A bill for an act

relating to health care; providing for MinnesotaCare outreach; creating a prescription drug discount program; expanding the benefit set for single adults; increasing the eligibility income limit for single adults; increasing the cap for inpatient hospitalization benefits for adults; modifying the definition of income for self-employed farmers; establishing a small employer option; appropriating money; amending Minnesota Statutes 2004, sections 256L.03, subdivision 3; 256L.04, subdivision 7, by adding a subdivision; Minnesota Statutes 2005 Supplement, sections 256L.01, subdivision 4; 256L.03, subdivisions 1, 5; 256L.07, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 256; 256L; repealing Minnesota Statutes 2005 Supplement, section 256L.035.

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

Section 1. **[256.9545] PRESCRIPTION DRUG DISCOUNT PROGRAM.**

Subdivision 1. **Establishment; administration.** The commissioner shall establish and administer the prescription drug discount program.

Subd. 2. **Commissioner's authority.** The commissioner shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall execute a rebate agreement from all manufacturers that choose to participate in the program for those drugs covered under the medical assistance program. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625, subdivision 13, and that is provided by a participating manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(c) "Enrolled individual" means a person who is eligible for the program under subdivision 4 and has enrolled in the program according to subdivision 5.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a joint self-insurance employee health plan operating under chapter 62H; a community integrated service network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a city, county, school district, or other political subdivision providing self-insured health coverage under section 471.617 or sections 471.98 to 471.982; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating manufacturer" means a manufacturer as defined in section 151.44, paragraph (c), that agrees to participate in the prescription drug discount program.

(f) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the prescription drug discount program.

Subd. 4. **Eligibility.** (a) To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in medical assistance, general assistance medical care, or MinnesotaCare;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in and have currently available prescription drug coverage under a Medicare supplement policy, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

(b) Notwithstanding paragraph (a), clause (3), an individual who is enrolled in a Medicare Part D prescription drug plan or Medicare Advantage plan is eligible for the program but only for drugs that are not covered under the Medicare Part D plan or for drugs that are covered under the plan, but according to the conditions of the plan, the individual is responsible for 100 percent of the cost of the prescription drug.

Subd. 5. **Application procedure.** (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the commissioner. The commissioner shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Upon notice of approval, the applicant must submit to the commissioner the enrollment fee specified in subdivision 10. Eligibility begins the month after the enrollment fee is received by the commissioner.

(b) An enrollee's eligibility must be renewed every 12 months with the 12-month period beginning in the month after the application is approved.

(c) The commissioner shall develop an application form that does not exceed one page in length and requires information necessary to determine eligibility for the program.

Subd. 6. **Participating pharmacy.** (a) Upon implementation of the prescription drug discount program, and until January 1, 2008, a participating pharmacy, with a valid prescription, must sell a covered prescription drug to an enrolled individual at the medical assistance rate.

(b) After January 1, 2008, a participating pharmacy, with a valid prescription, must sell a covered prescription drug to an enrolled individual at the medical assistance rate, minus an amount that is equal to the rebate amount described in subdivision 8, plus the amount of any switch fee established by the commissioner under subdivision 10, paragraph (b).

(c) Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. **Notification of rebate amount.** The commissioner shall notify each participating manufacturer, each calendar quarter or according to a schedule established by the commissioner, of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. **Provision of rebate.** To the extent that a participating manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide

a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased at a participating pharmacy by an enrolled individual. The participating manufacturer must provide full payment within 38 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. **Payment to pharmacies.** Beginning January 1, 2008, the commissioner shall distribute on a biweekly basis an amount that is equal to an amount collected under subdivision 8 to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals on or after January 1, 2008.

Subd. 10. **Enrollment fee; switch fee.** (a) The commissioner shall establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

(b) The commissioner shall establish a reasonable switch fee that covers expenses incurred by participating pharmacies in formatting for electronic submission claims for prescription drugs sold to enrolled individuals.

Subd. 11. **Dedicated fund; creation; use of fund.** (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, all enrollment fees paid by the enrollees, and any appropriations or allocations designated for the fund. The commissioner of finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner to reimburse participating pharmacies for prescription drugs provided to enrolled individuals under subdivision 6, paragraph (b); to reimburse the commissioner for costs related to enrollment, processing claims, and distributing rebates and for other reasonable administrative costs related to administration of the prescription drug discount program; and to repay the appropriation provided by law for this section. The commissioner must administer the program so that the costs total no more than funds appropriated plus the drug rebate proceeds.

Sec. 2. Minnesota Statutes 2005 Supplement, section 256L.01, subdivision 4, is amended to read:

Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the six-month period of eligibility using the net profit or loss reported on the applicant's federal income tax form for the previous year and using the medical assistance families with children methodology for determining allowable and nonallowable self-employment expenses and countable income.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the six-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year ~~and adding back in reported depreciation amounts that apply to the business in which the family is currently engaged~~.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the six-month period of eligibility.

Sec. 3. Minnesota Statutes 2005 Supplement, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** ~~For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply.~~ "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, mental health telemedicine, psychiatric consultation, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

Sec. 4. Minnesota Statutes 2004, section 256L.03, subdivision 3, is amended to read:

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. ~~Prior to July 1, 1997, the inpatient hospital benefit for adult enrollees is subject to an annual benefit limit of $10,000.~~ The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds ~~175~~ 190 percent of the federal poverty guidelines and who are not pregnant, is subject to an annual limit of ~~$10,000~~ $20,000.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

Sec. 5. Minnesota Statutes 2005 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(5) $6 for nonemergency visits to a hospital-based emergency room; and

(6) 50 percent of the fee-for-service rate for adult dental care services other than preventive care services for persons eligible under section 256L.04, subdivisions 1 to 7, with income ~~equal to or less~~ greater than ~~175~~ 190 percent of the federal poverty guidelines.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 ~~in households with family income equal to or less than 175 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income greater than 175 percent of the federal poverty guidelines for inpatient hospital admissions occurring on or after January 1, 2001~~.

(c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children under the age of 21.

(d) Adult enrollees with family gross income that exceeds ~~175~~ 190 percent of the federal poverty guidelines and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the ~~$10,000~~ $20,000 inpatient hospital benefit limit.

(e) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the ~~$10,000~~ $20,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

Sec. 6. Minnesota Statutes 2004, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than ~~175~~ 190 percent of the federal poverty guidelines.

Sec. 7. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 14. **MinnesotaCare outreach.** (a) The commissioner shall award grants to public or private organizations to provide information on the importance of maintaining insurance coverage and on how to obtain coverage through the MinnesotaCare program in areas of the state with high uninsured populations.

(b) In awarding the grants, the commissioner shall consider the following:

(1) geographic areas and populations with high uninsured rates;

(2) the ability to raise matching funds; and

(3) the ability to contact or serve eligible populations.

The commissioner shall monitor the grants and may terminate a grant if the outreach effort does not increase enrollment in medical assistance, general assistance medical care, or the MinnesotaCare program.

Sec. 8. Minnesota Statutes 2005 Supplement, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above ~~175~~ 190 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c) Notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the premium for a six-month policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Notwithstanding paragraphs (b) and (c), parents are not eligible for MinnesotaCare if gross household income exceeds $25,000 for the six-month period of eligibility.

Sec. 9. **[256L.20] MINNESOTACARE OPTION FOR SMALL EMPLOYERS.**

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

(b) "Dependent" means an unmarried child under the age of 21.

