certificate or other document provided by a Minnesota authority and presented in an application for a driver's license must conform to the standards established by the Commissioner of Health. It also requires that a birth certificate or other document from another state or country must provide equivalent assurance

of its authenticity. The commissioner may, by rule, provide detailed standards for the enforcement of this subdivision.

Section 5 appropriates $200,000 from the general fund to the Commissioner of Public Safety for an audit of the processes for the issuance of driver's licenses, birth certificates, and other vital statistics and other similar documents. The results of the audit must be reported to the Legislature and the governor.

KC:vs

Senators Kelley, Limmer and Sparks introduced--

S.F. No. 1440: Referred to the Committee on Health and Family Security.

A bill for an act

relating to identification documents; providing for uniform standards for drivers' licenses and other documents; prohibiting certain acts; providing for an audit; providing penalties; appropriating money; amending Minnesota Statutes 2004, sections 144.05, by adding a subdivision; 144.227, subdivision 2; 171.07, subdivision 9, by adding a subdivision.

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

Section 1. Minnesota Statutes 2004, section 144.05, is amended by adding a subdivision to read:

Subd. 5. [DOCUMENTS STANDARDS.] The Department of Health shall, by rule, provide uniform standards for the creation of birth certificates and other vital statistics documents. The standards shall be adopted in accordance with chapter 14. In preparing the standards, the commissioner of health shall consult the commissioner of public safety and other affected state departments and local authorities. The commissioner of health shall consider security requirements, the practices of other states, the proposals of state associations, and federal recommendations. Documents and replacements of documents issued in 2008 and thereafter shall conform to the standards.

Sec. 2. Minnesota Statutes 2004, section 144.227, subdivision 2, is amended to read:

Subd. 2. [FRAUD.] A person who, without lawful authority and with the intent to deceive, willfully and knowingly makes, counterfeits, alters, obtains, possesses, uses, or sells a

certificate, vital record, or report required to be filed under sections 144.211 to 144.227 or a certified certificate, vital record, or report, is guilty of a gross misdemeanor.

A public employee who willfully and knowingly issues a counterfeited or altered certificate, vital record, report, or copy of a certificate, vital record, or report filed under sections 144.211 to 144.227 is guilty of a gross misdemeanor.

A person who willfully and knowingly provides a blank document or other material for use in a counterfeited or altered certificate, vital record, or report of a kind required to be filed under sections 144.211 to 144.227 is guilty of a gross misdemeanor.

Sec. 3. Minnesota Statutes 2004, section 171.07, subdivision 9, is amended to read:

Subd. 9. [IMPROVED SECURITY.] The commissioner shall develop ~~new~~ drivers' licenses and identification cards~~,--to-be issued-beginning-January-1,-1994,~~ that must be as impervious to alteration as is reasonably practicable in their design and quality of material and technology. In the development of the licenses and cards, the commissioner shall consider the standards for documents provided under section 144.05, subdivision 5, security requirements, the practices of other states, the proposals of state associations, and federal recommendations. The driver's license security laminate shall be made from materials not readily available to the general public. The design and technology employed must enable the driver's license and identification card to be subject to two or more methods of visual verification capable of clearly indicating the presence of tampering or counterfeiting. The driver's license and identification card must not be susceptible to reproduction by photocopying or simulation and must be highly resistant to data or photograph substitution and other tampering.

Sec. 4. Minnesota Statutes 2004, section 171.07, is amended by adding a subdivision to read:

Subd. 9a. [INFORMATION DOCUMENTS.] In 2009 and thereafter, a birth certificate or other document provided by a Minnesota

authority and presented in an application for a driver's license must conform to the standards provided under section 144.05, subdivision 5. A birth certificate or other document from another state or country must provide equivalent assurance of its authenticity. The commissioner may, by rule, provide detailed standards for the enforcement of this subdivision.

Sec. 5. [DOCUMENT PROCESS AUDIT; APPROPRIATION.]

$200,000 is appropriated from the general fund to the Department of Public Safety for an audit of the processes for the issuance of drivers' licenses, birth certificates, and other vital statistics and similar documents in Minnesota to suggest improvements in those processes to better assure the accuracy of the documents, the security of their use for identification, and the avoidance of fraud. The commissioner shall report the results of the audit to the legislature and the governor.

ID Security FSL Partnership Project: Principles

The ID Security Principles outlined below were developed by members of the ID Security FSL Partnership Project including state legislators, legislative staff and private sector partners. The principles are recommendations of the project which have not been endorsed or adopted by any NCSL Committee and therefore do not constitute official NCSL policy.

GOAL: A State-Based, Secure, and Reasonably Convenient Means of Authenticating a Person's Identity and Verifying Privileges Related to that Identity Consistent with Individual Privacy

I. Secure

A. Each state should establish standard requirements to protect underlying identification documents or "breeder documents," such as birth certificates, death certificates, marriage and name change documents, from theft, alteration, destruction, or unauthorized access.
B. Breeder documents should be protected against forgery, through legal and technical measures.
C. States should have similar, minimum standards for the maintenance and protection of underlying documents so that no one state creates a weak point in the system.
D. Biometric data, including photos, fingerprints, retinal scan data, and possibly DNA, should be used where appropriate based on the level of risk and security required.
E. Federal identification and privilege documents (i.e. passports, social security cards) and related procedures should not conflict with state standards and procedures and must allow secure exchanges of data to extent necessary to prevent fraud and breaches of ID security.
F. Standard methods should be developed for reporting of and appropriate sharing of information about incidents of fraud and ID security breaches to enable public and private responses and effective countermeasures.
G. Standard minimum security processes should cover registration, document proofing, authentication, and authorization and include necessary audit and enforcement processes to detect and punish misuse and fraud.
H. States should ensure the security of their issuance systems including prevention of, and penalties for, collusion by issuing authorities, separation of data capture and ID issuance process steps, and establishing controls over materials and security features.
I. States should limit the validity of ID documents to a reasonable period of time and limit the use of "sticker" upgrades in order to reduce identity theft, enable regular updating of data in databases, and enable timely upgrade of security features.
J. Each state should verify identity information with at least one, and preferably two, databases prior to issuance, such as state databases, the Social Security Administration Database, National Immigration Services Databases, or commercial databases.