(c) "Eligible employee" means an employee who works at least 20 hours per week for an eligible employer. Eligible employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually. Coverage of an eligible employee includes the employee's spouse.

(d) "Eligible employer" means a business that employs at least two, but not more than 50, eligible employees, the majority of whom are employed in the state, and includes a municipality that has 50 or fewer employees.

(e) "Maximum premium" has the meaning given under section 256L.15, subdivision 2, paragraph (b), clause (3).

(f) "Participating employer" means an eligible employer who meets the requirements in subdivision 3 and applies to the commissioner to enroll its eligible employees and their dependents in the MinnesotaCare program.

(g) "Program" means the MinnesotaCare program.

Subd. 2. **Option.** Eligible employees and their dependents may enroll in MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The effective date of coverage is as defined in section 256L.05, subdivision 3.

Subd. 3. **Employer requirements.** The commissioner shall establish procedures for an eligible employer to apply for coverage through the program. In order to participate, an eligible employer must meet the following requirements:

(1) agree to contribute toward the cost of the premium for the employee, the employee's spouse, and the employee's dependents according to subdivision 4;

(2) certify that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;

(3) offer coverage to all eligible employees, spouses, and dependents of eligible employees; and

(4) have not provided employer-subsidized health coverage as an employee benefit during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

Subd. 4. **Premiums.** (a) The premium for coverage provided under this section is equal to the average monthly payment for families with children, excluding pregnant women and children under the age of two.

(b) For eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines and for eligible employees with dependents with income equal to or less than 275 percent of the federal poverty guidelines, the participating employer shall pay 50 percent of the premium established under paragraph (a) for the eligible employee, the employee's spouse, and any dependents, if applicable.

(c) For eligible employees without dependents with income over 175 percent of the federal poverty guidelines and for eligible employees with dependents with income over 275 percent of the federal poverty guidelines, the participating employer shall pay the full cost of the premium established under paragraph (a) for the eligible employee, the employee's spouse, and any dependents, if applicable. The participating employer may require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent. If the employer requires the employee to pay a portion of the premium, the employee shall pay the portion of the cost to the employer.

(d) The commissioner shall collect premium payments from participating employers for eligible employees, spouses, and dependents who are covered by the program as provided under this section. All premiums collected shall be deposited in the health care access fund.

Subd. 5. **Coverage.** The coverage offered to those enrolled in the program under this section must include all health services described under section 256L.03 and all co-payments and coinsurance requirements under section 256L.03, subdivision 5, apply.

Subd. 6. **Enrollment.** Upon payment of the premium, according to this section and section 256L.06, eligible employees, spouses, and dependents shall be enrolled in MinnesotaCare. For purposes of enrollment under this section, income eligibility limits established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established under section 256L.17 do not apply. The barriers established under section 256L.07, subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner may require eligible employees to provide income verification to determine premiums.

Sec. 10. **APPROPRIATION.**

$..... is appropriated from the health care access fund to the commissioner of human services for the fiscal year ending June 30, 2007, for the purposes of section 7.

Sec. 11. **REPEALER.**

Minnesota Statutes 2005 Supplement, section 256L.035, is repealed.

Sec. 12. **EFFECTIVE DATE.**

Sections 1 to 6, 8, 9, and 11 are effective August 1, 2006, or upon implementation of HealthMatch, whichever is later. Section 7 is effective July 1, 2006.

Minnesota
MINNESOTACARE
Informal Fiscal Analysis of Senate File 2725

Section 2. Self-employed farm income depreciation

To determine gross individual or gross family income for MinnesotaCare eligibility for self-employed applicants with farm income, current law requires that reported depreciation be added back to the adjusted gross income reported for income tax purposes. (Prior to legislation in 2001, the law required the add-back of depreciation, net operating loss and carry-over losses for both farm and self-employment income. In 2001 the add-back of net operating loss and carry-over losses was eliminated for farm income only. All three add-backs continue to be required for non-farm self-employment income.) This section eliminates the depreciation add-back for farm income, which would result in lower gross income being calculated for individuals and families with farm income.

Based on a special sample of MinnesotaCare cases with farm or self-employment income, the elimination of the add-back of depreciation for farm income would be expected to reduce premiums charged to 7% of family cases and 4% of adult cases by the monthly amounts shown in the tables which follow.

Because of the premium reductions, which are substantial for some cases, the elimination of the depreciation add-back would also be expected to increase enrollment of the type of cases affected by 0.7% for family cases and by 10.5% for adult-only cases.

The effective date is assumed to be January 1, 2007.

Families with Children	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Average cases with premiums reduced	0	1,074	1,862	1,419
Avg. monthly revenue	-$13.07	-$13.47	-$13.87	-$14.29
Total payments	$0	$0	$0	$0
Federal share %	55.67%	52.36%	51.76%	51.18%
Federal share	$0	$0	$0	$0
State share	$0	$0	$0	$0
Total revenue	$0	-$173,498	-$309,832	-$243,323
Federal share %	55.67%	52.36%	51.76%	51.18%
Federal share	$0	-$90,842	-$160,361	-$124,536
State share	$0	-$82,655	-$149,470	-$118,787
Net cost	$0	$173,498	$309,832	$243,323
Federal share	$0	$90,842	$160,361	$124,536

State share	$0	$82,655	$149,470	$118,787

Families with Children	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Average additional cases	0	20	35	26
Average additional enrollees	0	58	100	76
Avg. monthly payment	$236.62	$251.49	$286.14	$319.42
Avg. monthly revenue	$25.02	$27.16	$27.46	$27.46
Total payments	$0	$173,982	$343,202	$292,124
Federal share %	55.67%	52.36%	51.76%	51.18%
Federal share	$0	$91,096	$177,633	$149,513
State share	$0	$82,886	$165,569	$142,611
Total revenue	$0	$18,792	$32,940	$25,116
Federal share %	55.67%	52.36%	51.76%	51.18%
Federal share	$0	$9,839	$17,049	$12,855
State share	$0	$8,952	$15,891	$12,261
Net cost	$0	$155,191	$310,262	$267,008
Federal share	$0	$81,257	$160,584	$136,659
State share	$0	$73,934	$149,678	$130,350

Adults without Children	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Avg. cases with premiums reduced	0	498	1,038	1,062
Avg. monthly revenue	-$5.79	-$5.96	-$6.14	-$6.33
Total payments	$0	$0	$0	$0
Total revenue	$0	-$35,641	-$76,496	-$80,630
Net state cost	$0	$35,641	$76,496	$80,630

Adults without Children	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Average additional cases	0	58	121	124
Average additional enrollees	0	65	136	139

Avg. monthly payment	$338.83	$392.80	$437.33	$471.24
Avg. monthly revenue	$19.41	$20.49	$20.08	$19.59
Total payments	$0	$307,501	$713,416	$786,670
Total revenue	$0	$16,040	$32,755	$32,705
Net state cost	$0	$291,461	$680,661	$753,966

Total Program	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Total payments	$0	$481,483	$1,056,618	$1,078,795
Federal share	$0	$91,096	$177,633	$149,513
State share	$0	$390,387	$878,985	$929,281
Total revenue	$0	-$174,307	-$320,633	-$266,132
Federal share	$0	-$81,003	-$143,312	-$111,682
State share	$0	-$93,303	-$177,321	-$154,450
Net cost	$0	$655,790	$1,377,251	$1,344,927
Federal share	$0	$172,099	$320,945	$261,195
State share	$0	$483,691	$1,056,306	$1,083,732

Sections 3 and 14. Eliminate MinnesotaCare limited benefit set

These sections eliminate the MnCare Limited Benefit Set for adults with no children with income over 75% FPG. It is assumed that this would equalize the rates paid for adults with no children with income above and below 75% FPG. This would result in an increase in average payment for adults with no children with income over 75% FPG by about $35-$40 per month on average.