II. Reasonably Convenient

A. The level of security provided should be related to the risk posed by an error in identifying a person or verifying the privileges possessed by the person.
B. The standards for access to underlying documents should not prevent authorized family members from assisting in obtaining identity documents.
C. The identification document should be easy to use and flexible enough to be used for multiple purposes at the individual's option, including in-person, remote, and electronic transactions.

D. The document and related systems should protect against errors, (e.g. a fingerprint reader incorrectly rejecting the person being identified.) and include policies and procedures for quickly correcting errors and reversing unjust denials.

III. Authentication

A. The basic procedures and/or tools for identifying a person based on a document should use a standard set of practices that can be used from state to state while allowing states to enhance security with additional procedures and/or tools.
B. The appropriate number and mix of components of the three pillars of authentication—something you know, something you have, and something you are (biometric data) — should be used in accordance with the risk and desired level of security.
C. Federal and state governments should clearly, explicitly define in law and in user information, when the identification document is necessary for rights, benefits, privileges, and transactions.
D. Private sector uses of the identification document may be allowed but should not increase the risk of forgery or identity theft.
E. The individual should control uses of the ID document beyond a very limited set of government requirements and may choose to use the ID document to gain private sector rights, benefits, and privileges and conduct transactions.
F. Individual identity need not be a part of all forms of authentication and non-personally identifiable credentials can and should be used where compatible with the risk and desired level of security.
G. States should support the development of a diversity of authentication tools and providers of services, so that individuals are not forced to use one single identifier for various purposes.
H. States should support development of capabilities enabling verification of document authenticity across jurisdictions.

IV. Privileges

A. Methods of recognizing additional privileges possessed by a person should be standard from state to state.
B. Privileges accessed through the ID documents should be subject to individual choices, e.g., whether to add driving privileges.

V. Privacy

A. The ID document and related procedures should not create a means of unauthorized surveillance of an individual.
B. All records and information maintained in connection with the ID document and its uses should be maintained consistent with accepted good data practices.
C. The individual should be provided with notice about the purpose and uses of the ID document before information is collected or the document is issued.
D. The individual, with appropriate verification of identity, should be able to access his or her own information on the ID document and should be able to correct inaccuracies.
E. States should develop legal standards that determine the appropriate use and protection of biometric data before incorporating them into ID documents.
F. Data should not be accessible from an ID document without the citizen knowingly presenting the credential at a point of inspection or transaction.

VI. State-Based

A. States should cooperate in establishing uniform or standardized laws relating to the creation, use and protection of ID documents.

Senators Kiscaden and Kelley introduced--

S.F. No. 1641: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying best practices guidelines; establishing a quality improvement investment program; appropriating money; amending Minnesota Statutes 2004, section 62J.43.

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

Section 1. Minnesota Statutes 2004, section 62J.43, is amended to read:

62J.43 [~~BEST-PRACTICES~~ EVIDENCE-BASED HEALTH CARE GUIDELINES AND QUALITY IMPROVEMENT.]

~~(a)~~ Subdivision 1. [ADOPTION OF BEST PRACTICES.] To improve quality and reduce health care costs, state agencies shall encourage the ~~adoption~~ use of ~~best-practice~~ evidence-based health care guidelines and participation in best practices measurement activities by physicians, other health care providers, and health plan companies. The commissioner of health shall facilitate access to ~~best-practice~~ evidence-based health care guidelines and quality of care measurement information to providers, purchasers, and consumers by:

(1) identifying and promoting local community-based, physician-designed ~~best-practices-care~~, evidence-based health care guidelines across the Minnesota health care system;

(2) disseminating information available to the commissioner on adherence to ~~best-practices~~ evidence-based guidelines care by physicians and other health care providers in Minnesota;

(3) educating consumers and purchasers on how to effectively use this information in choosing their providers and in making purchasing decisions; and

(4) making ~~best practices~~ evidence-based health care guidelines and quality care measurement information available to enrollees and program participants through the Department of Health's Web site. The commissioner may convene an advisory committee to ensure that the Web site is designed to provide user friendly and easy accessibility.

~~(b)~~ Subd. 2. [COLLABORATION WITH MINNESOTA NONPROFIT ORGANIZATION.] The commissioner of health shall collaborate with a nonprofit Minnesota quality improvement organization specializing in best practices and quality of care measurements to provide ~~best practices~~ evidence-based health care guidelines criteria and assist in the collection of the data.

~~(c)~~ Subd. 3. [CRITERIA FOR EVIDENCE-BASED GUIDELINES.] Guidelines identified under this section must meet the following criteria:

(1) the scope and application are clear;

(2) authorship is stated and any conflicts of interest disclosed;

(3) authors represent all pertinent clinical fields or other means of input have been used;

(4) the development process is explicitly stated;

(5) the guideline is grounded in evidence;

(6) the evidence is cited and graded;

(7) the document itself is clear and practical;

(8) the document is flexible in use, with exceptions noted or provided for with general statements;

(9) measures are included for use in systems improvement; and

(10) the guideline has scheduled reviews and updating.