The effective date is assumed to be January 1, 2007.

	FY 2006	**FY 2007**	**FY 2008**	**FY 2009**
Number of eligibles (over 75% FPG)	16,458	16,899	17,066	16,809
Change in avg. monthly payment	$0.00	$35.53	$36.27	$38.99
Months	0	5	12	12
Total payments	$0	$3,002,237	$7,427,544	$7,864,831
HMO performance payment	$0	$0	$0	$353,474
Total state cost	$0	$3,002,237	$7,427,544	$8,218,305

Section 4. Increase inpatient hospital cap

ɔital cap in MinnesotaCare from the current law
level of $10,000 to $20,000. This would result in some additional inpatient hospital cost
ɜsotaCɛ

it is estimated that the PMPM cost will increase
175% FPG and $6 for adults without children.

The effective date is assumed to be January 1, 2007.

Families with Children	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
(Caretakers > 175% FPG)				
Number of eligibles	8,544	8,561	8,793	8,943
Avg. monthly payment increase	$1.97	$1.97	$1.97	$1.97
Months	0	5	12	12
Cost before performance payment	$0	$84,248	$207,692	$211,226
Performance payments	$0	$0	$0	$9,900
Total cost for families with children	$0	$84,248	$207,692	$221,126
Federal share %	55.38%	52.61%	52.03%	51.47%
Federal share	$0	$44,324	$108,063	$113,824
State share	$0	$39,925	$99,629	$107,302

Adults without Children	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
(Adults <= 75% FPG: non-MLB)				
Number of eligibles	13,829	22,818	33,916	34,641
Avg. monthly payment increase	$5.89	$5.89	$5.89	$5.89
Months	0	5	12	12
Cost before performance payment	$0	$672,277	$2,398,257	$2,449,538
Performance payments	$0	$0	$0	$98,495
Total cost for adults <=75% FPG	$0	$672,277	$2,398,257	$2,548,033

Adults without Children	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
(Adults > 75% FPG: MLB)				
Number of eligibles	16,458	16,899	17,066	16,809
Avg. monthly payment increase	$5.92	$5.92	$5.92	$5.92
Months	0	5	12	12
Cost before performance payment	$0	$500,321	$1,212,677	$1,194,361

Performance payments	$0	$0	$0	$58,245
Total cost for adults >75% FPG	$0	$500,321	$1,212,677	$1,252,606
Total state cost	$0	$1,212,523	$3,710,563	$3,907,941

Section 5. Dental copays and inpatient hospital cap for parents

This section changes which MinnesotaCare enrollees are impacted by the 50% dental copay and the inpatient hospital cap on benefits.

Under current law, adults with incomes equal to or less than 175% FPG are subject to a 50% dental copay for non-preventive services. This section changes the dental copay policy to make adults with incomes greater than 190% FPG subject to the 50% copay.

A. Eliminate Dental Copay for Adults Under 175% FPG

The effective date is assumed to be January 1, 2007.

Families with Children Caretakers Under 175% FPG	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Number of eligibles	31,855	31,918	29,455	24,827
Avg. monthly payment	$0.00	$2.11	$5.51	$5.72
Net cost	$0	$808,643	$1,947,784	$1,704,484
Federal share %	57.36%	53.35%	52.90%	52.73%
Federal share	$0	$431,425	$1,030,362	$898,752
State share	$0	$377,218	$917,423	$805,732

Adults without Children Adults Under 75% FPG	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Number of eligibles	13,829	22,818	33,916	34,641
Avg. monthly payment	$0.00	$2.48	$7.26	$7.79
Net cost	$0	$678,002	$2,956,743	$3,238,116

B. Add Dental Copay for Adults Over 190% FPG

The effective date is assumed to be January 1, 2007.

Families with Children Caretakers Over 190% FPG	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Number of eligibles	6,010	6,022	6,185	6,290

Avg. monthly payment	$0.00	-$2.11	-$5.51	-$5.72
Net cost	$0	-$152,553	-$409,011	-$431,873
Federal share %	55.38%	52.61%	52.03%	51.47%
Federal share	$0	-$80,259	-$212,810	-$222,306
State share	$0	-$72,294	-$196,201	-$209,567

Adults without Children	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Adults Over 190% FPG				
Number of eligibles	0	0	0	0
Avg. monthly payment	$0.00	-$2.24	-$6.13	-$6.61
Net cost	$0	$0	$0	$0
Total state cost for the dental copay chang	$0	$982,926	$3,677,965	$3,834,281

C. Exempt Parents Between 175-190% FPG From Inpatient Cap

Under current law, MinnesotaCare parents with incomes above 175% FPG are subject to the inpatient hospital cap on benefits. This section moves this income threshhold to 190% FPG. In other words, relative to current law, this section exempts parents with incomes between 175%-190% FPG from the inpatient hospital cap. The fiscal estimates here represent the marginal effects of eliminating the inpatient hospital cap beyond the $20,000 limit set in section 4. That is, these fiscal estimates assume a $20,000 inpatient cap as the starting point.

The effective date is assumed to be January 1, 2007.

Families with Children	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Caretakers Between 175%-190% FPG				
Number of eligibles	2,534	2,539	2,608	2,653
Avg. monthly payment increase	$0.38	$0.38	$0.38	$0.38
Months	0	5	12	12
Cost before performance payment	$0	$4,793	$11,816	$12,017
Performance payments	$0	$0	$0	$563
Total cost for the inpatient cap (families wit	$0	$4,793	$11,816	$12,581
Federal share %	55.38%	52.61%	52.03%	51.47%
Federal share	$0	$2,522	$6,148	$6,476
State share	$0	$2,271	$5,668	$6,105

Adults without Children	FY 2006	FY 2007	FY 2008	FY 2009
Adults Between 175%-190% FPG				
Number of eligibles	0	275	1,925	2,200
Avg. monthly payment increase	$2.47	$2.47	$2.47	$2.47
Months	0	5	12	12
Cost before performance payment	$0	$3,393	$57,005	$65,149
Performance payments	$0	$0	$0	$1,679
Total cost for the inpatient cap (adults w/ou	$0	$3,393	$57,005	$66,828
Total state cost for the inpatient cap chang	$0	$5,665	$62,673	$72,932

Sections 6 and 7. Adults without kids e 190%FPG

Prior to the benefit limits implemented in October 2003, enrollment of adults with no kids with incomes from 150% FPG to 175% FPG was approximately 4400. Based on the corresponding ratio of enrollment by parents from 175% FPG to 200% FPG compared to enrollment from 150% FPG to 175% FPG, we project that expanding eligibility for adults with no kids to 200% FPG would result in increased enrollment equal to 75% of 4400 or 3300. Limiting the enrollment expansion to 190% FPG is assumed to reduce the 3300 projection by one-third, resulting in a projected increase of 2200 enrollees.