Subd. 4. [INITIAL EVIDENCE-BASED HEALTH CARE GUIDELINES.] The initial ~~best practices~~ evidence-based health care guidelines and quality of care measurement criteria developed shall include asthma, diabetes, and at least two other preventive health

measures. Hypertension and coronary artery disease shall be included within one year following availability.

~~(d)~~ Subd. 5. [USE IN STATE CONTRACTS WITH HEALTH PLANS.] The commissioners of human services and employee relations may use the data to make decisions about contracts they enter into with health plan companies.

~~(e)~~ Subd. 6. [LIMITATIONS.] This section does not apply if the ~~best-practices~~ evidence-based health care guidelines authorize or recommend denial of treatment, food, or fluids necessary to sustain life on the basis of the patient's age or expected length of life or the patient's present or predicted disability, degree of medical dependency, or quality of life.

~~(f) The commissioner of health, human services, and employee relations shall report to the legislature by January 15, 2005, on the status of best practices and quality of care initiatives, and shall present recommendations to the legislature on any statutory changes needed to increase the effectiveness of these initiatives.~~

~~(g) This section expires June 30, 2006.~~

Sec. 2. [QUALITY IMPROVEMENT INVESTMENT PROGRAM.]

The commissioner of health, in consultation with the commissioners of finance and administration, shall submit recommendations to the legislature by December 15, 2005, to establish a quality improvement investment program to provide technical assistance, grants, and low-interest loans to health care organizations and health professional associations to support establishing or updating electronic information systems in all health care settings to support the efficient and effective delivery of safe, evidence-based health care services and to reduce administrative costs.

Sec. 3. [APPROPRIATION.]

$..... is appropriated from the general fund to the commissioner of health for the fiscal year ending June 30, 2006, for the report required under section 2.

Sec. 4. [EFFECTIVE DATE.]

Sections 1 to 3 are effective July 1, 2005.

Senator ..... moves to amend S.F. No. 1641 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 62J.43, is amended to read:

62J.43 [~~BEST-PRACTICES~~ EVIDENCE-BASED HEALTH CARE GUIDELINES AND QUALITY IMPROVEMENT.]

~~(a)~~ Subdivision 1. [ADOPTION OF ~~BEST PRACTICES~~ EVIDENCE-BASED GUIDELINES.] To improve quality and reduce health care costs, state agencies shall encourage the ~~adoption~~ use of ~~best-practice~~ evidence-based health care guidelines and participation in ~~best-practices~~ quality of care measurement activities by ~~physicians~~ medical groups, hospitals, other health care providers, and health plan companies. The commissioner of health shall facilitate access to ~~best-practice~~ evidence-based health care guidelines and quality of care measurement information ~~to~~ for providers, purchasers, and consumers by:

(1) identifying and promoting ~~local-community-based, physician-designed-best-practices-care~~ evidence-based health care guidelines across the Minnesota health care system using local community-based, physician-designed guidelines whenever they are available and meet the criteria set forth in subdivision 2;

(2) disseminating information available to the commissioner on ~~adherence-to-best-practices-care-by-physicians~~ the performance of Minnesota medical groups, hospitals, and other health care providers ~~in-Minnesota~~ in providing care in accordance with evidence-based health care guidelines;

(3) educating consumers and purchasers on how to ~~effectively~~ use this information effectively in choosing their providers and in making purchasing decisions; and

(4) making ~~best-practices~~ evidence-based health care guidelines and quality of care measurement information available to enrollees and program participants through the Department of Health's Web site. The commissioner may convene an advisory committee to ensure that the Web site is designed to provide

user friendly and easy accessibility.

~~(b) The commissioner of health shall collaborate with a nonprofit Minnesota quality improvement organization specializing in best practices and quality of care measurements to provide best practices criteria and assist in the collection of the data.~~

~~(c)~~ Subd. 2. [CRITERIA FOR EVIDENCE-BASED GUIDELINES.] Guidelines identified under this section must meet the following criteria:

(1) the scope and intended use of the guideline application are clearly stated;

(2) the authors are listed and any conflicts of interest are disclosed;

(3) the authors represent all pertinent clinical fields or other means of input have been used for pertinent clinical fields not represented among the authors;

(4) the development process is explicitly stated;

(5) the guideline is grounded in evidence;

(6) the evidence is cited and graded with respect to its strength;

(7) the document itself is clear and practical;

(8) the document is flexible in use, with exceptions noted or provided for with general statements;

(9) measures are included for use in systems improvement pursued to improve the likelihood that health care will be provided in accordance with the guideline; and

(10) the document provides for scheduled reviews and updating.

Subd. 3. [IDENTIFICATION OF EVIDENCE-BASED HEALTH CARE GUIDELINES.] In order to identify evidence-based guidelines for promotion under this section, the commissioner of health shall collaborate with a nonprofit Minnesota quality improvement organization that specializes in producing guidelines and using them to improve health care. The guidelines identified may be ones produced by that organization or ones produced by other nonprofit Minnesota or national organizations, provided that the

guidelines fulfill the criteria set forth in subdivision 2.

Subd. 4. [INITIAL EVIDENCE-BASED HEALTH CARE GUIDELINES.] The ~~initial best practices and quality of care measurement criteria developed~~ topics of the evidence-based health care guidelines initially identified and promoted shall include asthma, diabetes, ~~and at least two other preventive health measures. Hypertension and coronary artery diseases shall be included within one year following availability~~ hypertension, coronary artery disease, depression, preventive services, acute myocardial infarction, heart failure, pneumonia, and surgical infections. The guidelines on these topics shall be identified and promotion begun by December 15, 2005.

Subd. 5. [MEASUREMENT AND REPORTING OF PERFORMANCE.] In order to disseminate information on the performance of medical groups, hospitals, and other health care providers in providing care in accordance with evidence-based guidelines, the commissioner shall collaborate with one or more nonprofit Minnesota organizations that specialize in the development of health care quality measures derived from evidence-based guidelines, in the measurement of performance by health care providers, and in the reporting of performance using publicly accessible means, including Web sites. The Department of Health shall not measure performance directly but shall determine whether performance is being measured competently and accurately by one or more nonprofit organizations and shall provide on its Web site links to the Web site or sites of the measuring organization or organizations chosen by the commissioner. The commissioner shall encourage the development over time of a single nonprofit Minnesota measurement and reporting organization that reports on the performance of medical groups, hospitals, and other health care providers.

~~(d)~~ Subd. 6. [USE IN STATE CONTRACTS WITH HEALTH PLANS.] The commissioners of human services and employee relations may use the ~~data~~ publicly reported performance measurements described in subdivision 5 to make decisions about contracts they enter into with health plan companies and to establish

programs of performance payment designed to reward either high-quality care or improvements in quality achieved by medical groups, hospitals, and other health care providers.

~~(e)~~ Subd. 7. [LIMITATIONS.] This section does not apply if the ~~best practices~~ evidence-based health care guidelines authorize or recommend denial of treatment, food, or fluids necessary to sustain life on the basis of the patient's age or expected length of life or the patient's present or predicted disability, degree of medical dependency, or quality of life.

~~(f) The commissioner of health, human services, and employee relations shall report to the legislature by January 15, 2005, on the status of best practices and quality of care initiatives, and shall present recommendations to the legislature on any statutory changes needed to increase the effectiveness of these initiatives.~~

~~(g) This section expires June 30, 2006.~~

Sec. 2. [QUALITY IMPROVEMENT INVESTMENT PROGRAM.]

The commissioner of health, in consultation with the commissioners of finance and administration, shall submit recommendations to the legislature by December 15, 2005, to establish a quality improvement investment program to provide technical assistance, grants, and low-interest loans to health care organizations and health professional associations to support establishing or updating electronic information systems in all health care settings to support the efficient and effective delivery of safe, evidence-based health care services and to reduce administrative costs.

Sec. 3. [APPROPRIATION.]

$..... is appropriated from the general fund to the commissioner of health for the fiscal year ending June 30, 2006, for the report required under section 2.

Sec. 4. [EFFECTIVE DATE.]

Sections 1 to 3 are effective July 1, 2005."

Minnesota Nurses Association

nurses in vision and voice

Professional Distinction

Personal Dignity

Patient Advocacy

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ANA AMERICAN NURSES ASSOCIATION
UAN UNITED AMERICAN NURSES, AFL-CIO

March 24, 2005

Dianne M. Mandernach
Commissioner
P.O Box 64882
St. Paul, MN 55164-0882

Dear Ms. Mandernach:

The purpose of this letter is to provide support to the recently introduced legislation on systems improvement and the use of evidenced-based guidelines. Representatives from the Minnesota Nurses Association participated in the process of developing Health Care Guidelines which were presented to the Governor's Health Care Cabinet in January. The report reflects a thoughtful approach by a broad array of health care providers with considerable knowledge and expertise in this arena.

One of the goals of this initiative was to "facilitate access to best practice guidelines and quality of care measurement information for providers, purchasers, and consumers..." Minnesota is fortunate to have current projects and systems that further this goal such as the Community Measurement Project, the Institute of Clinical Systems Improvement, and the Minnesota Department of Health's new health information website. The recommendations of the Health Care Guidelines Work Group builds on these initiatives.

The Minnesota Nurses Association has a 100 year (1905-2005) history of supporting access to quality care for all citizens and is pleased to support the continued important work of developing Health Care Guidelines on systems improvement and evidenced-based practice.

Sincerely,

Erin Murphy, RN
Executive Director
Minnesota Nurses Association

EM/lso

cc: Carol Diement, RN, MSN, Staff Specialist, Nursing Practice

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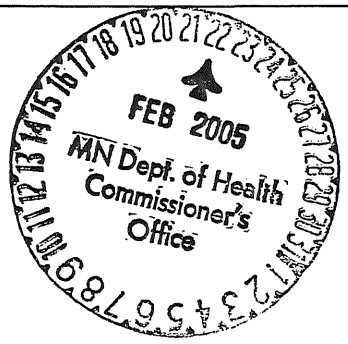
MMA
Minnesota Medical Association

Physicians working for a healthy Minnesota



February 18, 2005

Dianne Mandernach
Commissioner
Minnesota Department of Health
P. O. Box 64882
St. Paul, Minnesota 55164-0882

Dear Commissioner Mandernach:

On behalf of the more than 9,000 members of the Minnesota Medical Association (MMA), I am pleased to support the *Recommendations on Systems Improvements to Advance Evidenced-Based Health Care Report* submitted in January 2005 by the Evidenced-Based Medicine Task Force of the Governor's Health Care Cabinet.