Using the same data and methodology, we project that expanding eligibility for adults with no kids from 200% FPG to 225% FPG would result in additional enrollment equal to 50% of 4400 or 2200 enrollees. Limiting the enrollment expansion to 215% FPG is assumed to reduce the 2200 projection by one-third, resulting in a projected increase of 1467 enrollees between 200% FPG and 215% FPG.

The effective date is assumed to be January 1, 2007.

	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	0	275	1,925	2,200
Avg. monthly payment ($10,000 cap, no M	$299.20	$384.14	$438.08	$471.88
Avg. monthly pmt increase with $20,000 ca	$5.92	$5.92	$5.92	$5.92
Avg. monthly payment	$305.12	$390.06	$444.00	$477.80
Avg. monthly revenue	$77	$77	$77	$77
Total payments	$0	$1,072,718	$10,257,019	$12,614,464
HMO performance payment	$0	$0	$0	$326,380

Total revenue	$0	$254,113	$1,778,789	$2,032,902
Net state cost	$0	$818,605	$8,478,230	$10,907,943

Sections 9 and 10. Eliminate Insurance Barriers for Children Above 150% FPG

These sections eliminate all insurance barriers for children with income above 150% FPG. Section 9 eliminates all ESI barriers while section 10 eliminates all other health insurance barriers. The fiscal analysis below includes the effects of both sections. The fiscal impact of these sections arise from additional children who would be able to access MinnesotaCare in the absence of insurance barriers.

The effective date is assumed to be January 1, 2007, with a one year phase-in implying one-quarter of the total effect in the first year, and three-quarters in the second year.

	FY 2006	FY 2007	FY 2008	FY 2009
Number of additional eligibles	0	940	2,849	3,836
Avg. monthly payment	$0.00	$168.50	$191.71	$214.01
Avg. monthly revenue	$0.00	$53.73	$54.32	$54.32
Total payments	$0	$1,900,942	$6,553,333	$9,851,882
Federal share %	50.00%	50.00%	50.00%	50.00%
Federal share	$0	$950,471	$3,276,667	$4,925,941
State share	$0	$950,471	$3,276,667	$4,925,941
Total revenue	$0	$606,125	$1,856,837	$2,500,540
Federal share %	50.00%	50.00%	50.00%	50.00%
Federal share	$0	$303,063	$928,418	$1,250,270
State share	$0	$303,063	$928,418	$1,250,270
Net cost	$0	$1,294,816	$4,696,497	$7,351,342
Federal share	$0	$647,408	$2,348,248	$3,675,671
State share	$0	$647,408	$2,348,248	$3,675,671

Section 11. Eliminate 8% MinnesotaCare Premium Increase

This section eliminates the 8% MinnesotaCare premium increase scheduled to become effective July 1, 2006.

FAMILIES WITH CHILDREN	FY 2006	FY 2007	FY 2008	FY 2009
Effect on enrollment	0	284	239	179

State share net cost effect of enrollment de	$0	$340,586	$366,469	$313,198
State share revenue increase	$0	-$1,031,231	-$1,092,745	-$1,125,575
State share cost for families with children	$0	$1,371,817	$1,459,214	$1,438,773

ADULTS WITH NO CHILDREN	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Effect on enrollment	0	62	62	62
State share net cost effect of enrollment de	$0	$230,229	$281,920	$312,957
State share revenue increase	$0	-$395,512	-$399,419	-$393,408
State share cost for adults with no children	$0	$625,741	$681,339	$706,365
Total state share cost	$0	$1,997,558	$2,140,554	$2,145,138

Section 12. MinnesotaCare option for small employers

This section provides an option for small employers (2-50 umployees) to enroll uninsured employees and dependents in MinnesotaCare.
To use this option employers must enroll 75% of their employees who not not have other health coverage. The employer must not have provided employer-subsidized health coverage during the previous 12 months.
For enrollees within the income limits of the MinnesotaCare program (175% FPG for singles / 275% FPG for families) the employer must pay an amount equal to 50% of the MinnesotaCare full cost premium. For enrollees over these limits the employer must pay the entire full cost premium but may charge the employee up to 50% of the full cost premium.

The following data describes the estimated population of employees and their dependents of businesses that do not offer health coverage. (estimates provided by Health Economics, Minnesota Dept. of Health):

Employed by Small Employer (2-50) Not Offering Health Coverage

Uninsured Employees / Dependents

Status If Covered

	Total Persons	**Number of Single Persons**	**Number of Family Persons**	**Family Policies**
All	79,500	21,800	57,700	16,600
Within income limits	54,300	13,100	41,200	10,500
Above income limits	25,200	8,700	16,500	6,100

Insured Employees / Dependents

	Total Persons	Single Individuals Covered	Individuals with Family Coverage
All	249,500	7,700	241,800
Within income limits	64,700	1,100	63,600
Above income limits	184,800	6,600	178,200

Employed by Small Employer (2-50) Not Offering Health Coverage
Total of
Insured Employees / Dependents and
Uninsured Employees / Dependents

	Total Persons	Single Individuals	Family Members
All	329,000	29,500	299,500
Within income limits	119,000	14,200	104,800
Above income limits	210,000	15,300	194,700

"Healthy New York", a generally similar program experienced an enrollment rate after three years equal to 2.9% of the number of employees in small firms not offering coverage. MinnesotaCare offers more comprehensive coverage, but the cost to employers, assuming 50% of the full cost premium, is about 50% higher than in Healthy New York.

Based on this experience, we assume an average enrollment rate of 3.0% from the total population of uninsured or insured employees and dependents of small firms not offering health coverage, phased in over three years.

We assume relatively higher enrollment by families with children, and relatively higher enrollment by the more subsidized group within MinnesotaCare income limits. We assume 5.5% enrollment by family members and 3.3% enrollment by individuals in the more subsidized group within MinnesotaCare income limits. Enrollment by the group above MinnesotaCare income limits is projected at one-third of the rates for those within the limits.

The effective date is assumed to be January 1, 2007.

	Total Persons	Single Individuals	Family Members

Enrollment Rates

All	3.03%	2.16%	3.12%
Within income limits	5.24%	3.30%	5.50%
Above income limits	1.78%	1.10%	1.83%

Enrollment

All	9,970	637	9,334
Within income limits	6,233	469	5,764
Above income limits	3,738	168	3,570

	FY 2006	FY 2007	FY 2008	FY 2009
Families with Children				
Average number of enrollees:				
Pregnant women	0	18	128	147
Under age 2	0	50	350	400
Other children & parents	0	1,098	7,688	8,787
Total	0	1,167	8,167	9,334
Avg. monthly payment				
Pregnant women	$459.78	$506.70	$538.85	$557.30
Under age 2	$300.90	$312.45	$343.47	$402.72
Other children & parents	$236.62	$251.49	$286.14	$319.42
Total payments				
Pregnant women	$0	$111,374	$829,091	$979,966
Under age 2	$0	$187,658	$1,444,030	$1,935,036
Other children & parents	$0	$3,314,596	$26,398,518	$33,679,710
Total	$0	$3,613,629	$28,671,638	$36,594,713
Adults without children				
Average number of enrollees	0	80	557	637
Avg. monthly payment	$386.00	$424.49	$518.92	$556.40
Total payments	$0	$405,534	$3,470,242	$4,252,477
Revenue				
Family enrollees @ 50% of full premium	0	721	5,044	5,764