The MMA's recently released heath care reform proposal, *Physicians' Plan for a Healthy Minnesota*, endorses the use of evidenced-based health care guidelines as one means by which to improve the amount of effective care delivered to Minnesota patients. We see great overlap between the MMA plan and the department's report. The report identifies five key strategies that promote access to and appropriate use of evidenced-based health care guidelines. These guidelines are integral in systems and processes created to improve the quality of care and outcomes for our patients and has the potential to lower costs.

We urge the Minnesota Legislature to accept the report and recommendations of the Evidenced-Based Medicine Task Force.

Thank you for the opportunity to participate in this important effort.

Sincerely,

J. Michael Gonzalez-Campoy, M.D., Ph.D., FACE
President
Minnesota Medical Association

c: Richard Geier, M.D.
Robert Meiches, M.D.
Patricia Lindholm, M.D.
Shawn Holmes

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Health Care Cost Control: Purchasing for Value

Goals

- ✓ Improve quality
- ✓ Increase value
- ✓ Inform patients, purchaser
- ✓ Improve function of marketplace for health care

$$\text{VALUE} = \frac{\text{Quality}}{\text{Cost}}$$

Evidence-based Guidelines:

Developed or being developed by state or national experts and resources.

EXAMPLES:

Prevention
- immunizations
- annual screenings
- tobacco cessation

Ambulatory Care
- asthma
- diabetes
- hypertension
- coronary artery disease
- depression

Inpatient Care
- heart failure
- pneumonia
- surgical infection
- acute myrocardial infraction
- central line bloodstream infections
- medical errors
- patient mortality

Measurement:

Example: Institute of Medicine's Six Factors:

- Effectiveness
- Efficiency
- Timeliness
- Responsive to Patient
- Equity
- Safety

- Data collected and used by providers for quality improvement.
- Data used by accrediting organization.

Quality and Performance:

Public and private purchasers use measurement to make decisions, create incentives, and/or set payments.

- Data reported by provider groups, hospitals and integrated systems.
- Use of consistent data elements allows consumers/ payers/regulators to compare providers/systems.

Table A:
Example Measures of Health Care Performance

IOM Category	Examples of Measures that Might be Used	Applicable to	Desirable Attributes of Example Measures ‡						Comments
			Volume	Gravity	Evidence	Gap	Prospects	Functionality	
Safety	• Adverse drug events per 1,000 doses	HC *	√ †	√	√	√	√	√	Tool available from IHI
	• Never-events per 1,000 hospital days	HC		√	√	√		√	Routinely collected in Minnesota
	• Central-line associated blood stream infections per 1,000 line-days	HC	√	√	√	√	√	√	
	• Wrong-site surgery per 1,000,000 procedures	HC,IS		√	√	√	√	√	
	• Falls per 1,000 patient days	HC	√		√	√	√	√	
	• Number of new pressure ulcers per 1,000 days	HC	√	√	√	√	√	√	
Effective-ness	• Percentage of 2-year-olds whose preventive services are up-to-date	AC	√	√	√	√	√	√	HEDIS measure
	• Percentage of diabetic patients with optimal care (controlled HbA1c, LDL & BP, not using tobacco & taking daily ASA)	AC,IS	√	√	√	√	√	√	MCMP measure
	• Rate of visits by asthma patients to ERs	AC,IS	√	√	√	√	√	√	
	• Percentage of CABG patients alive 30 days after surgery	HC	√	√	√	√	√	√	
	• Percentage of CHF patients readmitted within 30 days	HC	√	√	√	√	√	√	CMS & JCAHO measure
	• Hospital standardized mortality ratio	HC	√	√	√	√	√	√	Comprehensive but complex

* Abbreviations at the end of the Table ‡ Explanation of these attributes on the fourth page of the Table † √ = desirable attribute present

Table A Continued:
Example Measures of Health Care Performance

IOM Category	Examples of Measures that Might be Used	Applicable to	Desirable Attributes of Example Measures ‡						Comments
			Volume	Gravity	Evidence	Gap	Prospects	Functionality	
Patient-centered-ness	• Press Ganey survey measures	IS *	√ †	√	√	√	√	√	Widely used
	• NRC (Picker) survey measures	IS	√	√	√	√	√	√	Widely used
	• Hospital CAHPS survey measures	HC	√	√	√	√	√	√	Widely used
	• Ambulatory CAHPS survey measures	AC	√	√	√	√	√	√	New
	• CAHPS survey measures	IS	√	√	√	√	√	√	Melds health plan, hospital, and ambulatory
Timeli-ness	• Waiting time for 3rd next available appointment	AC	√		√	√	√	√	Widely used
	• Waiting time in clinic once arrived for appointment	AC	√		√	√	√	√	
	• Lag time between ER decision to admit and arrival in hospital bed	HC	√		√	√	√	√	
	• Lag time between abnormal mammogram and firm diagnosis	IS	√	√	√	√	√	√	
	• Lag time between onset of chest pain and definitive treatment	IS	√	√	√	√	√		Difficult to measure routinely
	• Time on telephone until issue definitively addressed	AC	√		√	√	√		May be difficult to define and measure

* Abbreviations at the end of the Table ‡ Explanation of these attributes on the fourth page of the Table † √ = desirable attribute present

Table A Continued:
Example Measures of Health Care Performance

IOM Category	Examples of Measures that Might be Used	Applicable to	Desirable Attributes of Example Measures ‡						Comments
			Volume	Gravity	Evidence	Gap	Prospects	Functionality	
Efficiency	• Costs for selected Episode Treatment Groups	HC,IS *	√ †	√	√	√	√	√	None of these measures is a true efficiency measure. All are measures of cost for selected items regardless of outcome.
	• Average LOS for selected DRGs or other hospitalization categories	HC	√	√	√	√	√	√	
	• Costs for selected Ambulatory Care Groups per year	AC	√	√	√	√	√	√	
	• Risk-adjusted costs per patient per month for selected populations	IS	√	√	√	√	√	√	
	• Pharmacy costs per patient per month for selected populations	AC	√	√	√	√	√	√	
	• Cost during first 6 weeks of care for acute low back pain	AC	√	√	√	√	√	√	
Equity	• Contrasts of process and outcome measures between genders	AC,HC, IS	√	√	√	√			Equity measures in general are not well developed. Evidence is also often lacking on effectiveness of action under optimal circumstances and in real-world health systems.
	• Contrasts of process and outcome measures across different ethnic groups	AC,HC, IS	√	√	√	√	√	√	
	• Contrasts of process and outcome measures across different income groups	AC,HC, IS	√	√	√	√		√	
	• Contrasts of process and outcome measures among urban, suburban, and rural populations	AC,HC, IS	√	√	√	√			

* Abbreviations at the end of the Table ‡ Explanation of these attributes on the fourth page of the Table † √ = desirable attribute present

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Senate

State of Minnesota

S.F. No. 1638 - Health Care Reform

Author: Senator Sheila M. Kiscaden

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KC

Date: March 29, 2005

S.F. No. 1638 provides for a statewide plan for improving the delivery of health care.

Article 1

Section 1 (145A.12, subdivision 8) requires the Commissioner of Health, in consultation with the Minnesota Health Improvement Partnership, to develop and implement a statewide action plan for improving the health status of Minnesotans through strategic and coordinated action of communities, businesses, health care professionals, health care organizations, health plans, schools, and other public and private entities. The plan must identify up to three of the public health outcomes identified for the local public health grant funds and provide for steps to be taken that will provide measurable improvements in the health status and reductions in the incidence of disease and injury and related health care costs.

Section 2 (145A.12, subdivision 9) requires the commissioner to establish a public health challenge grant fund and program to award grants to statewide and local health improvement public-private partnerships to support collaborative actions to reduce the rate of increase in health care costs by improving health status and the prevention of illness and injury.

Section 3 requires the state agency commissioners serving on the Governor's Health Care Cabinet, in cooperation with other organizations, to identify and contract with a private, nonprofit organization to serve as a statewide source of comparative information on health care costs and quality.

Section 4 appropriates money from the health care access fund to the Commissioner of Health for the challenge grant fund.

Article 2

Section 1 (62Q.166) establishes universal health coverage.

Subdivision 1 requires each Minnesota resident to obtain and maintain health coverage that includes at least the secure benefit set by January 1, 2009. Any person who becomes a Minnesota resident must obtain coverage no later than 90 days after becoming a resident. A child must have coverage from the moment of birth.

Subdivision 2 states that every health plan offered, issued, sold, or renewed to cover a Minnesota resident must include the secure benefit set. A health plan may include coverage in addition to the secure benefit set, provided that this additional coverage is provided as optional coverage for a separately stated premium.

Subdivision 3 states that each health plan company shall offer, sell, issue, or renew the secure benefit set on a guaranteed issue basis. Any optional coverage provided need not be provided on a guaranteed issue basis.

Subdivision 4 states that the community rate bands for the secure benefit set must not vary based on health history or status, whether the coverage is individual or group, gender, geographic location, purchase of additional coverage, or any other factor except to reflect actuarially valid differences attributable to age or the nonuse of tobacco, compliance with recommended health screenings and preventive care, or other health promoting behaviors. Any premium rate variations must be in accordance with Minnesota Statutes, section 62L.08, and must be approved by the commissioner. These rate bands do not apply to optional coverage.

Subdivision 5 states that the health plan may exclude or limit coverage of a preexisting condition under the secure benefit set but only if the condition developed at a time when the applicant or enrollee did not have coverage for the secure benefit set.

Section 2 (290.01, subdivision 19b) permits any amount paid for health coverage that is not already deducted in determining federal taxable income to be subtracted from federal taxable income.

Section 3 requires the Commissioner of Commerce to present to the Legislature no later than November 15, 2005, a plan for reactivating the reinsurance pool established under sections 62L.13 to 62L.23 and converting it to a reinsurance pool for high cost cases in the individual and group market.

Section 4 requires the Commissioner of Health to prepare and submit to the Legislature by December 15, 2005, a report with recommendations and proposed legislation for enforcing the requirement that all individuals maintain continuous health coverage.

Section 5 requires the Commissioners of Health, Human Services, Labor and Industry, Employee Relations, Corrections, Commerce and Administration and the board of directors for the Minnesota Comprehensive Health Association, in consultation with a panel of health care policy experts, to define a secure benefit set that includes coverage for preventive health services, prescription drug coverage, and catastrophic health coverage.