Family enrollees charged @ 50% of full pre	0	721	5,044	5,764
Individual enrollees @ 50% of full premiun	0	59	410	469
Total enrollees charged @ 50% of full prer	0	779	5,454	6,233
Family enrollees @ full premium	0	446	3,123	3,570
Family enrollees charged @ full premium	0	446	3,123	3,570
Individual enrollees @ full premium	0	21	147	168
Total enrollees charged @ full premium	0	467	3,271	3,738
Half of full premium	$119	$126	$143	$160
Full premium (=avg. pmt. for children and	$237	$251	$286	$319
Revenue @ 50% of full premium	$0	$1,173,287	$9,358,249	$11,929,196
Revenue @ full premium	$0	$1,407,282	$11,224,613	$14,308,298
Total revenue	$0	$2,580,569	$20,582,862	$26,237,495
Net Cost of small employer option	$0	$1,438,593	$11,559,018	$14,609,695

FISCAL SUMMARY	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
		(in thousands)		
Self-employed farm income	$0	$484	$1,056	$1,084
Eliminate MLB	$0	$3,002	$7,428	$8,218
Increase inpatient cap to $20,000	$0	$1,213	$3,711	$3,908
Dental copays and inpatient cap changes	$0	$989	$3,741	$3,907
Increase eligibility for adults without kids	$0	$819	$8,478	$10,908
Eliminate insurance barriers for children	$0	$647	$2,348	$3,676
Eliminate 8% premium increase	$0	$1,998	$2,141	$2,145
Small employer option	$0	$1,439	$11,559	$14,610
Grand total state budget cost	$0	$10,589	$40,461	$48,456

DRAFT

Fiscal Note Request Worksheet

Bill #: SF 2725
Title: MinnesotaCare Changes
Companion #:
Author: Berglin; Koering; Solon; Johnson, D.E.; Lourey
Agency: Human Services
Urgent:
Due Date:
Committee:
Consolidated:
Lead Agency:
Contact Person: Steve Nelson 651-431-2201

What version of the bill are you working on? 1A
(Changing the version of the bill will automatically create a new fiscal note request.)

(The following four fiscal impact questions must be answered before an agency can sign off on a fiscal note.)

Fiscal Impact	Yes	No
State (Does this bill have a fiscal impact to your Agency?)	X	
Local (Does this bill have a fiscal impact to a Local Gov Body?)		X
Fee/Dept Earnings (Does this bill impact a Fee or Dept Earning?)		X
Tax Revenue (Does this bill impact Tax Revenues?)		X

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Fund-General-Transfer to Special Rev. Fund			0	594	1,389
Fund-HCAF			0	447	9,858
Fund					
Less Agency Can Absorb					
Fund					
Fund					
Fund					
Net Expenditures					
Fund-General			0	594	1,389
Fund-HCAF			0	447	9,858
Fund					
Revenues					
Fund-HCAF			0	20	0
Fund					
Fund					
Net Cost <Savings>					
Fund-General			0	594	1,389
Fund-HCAF			0	427	9,858
Fund					
Total Cost <Savings> to the State			0	1,021	11,247

	FY05	FY06	FY07	FY08	FY09
Full-Time Equivalents					
Fund					
Fund					
Fund					
Total FTE			0	0	0

FI-00085-14 (09/02)

Bill Description
All sections are effective August 1, 2006, or upon implementation of HealthMatch, whichever is later.

Section 1 - Prescription Drug Discount Program: Establishes a prescription drug discount program. Participating pharmacies must sell prescriptions to enrollees at the Medical Assistance rate. After January 1, 2008, pharmacies would sell prescriptions to enrollees at the Medical Assistance rate minus the pharmaceutical rebate, plus the amount of a switch fee established by the commissioner. Provides coverage for individuals enrolled in Medicare Part D, for drugs not covered by their Part D plan and for drugs during the 100% coinsurance period (donut hole). Enrollees must be permanent residents; not be enrolled in Medical Assistance, General Assistance Medical Care, or MinnesotaCare; and not have any other prescription drug coverage through a health plan, employer plan, pharmacy benefit program, or Medicare supplement. Enrollees would pay an annual enrollment fee.

Section 2 - MinnesotaCare Farm Self-Employment Income: Eliminates the add back of depreciation in the MinnesotaCare calculation of farm self-employment income.

Section 3 - MinnesotaCare Covered Services: Extends MinnesotaCare Basic + One benefits to adults without children with income above 75 percent of the federal poverty guidelines (FPG).

Section 4 - MinnesotaCare Inpatient Hospital: Removes the inpatient hospital limit for parents with income between 175 and 190 percent FPG. Increases the inpatient hospital limit for adults from $10,000 to $20,000.

Section 5 - MinnesotaCare Copayments: Eliminates the 50 percent dental coinsurance for adults without children. Eliminates the 50 percent dental coinsurance for parents with income at or below 175 percent FPG and institutes it for parents with income above 190 percent FPG.

Sections 6 & 8 - MinnesotaCare Adults without Children: Raises the income limit for adults without children from 175 to 190 percent FPG.

Sections 7 & 10, as amended (A-1): Restores MinnesotaCare outreach grants with an unknown appropriation amount.

Section 9 - MinnesotaCare Option for Small Employers: Adds a MinnesotaCare buy-in option for small employers. Eligible employers include businesses that employ 2-50 eligible employees, the majority of whom are employed in Minnesota, and municipalities with 50 or fewer employees. Eligible employees are those who work at least 20 hours per week and more than 26 weeks annually. Employers must certify that at least 75 percent of their eligible employees who do not have health insurance are enrolled, they must offer the plan to all eligible employees, their spouses and dependents, and they must not have provided employer-subsidized insurance as an employee benefit in the past 12 months.

The premium would be based on the average monthly payment for families with children, excluding pregnant women and infants under age two. Employers would be charged half the premium for employees and dependents with income within the relevant MinnesotaCare income standard, and the full premium for employees and dependents with income above the relevant MinnesotaCare income standard. Employers who pay the full premium must agree to pay at least 50 percent of the premium. Employers would collect the employee contributions.

Section 11 - Repealer: Repeals the MinnesotaCare limited benefit set for adults without children.

Assumptions
The analysis assumes that all provisions will be effective January 1, 2009, after completion of HealthMatch implementation.

Section 1 - Prescription Drug Discount Program: There are no income or asset limits for participation. The enrollment fee will fund administration of the program. Given that an enrollment fee reduces expected enrollment, and a higher fee has a greater reduction effect, we project that it is not possible to establish a fee which will cover DHS's costs. So we have assumed the lowest fee which comes close to maximizing projected fee revenue

and have assumed that the balance of administrative costs is made up by reducing discounts. No federal approval is needed to implement.

The Department could implement the prescription drug discount program as an independently administered health care program on MMIS effective January 1, 2009. The additional rebate discounts would begin at the same time.

Section 2 - MinnesotaCare Farm Self-Employment Income: Federal approval is needed prior to implementing this change.

Sections 3, 4, 5, 6, 8 and 11 - Eligibility, Benefit and FPG Changes: Managed care contracts would need to be negotiated to include the changes, and federal approval would be required for certain provisions. The Department could implement the benefit set and FPG changes effective January 1, 2009, with federal approval.

Section 9 - MinnesotaCare Option for Small Employers: Employers will attest to meeting the requirements of participation, such as employing 2-50 individuals, being located in Minnesota, not having offered ESI in the past 12 months. Verification of these criteria will be requested only as needed to clarify information or resolve discrepancies.