KC:ph

Senators Kiscaden, Solon and Lourey introduced--
S.F. No. 1638: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; providing for a statewide plan for improving health; requiring health plans to issue coverage to all applicants and charge community rates; developing a secure benefit set for all health plans; creating an income tax deduction for health coverage premiums; requiring all persons to maintain health coverage; amending laws promoting high-quality health care; providing for public information on health care cost and quality; requiring reports; appropriating money; amending Minnesota Statutes 2004, sections 145A.12, by adding subdivisions; 290.01, subdivision 19b; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

ARTICLE 1

HEALTHIER MINNESOTANS

Section 1. Minnesota Statutes 2004, section 145A.12, is amended by adding a subdivision to read:

Subd. 8. [COORDINATED STATEWIDE HEALTH IMPROVEMENT ACTION PLAN.] The commissioner, in consultation with the Minnesota Health Improvement Partnership, shall develop and implement a statewide action plan for improving the health status of Minnesotans through strategic and coordinated action of communities, businesses, health care professionals, health care organizations, health plans, schools, and other public and private entities. The plan must identify up to three of the statewide public health outcomes as determined under subdivision 7 and provide for specific steps to be taken that will produce measurable improvements in health status and corresponding

reductions in the incidence of disease or injury and related health care costs. The plan must encourage and facilitate the formation of local public-private partnerships to take action on the statewide goals.

Sec. 2. Minnesota Statutes 2004, section 145A.12, is amended by adding a subdivision to read:

Subd. 9. [CHALLENGE GRANT FUND.] The commissioner shall establish a public health challenge grant fund and program to award grants to statewide and local health improvement public-private partnerships to support collaborative actions that will reduce the rate of increase in health care costs through improvements in the health status or the prevention of illness and injury in the population of the state or a local community. The commissioner shall require grantees to provide an equal match of local funding provided from public or private sources. Each grant program must include a methodology approved by the commissioner for measuring the impact of the grantees' actions on health care costs incurred by public or private health insurance plans, local public health programs, and health care providers' uncompensated care costs. Each grant program must include written agreements between participating public and private entities that provide health care services or health coverage under which the entities agree to contribute, to the challenge grant fund, 20 percent of any savings they realize as a result of the program. The commissioner of human services and the commissioner of employee relations shall agree to enter into agreements with grantees regarding the payment of the 20 percent of savings in their health coverage programs to the challenge grant fund.

Sec. 3. [COST AND QUALITY DISCLOSURE.]

The state agency commissioners serving on the governor's Health Care Cabinet, in cooperation with organizations representing consumers, employers, physicians and other health professionals, hospitals, long-term care facilities, health plan companies, quality improvement organizations, research and education institutions, and other appropriate constituencies,

shall identify and contract with a private, nonprofit organization to serve as a statewide source of comparative information on health care costs and quality.

Sec. 4. [APPROPRIATION.]

$..... is appropriated from the health care access fund to the commissioner of health for the challenge grant fund under Minnesota Statutes, section 145A.12, subdivision 9, for the fiscal year ending June 30, 2006. This appropriation shall be repaid from repayments to the challenge grant fund by June 30, 2008.

Sec. 5. [EFFECTIVE DATE.]

Sections 1 and 2 are effective July 1, 2005.

ARTICLE 2

HEALTH INSURANCE REFORM

Section 1. [62Q.166] [UNIVERSAL HEALTH COVERAGE.]

Subdivision 1. [REQUIREMENT OF COVERAGE.] (a) Effective January 1, 2009, each Minnesota resident shall obtain and maintain health coverage that includes at least the secure benefit set described under section 5.

(b) A person who becomes a Minnesota resident must obtain the coverage no later than 90 days after becoming a Minnesota resident.

(c) A child must have the coverage at the moment of birth.

Subd. 2. [SECURE BENEFIT SET.] (a) Every health plan offered, issued, sold, or renewed to cover a Minnesota resident must include the secure benefit set as described under section 5.

(b) A health plan may include coverage in addition to the secure benefit set, provided that the additional coverages are provided as optional coverage, for a separately stated premium.

Subd. 3. [GUARANTEED ISSUE.] (a) Each health plan company shall offer, sell, issue, or renew the secure benefit set on a guaranteed issue basis, as defined in section 62Q.18, subdivision 1, clause (2).

(b) Optional coverages under subdivision 2, paragraph (b), need not be provided on a guaranteed issue basis.

Subd. 4. [COMMUNITY RATE BANDS.] (a) The premium rate

bands for the secure benefit set must not vary based upon health history or status, whether coverage is group or individual, gender, geographic location, purchase of additional coverage, or any other factor except as permitted under paragraph (b).

(b) Premium rate bands for the secure benefit set may vary to reflect actuarially valid differences attributable to age or to nonuse of tobacco, compliance with recommended health screenings and preventive care, or other health-promoting behaviors. Premium rate variations must be in accordance with section 62L.08 and must be approved by the commissioner prior to their use.

(c) Paragraphs (a) and (b) do not apply to optional coverage provided as an addition to the secure benefit set.

Subd. 5. [PREEXISTING CONDITIONS.] A health plan may exclude or limit coverage of a preexisting condition under the secure benefit set only if the condition developed at a time when the applicant or enrollee did not have coverage for the secure benefit set.

Sec. 2. Minnesota Statutes 2004, section 290.01, subdivision 19b, is amended to read:

Subd. 19b. [SUBTRACTIONS FROM FEDERAL TAXABLE INCOME.] For individuals, estates, and trusts, there shall be subtracted from federal taxable income:

(1) interest income on obligations of any authority, commission, or instrumentality of the United States to the extent includable in taxable income for federal income tax purposes but exempt from state income tax under the laws of the United States;

(2) if included in federal taxable income, the amount of any overpayment of income tax to Minnesota or to any other state, for any previous taxable year, whether the amount is received as a refund or as a credit to another taxable year's income tax liability;

(3) the amount paid to others, less the amount used to claim the credit allowed under section 290.0674, not to exceed $1,625 for each qualifying child in grades kindergarten to 6 and

$2,500 for each qualifying child in grades 7 to 12, for tuition, textbooks, and transportation of each qualifying child in attending an elementary or secondary school situated in Minnesota, North Dakota, South Dakota, Iowa, or Wisconsin, wherein a resident of this state may legally fulfill the state's compulsory attendance laws, which is not operated for profit, and which adheres to the provisions of the Civil Rights Act of 1964 and chapter 363A. For the purposes of this clause, "tuition" includes fees or tuition as defined in section 290.0674, subdivision 1, clause (1). As used in this clause, "textbooks" includes books and other instructional materials and equipment purchased or leased for use in elementary and secondary schools in teaching only those subjects legally and commonly taught in public elementary and secondary schools in this state. Equipment expenses qualifying for deduction includes expenses as defined and limited in section 290.0674, subdivision 1, clause (3). "Textbooks" does not include instructional books and materials used in the teaching of religious tenets, doctrines, or worship, the purpose of which is to instill such tenets, doctrines, or worship, nor does it include books or materials for, or transportation to, extracurricular activities including sporting events, musical or dramatic events, speech activities, driver's education, or similar programs. For purposes of the subtraction provided by this clause, "qualifying child" has the meaning given in section 32(c)(3) of the Internal Revenue Code;

(4) income as provided under section 290.0802;

(5) to the extent included in federal adjusted gross income, income realized on disposition of property exempt from tax under section 290.491;

(6) to the extent included in federal taxable income, postservice benefits for youth community service under section 124D.42 for volunteer service under United States Code, title 42, sections 12601 to 12604;

(7) to the extent not deducted in determining federal taxable income by an individual who does not itemize deductions

for federal income tax purposes for the taxable year, an amount equal to 50 percent of the excess of charitable contributions allowable as a deduction for the taxable year under section 170(a) of the Internal Revenue Code over $500;

(8) for taxable years beginning before January 1, 2008, the amount of the federal small ethanol producer credit allowed under section 40(a)(3) of the Internal Revenue Code which is included in gross income under section 87 of the Internal Revenue Code;

(9) for individuals who are allowed a federal foreign tax credit for taxes that do not qualify for a credit under section 290.06, subdivision 22, an amount equal to the carryover of subnational foreign taxes for the taxable year, but not to exceed the total subnational foreign taxes reported in claiming the foreign tax credit. For purposes of this clause, "federal foreign tax credit" means the credit allowed under section 27 of the Internal Revenue Code, and "carryover of subnational foreign taxes" equals the carryover allowed under section 904(c) of the Internal Revenue Code minus national level foreign taxes to the extent they exceed the federal foreign tax credit;

(10) in each of the five tax years immediately following the tax year in which an addition is required under subdivision 19a, clause (7), an amount equal to one-fifth of the delayed depreciation. For purposes of this clause, "delayed depreciation" means the amount of the addition made by the taxpayer under subdivision 19a, clause (7), minus the positive value of any net operating loss under section 172 of the Internal Revenue Code generated for the tax year of the addition. The resulting delayed depreciation cannot be less than zero; and

(11) job opportunity building zone income as provided under section 469.316; and

(12) to the extent not deducted in determining federal taxable income, amounts paid for health coverage described as the secure benefit set under section 5.

Sec. 3. [DESIGN OF HEALTH REINSURANCE POOL.]

The commissioner of commerce shall, no later than November 15, 2005, present to the legislature a plan for reactivating the reinsurance pool established under Minnesota Statutes, sections 62L.13 to 62L.23, and converting it to a reinsurance pool for high-cost cases in the entire individual and group market in this state.

Sec. 4. [ENFORCEMENT OF COVERAGE REQUIREMENT.]

The commissioner of health shall prepare and submit to the legislature by December 15, 2005, a report with recommendations and proposed legislation for enforcing the requirement that all individuals maintain continuous health coverage under Minnesota Statutes, section 62Q.166, subdivision 1. In preparing the report, the commissioner shall consider whether to require evidence of coverage for applying for a driver's license, registering for school, or filing state income tax returns.

Sec. 5. [SECURE BENEFIT SET DESIGN.]

The commissioners of health, human services, labor and industry, employee relations, corrections, commerce, and administration and the Minnesota Comprehensive Health Association board of directors, in consultation with a panel of health care policy experts, shall define a secure benefit set that includes coverage for preventive health services, as specified in preventive services guidelines for children and adults developed by the Institute for Clinical Systems Improvement, prescription drug coverage, and catastrophic health coverage.

Sec. 6. [EFFECTIVE DATE.]

Sections 1 and 2 are effective January 1, 2007. Sections 3, 4, and 5 are effective July 1, 2005.

Senator ..... moves to amend S.F. No. 1638 as follows:

Page 1, line 21, delete "the" and insert "a"

Page 3, line 3, after "quality" insert "for both ambulatory and inpatient care"

Page 4, lines 6 and 7, delete "age or to"

Page 4, delete lines 14 to 18

Page 7, line 20, after the second "of" insert "health care providers and"

Page 7, line 26, after the period, insert "The commissioners shall submit the defined secure benefit set to the legislature by January 15, 2006."

Senator ..... moves to amend S.F. No. 1638 as follows:

Page 3, line 3, after the period, insert "This organization shall provide statewide comparative information in an easily understood format that promotes comparisons by integrated health care systems, individual medical groups, single physician practices, specialty groups, and hospitals."