The calculation of income for purposes of determining full or half premium will be in accordance with MinnesotaCare income calculation. There will be no auto-newborn or pregnant woman protections against cancellation.

This section specifies a different premium from the MinnesotaCare "maximum premium", with separate premiums for families with children and for adults with no children. We have interpreted these to be premiums the amounts of which are projected based on anticipated costs for certain enrollee groups under this option. The bill does not make clear how the premium charges are applied. Pending clarification, we have treated it in our projections as a per-enrollee premium.

Federal approval is not needed to implement this change.

Incorporating this into HealthMatch would likely be cost prohibitive due to the significant delay this would cause. The Department could implement the small employer option as in independently administered health care program on MMIS effective January 1, 2009.

Sections 7 & 10, as amended (A-1): The Department will dedicate FTEs to administer and monitor the outreach grants to assure effectiveness.

Expenditure and/or Revenue Formula

Fiscal Summary
SF-2725

HCAF BACT	Section	Description	FY07	FY08	FY09
40-MnCare Grants	Various	Program Costs	0	0	9,858
50-HC Admin.	9	Actuary Costs	0	50	0
51-HC Operations	9	MMIS (state share)	0	343	0
51-HC Operations	3	MMIS (state share)	0	4	0
51-HC Operations	4	MMIS (state share)	0	45	0
51-HC Operations	Various	MMIS (state share)	0	5	0
Total HCAF Costs			0	447	9,858
Dedicated FFP @ 40%			0	20	0
Net Cost to State-HCAF			0	427	9,858

General Fund

41-MA Basic HC Grants F&C	1	Transfer to Spec. Revenue Fund	0	594	1,389
Net Cost to State			0	1,021	11,247

The effective date on this legislation is August 1, 2006 or upon implementation of HealthMatch, which ever is later. Provisions effective upon HealthMatch implementation are assumed to be in effect January 1, 2009.

Minnesota
MINNESOTACARE
Fiscal Analysis of Senate File 2725

Minnesota Pharmacy Access Program (MnPAP)
No age limit, DHS administers eligibility, no asset test

Estimates the cost to the state to advance rebate revenues to pharmacies for discounted drugs provided to individuals without prescription drug coverage. Rebate revenues are billed and received by the second quarter after the quarter of rebate payment. We assume that all of revenue for a quarter is received by the end of the second subsequent quarter.

	Total Population
Minnesota population in 2009	5,408,000
Assume 16% lack prescription drug coverage	865,000
Number with Medicare lacking prescription drug coverage,	257,200
Number without Medicare lacking prescription drug coverage,	607,800
Assume 57% of those with Medicare have drug costs at least $250 / year	146,604
Assume 5% of those w/o Medicare have drug costs at least $250 / year	30,390
Assume 5% enrollment by those with Medicare	7,330
Assume 50% enrollment by those without Medicare	15,195
Total enrollment by second quarter of CY 2009 (with no enrollment fee)	22,525
Effect of enrollment fee on projected enrollment	1
Total enrollment by second quarter of CY 2009 (adjusted for fee)	15,410
Assume program participants with Medicare will have 18 Rx per year	18.00
Assume program participants w/o Medicare will have 24 Rx per year	24.00
Weighted average Rx per year (without fee adj. to enrollment)	22.05
Effect of fee adjustment to enrollment on avg. Rx per year	1.5
Weighted average Rx per year (with fee adjustment to enrollment)	32.2
Weighted average Rx per quarter	8.1

Calculation of admin fee per prescription:

	MMIS	Enrollment	Recipient Hlp Dsk	Rebates	Other	DHS Admin. Costs
DHS administrative costs:						
FY 2008	404,000	75,000	10,000	80,000	25,000	594,000
FY 2009		302,000	38,000	80,000	50,000	470,000
FY 2010		588,000	75,000	80,000	50,000	793,000

FI-00085-14 (09/02)

FY 2011	588,000	75,000	80,000	50,000	793,000
FY 2012	588,000	75,000	80,000	50,000	793,000
FY 2013	588000	75,000	80,000	50,000	793,000
FY 2014	588,000	75,000	80,000	50,000	793,000
FY 2015	588,000	75,000	80,000	50,000	793,000
Total					5,822,000

	Proj. Number of Prescriptions	Admin. Cost per Rx
FY 2008	0	
FY 2009	68,286	6.88
FY 2010	319,701	2.48
FY 2011	459,377	1.73
FY 2012	517,422	1.53
FY 2013	552,211	1.44
FY 2014	557,733	1.42
FY 2015	563,310	1.41
Total	3,038,039	1.92

Projected avg rebate per Rx	18.38
Offsets to discount per Rx retained by DHS:	
to offset cash-flow costs:	$1.0
for DHS admin. costs:	$1.6
Total retained by DHS per Rx	$2.6
Offset to discount for switch fee:	$0.0
Net rebate per Rx to consumer:	$15.83
Enrollment fee	$30.00

Section 1, Subd. 10 requires that the enrollment fee be set at a level which covers DHS costs for the operation of the program. Given that an enrollment fee reduces expected enrollment, and a higher fee has a greater reduction effect, we project that it is not possible to establish a fee which will cover DHS's costs. So we have assumed the lowest fee which comes close the maximizing projected fee revenue and assumed that the balance of administrative costs is made up by reducing discounts.

	Fee Revenue	Admin. Costs	Excess of Admin Costs Over Fee Revenue
FY 2008	$0	$594,000	$594,000
FY 2009	$300,504	$470,000	$169,496
FY 2010	$416,083	$793,000	$376,917
Total	716,587	$1,857,000	$1,140,413

Enrollment and Cost Projections

CY 2008	Q1	Q2	Q3	Q4	
Enrollment					0
Prescriptions		0	0	0	0
Rebate Outlay		0	0	0	

Rebate Revenue	0	0	0	0
Premium Revenue	0	0	0	0
DHS Admin. costs	297,000	297,000	117,500	117,500
Quarterly Balance	-297,000	-297,000	-117,500	-117,500
Running Balance	-297,000	-594,000	-711,500	-829,000
CY 2009	Q1	Q2	Q3	Q4
Enrollment	3,082	5,394	7,320	9,246
Prescriptions	24,831	43,455	58,974	74,494
Rebate Outlay	393,078	687,886	933,559	1,179,233
Rebate Revenue	0	0	456,397	798,695
Premium Revenue	92,463	69,347	69,347	69,347
DHS Admin. costs	117,500	117,500	198,250	198,250
Quarterly Balance	-418,115	-736,039	-606,065	-509,441
Running Balance	-1,247,115	-1,983,153	-2,589,218	-3,098,659
CY 2010	Q1	Q2	Q3	Q4
Enrollment	10,787	12,328	13,099	13,869
Prescriptions	86,909	99,325	105,533	111,740
Rebate Outlay	1,375,772	1,572,310	1,670,580	1,768,849
Rebate Revenue	1,083,943	1,369,191	1,597,390	1,825,588
Premium Revenue	104,021	104,021	104,021	104,021
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	-386,058	-297,348	-167,419	-37,490
Running Balance	-3,484,717	-3,782,065	-3,949,484	-3,986,974
CY 2010	Q1	Q2	Q3	Q4
Enrollment	14,640	15,410	15,449	15,488
Prescriptions	117,948	124,156	124,466	124,777
Rebate Outlay	1,867,119	1,965,388	1,970,301	1,975,227
Rebate Revenue	1,939,688	2,053,787	2,167,886	2,281,985
Premium Revenue	116,157	116,157	116,157	116,157
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	-9,524	6,306	115,492	224,666
Running Balance	-3,996,498	-3,990,192	-3,874,700	-3,650,034
CY 2012	Q1	Q2	Q3	Q4
Enrollment	16,258	17,029	17,071	17,114
Prescriptions	130,985	137,193	137,536	137,880
Rebate Outlay	2,073,497	2,171,766	2,177,195	2,182,638
Rebate Revenue	2,287,690	2,293,410	2,407,509	2,521,608
Premium Revenue	128,354	128,354	128,354	128,354
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	144,298	51,748	160,418	269,074
Running Balance	-3,505,736	-3,453,987	-3,293,569	-3,024,495
CY 2013	Q1	Q2	Q3	Q4
Enrollment	17,157	17,200	17,243	17,286
Prescriptions	138,225	138,570	138,917	139,264
Rebate Outlay	2,188,095	2,193,565	2,199,049	2,204,547
Rebate Revenue	2,527,912	2,534,232	2,540,568	2,546,919
Premium Revenue	129,643	129,643	129,643	129,643
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	271,210	272,060	272,911	273,765

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Running Balance	-2,753,285	-2,481,225	-2,208,314	-1,934,549
CY 2014	Q1	Q2	Q3	Q4
Enrollment	17,329	17,372	17,416	17,459
Prescriptions	139,612	139,961	140,311	140,662
Rebate Outlay	2,210,058	2,215,583	2,221,122	2,226,675
Rebate Revenue	2,553,286	2,559,669	2,566,069	2,572,484
Premium Revenue	130,944	130,944	130,944	130,944
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	275,922	276,780	277,641	278,503
Running Balance	-1,658,627	-1,381,846	-1,104,205	-825,702
CY 2015	Q1	Q2	Q3	Q4
Enrollment	17,503	17,547	17,590	17,634
Prescriptions	141,013	141,366	141,719	142,074
Rebate Outlay	2,232,242	2,237,822	2,243,417	2,249,025
Rebate Revenue	2,578,915	2,585,362	2,591,826	2,598,305
Premium Revenue	132,258	132,258	132,258	132,258
DHS Admin. costs	198,250	198,250	198,250	198,250
Quarterly Balance	280,682	281,549	282,417	283,288
Running Balance	-545,021	-263,472	18,945	302,234

Net funding needed:		
Transfer in From General Fund	FY 2008	$594,000
Transfer in From General Fund	FY 2009	$1,389,153
Transfer in From General Fund	FY 2010	$1,798,912
Transfer in From General Fund	FY 2011	$208,127
Negative = Held in Fund Balance	FY 2012	($536,204)
Negative = Held in Fund Balance	FY 2013	($972,762)
Negative = Held in Fund Balance	FY 2014	($1,099,379)
Negative = Held in Fund Balance	FY 2015	($1,118,374)
	Total	$263,472

The figures above represent projected cash-basis costs, by fiscal year, to advance the rebates.

Rationale:

1) 5,408,000	Projected Population of MN in 2005, increased by 1% per year to 2009
2) 16%	Estimated percentage of Minnesotans without prescription coverage.
3) 5%	Percentage of people without Medicare and prescription drug coverage who spent more than $250 on prescriptions annually
	non-Medicare population of people lacking pharmacy coverage by 20%.
4) Cash Flow	All rebates billed for a quarter will paid in full in the second subsequent quarter.

Footnotes:

1) Items 1-2 are based on data from "Prescription Drug Coverage in Minnesota and the United States", Minnesota Dept. of Health, December 2000.
2) Item 3 is based on information form "Report to the President, Prescription Drug Coverage, Spending, Utilization and Prices", Federal Department of HHS, April 2000
3) Since DHS is to recover admin costs from rebates that are collected, this change effectively reduces the average discount per prescription received by participants.

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Section 2. Self-employed farm income depreciation
To determine gross individual or gross family income for MinnesotaCare eligibility for self-employed applicants with farm income, current law requires that reported depreciation be added back to the adjusted gross income reported for income tax purposes. (Prior to legislation in 2001, the law required the add-back of depreciation, net operating loss and carry-over losses for both farm and self-employment income. In 2001 the add-back of net operating loss and carry-over losses was eliminated for farm income only. All three add-backs continue to be required for non-farm self-employment income.) This section eliminates the depreciation add-back for farm income, which would result in lower gross income being calculated for individuals and families with farm income.

Based on a special sample of MinnesotaCare cases with farm or self-employment income, the elimination of the add-back of depreciation for farm income would be expected to reduce premiums charged to 7% of family cases and 4% of adult cases by the monthly amounts shown in the tables which follow.

Because of the premium reductions, which are substantial for some cases, the elimination of the depreciation add-back would also be expected to increase enrollment of the type of cases affected by 0.7% for family cases and by 10.5% for adult-only cases.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children		FY 2006	FY 2007	FY 2008	FY 2009
Average cases with premiums reduced		0	0	0	710
Avg. monthly revenue		($13.07)	($13.47)	($13.87)	($14.29)
Total payments		$0	$0	$0	$0
	Federal share %	55.67%	52.36%	51.76%	51.18%
	Federal share	$0	$0	$0	$0
	State share	$0	$0	$0	$0
Total revenue		$0	$0	$0	($121,662)
	Federal share %	55.67%	52.36%	51.76%	51.18%
	Federal share	$0	$0	$0	($62,268)
	State share	$0	$0	$0	($59,393)
Net cost		$0	$0	$0	$121,662
	Federal share	$0	$0	$0	$62,268
	State share	$0	$0	$0	$59,393

Families with Children	FY 2006	FY 2007	FY 2008	FY 2009
Average additional cases	0	0	0	13
Average additional enrollees	0	0	0	38
Avg. monthly payment	$236.62	$251.49	$286.14	$319.42
Avg. monthly revenue	$25.02	$27.16	$27.46	$27.46

Total payments		$0	$0	$0	$146,062
	Federal share %	55.67%	52.36%	51.76%	51.18%
	Federal share	$0	$0	$0	$74,757
	State share	$0	$0	$0	$71,305
Total revenue		$0	$0	$0	$12,558
	Federal share %	55.67%	52.36%	51.76%	51.18%
	Federal share	$0	$0	$0	$6,427
	State share	$0	$0	$0	$6,131
Net cost		$0	$0	$0	$133,504
	Federal share	$0	$0	$0	$68,329
	State share	$0	$0	$0	$65,175

Adults without Children	FY 2006	FY 2007	FY 2008	FY 2009
Avg. cases with premiums reduced	0	0	0	531
Avg. monthly revenue	($5.79)	($5.96)	($6.14)	($6.33)
Total payments	$0	$0	$0	$0
Total revenue	$0	$0	$0	($40,315)
Net state cost	$0	$0	$0	$40,315

Adults without Children	FY 2006	FY 2007	FY 2008	FY 2009
Average additional cases	0	0	0	62
Average additional enrollees	0	0	0	70
Avg. monthly payment	$338.83	$392.80	$437.33	$471.24
Avg. monthly revenue	$19.41	$20.49	$20.08	$19.59
Total payments	$0	$0	$0	$393,335
Total revenue	$0	$0	$0	$16,352
Net state cost	$0	$0	$0	$376,983

Total Program		FY 2006	FY 2007	FY 2008	FY 2009
Total payments		$0	$0	$0	$539,397
	Federal share	$0	$0	$0	$74,757
	State share	$0	$0	$0	$464,641
Total revenue		$0	$0	$0	($133,066)
	Federal share	$0	$0	$0	($55,841)
	State share	$0	$0	$0	($77,225)
Net cost		$0	$0	$0	$672,463
	Federal share	$0	$0	$0	$130,598
	State share	$0	$0	$0	$541,866

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Sections 3 and 11. Eliminate MinnesotaCare limited benefit set
These sections eliminate the MnCare Limited Benefit Set for adults with no children with income over 75% FPG. It is assumed that this would equalize the rates paid for adults with no children with income above and below 75% FPG. This would result in an increase in average payment for adults with no children with income over 75% FPG by about $35-$40 per month on average.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles (over 75% FPG)	16,458	16,899	17,066	16,809
Change in avg. monthly payment	$0.00	$35.53	$36.27	$38.99
Months	0	0	0	5
Total payments	$0	$0	$0	$3,277,013
HMO performance payment	$0	$0	$0	$0
Total state cost	0	0	0	3,277,013

Section 4. Increase inpatient hospital cap
This section increases the inpatient hospital cap in MinnesotaCare from the current law level of $10,000 to $20,000. This would result in some additional inpatient hospital cost to the MinnesotaCare program.

Based on the Department's claims data, it is estimated that the PMPM cost will increase by about $2 for adult caretakers above 175% FPG and $6 for adults without children.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children (Caretakers > 175% FPG)	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	8,544	8,561	8,793	8,943
Avg. monthly payment increase	$1.97	$1.97	$1.97	$1.97
Months	0	0	0	5
Cost before performance payment	$0	$0	$0	$88,011
Performance payments	$0	$0	$0	$0
Total cost for families with children	$0	$0	$0	$88,011
Federal share %	55.38%	52.61%	52.03%	51.47%
Federal share	$0	$0	$0	$45,304
State share	$0	$0	$0	$42,707

Adults without Children (Adults <= 75% FPG: non-MLB)	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	13,829	22,818	33,916	34,641
Avg. monthly payment increase	$5.89	$5.89	$5.89	$5.89
Months	0	0	0	5
Cost before performance payment	$0	$0	$0	$1,020,641
Performance payments	$0	$0	$0	$0

Total cost for adults <=75% FPG	$0	$0	$0	$1,020,641

Adults without Children (Adults > 75% FPG: MLB)	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	16,458	16,899	17,066	16,809
Avg. monthly payment increase	$5.92	$5.92	$5.92	$5.92
Months	0	0	0	5
Cost before performance payment	$0	$0	$0	$497,650
Performance payments	$0	$0	$0	$0
Total cost for adults >75% FPG	$0	$0	$0	$497,650
Total state cost	$0	$0	$0	$1,560,999

Section 5. Dental copays and inpatient hospital cap for parents
This section changes which MinnesotaCare enrollees are impacted by the 50% dental copay and the inpatient hospital cap on benefits.

Under current law, adults with incomes equal to or less than 175% FPG are subject to a 50% dental copay for non-preventive services. This section changes the dental copay policy to make adults with incomes greater than 190% FPG subject to the 50% copay.

A. Eliminate Dental Copay for Adults Under 175% FPG

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children Caretakers Under 175% FPG		FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles		31,855	31,918	29,455	24,827
Avg. monthly payment		$0.00	$0.00	$0.00	$2.38
Net cost		$0	$0	$0	$710,202
	Federal share %	57.36%	53.35%	52.90%	52.73%
	Federal share	$0	$0	$0	$374,480
	State share	$0	$0	$0	$335,722

Adults without Children Adults Under 75% FPG	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	13,829	22,818	33,916	34,641
Avg. monthly payment	$0.00	$0.00	$0.00	$3.25
Net cost	$0	$0	$0	$1,349,215

B. Add Dental Copay for Adults Over 190% FPG

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children Caretakers Over 190% FPG	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	6,010	6,022	6,185	6,290
Avg. monthly payment	$0.00	$0.00	$0.00	($2.38)

Net cost		$0	$0	$0	($179,947)
	Federal share %	55.38%	52.61%	52.03%	51.47%
	Federal share	$0	$0	$0	($92,627)
	State share	$0	$0	$0	($87,320)
Total state cost for the dental copay change		$0	$0	$0	$1,597,617

C. Exempt Parents Between 175-190% FPG From Inpatient Cap

Under current law, MinnesotaCare parents with incomes above 175% FPG are subject to the inpatient hospital cap on benefits. This section moves this income threshhold to 190% FPG. In other words, relative to current law, this section exempts parents with incomes between 175%-190% FPG from the inpatient hospital cap.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

Families with Children	FY 2006	FY 2007	FY 2008	FY 2009
Caretakers Between 175%-190% FPG				
Number of eligibles	2,534	2,539	2,608	2,653
Avg. monthly payment increase	$1.66	$1.66	$1.66	$1.66
Months	0	0	0	5
Cost before performance payment	$0	$0	$0	$22,008
Performance payments	$0	$0	$0	$0
Total cost for the inpatient hospital cap change	$0	$0	$0	$22,008
Federal share %	55.38%	52.61%	52.03%	51.47%
Federal share	$0	$0	$0	$11,329
State share	$0	$0	$0	$10,680

Sections 6 and 8. Adults without children eligible to 190% FPG
Prior to the benefit limits implemented in October 2003, enrollment of adults with no kids with incomes from 150% FPG to 175% FPG was approximately 4400. Based on the corresponding ratio of enrollment by parents from 175% FPG to 200% FPG compared to enrollment from 150% FPG to 175% FPG, we project that expanding eligibility for adults with no kids to 200% FPG would result in increased enrollment equal to 75% of 4400 or 3300. Limiting the enrollment expansion to 190% FPG is assumed to reduce the 3300 projection by one-third, resulting in a projected increase of 2200.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	0	0	0	275
Avg. monthly payment	$299.20	$384.14	$438.08	$471.88
Avg. monthly revenue	$77	$77	$77	$77
Total payments	$0	$0	$0	$1,297,722
HMO performance payment	$0	$0	$0	$0
Total revenue	$0	$0	$0	$254,113

Net state cost	$0	$0	$0	$1,043,609

Section 9. MinnesotaCare option for small employers

This section provides an option for small employers (2-50 umployees) to enroll uninsured employees and dependents in MinnesotaCare.

To use this option employers must enroll 75% of their employees who not not have other health coverage. The employer must not have provided employer-subsidized health coverage during the previous 12 months.

For enrollees within the income limits of the MinnesotaCare program (175% FPG for singles / 275% FPG for families) the employer must pay an amount equal to 50% of the MinnesotaCare full cost premium. For enrollees over these limits the employer must pay the entire full cost premium but may charge the employee up to 50% of the full cost premium.

The following data describes the estimated population of employees and their dependents of businesses that do not offer health coverage. (estimates provided by Health Economics, Minnesota Dept. of Health):

Employed by Small Employer (2-50) Not Offering Health Coverage

Uninsured Employees / Dependents

		Status If Covered		
	Total Persons	Number of Single Persons	Number of Family Persons	Family Policies
All	79,500	21,800	57,700	16,600
Within income limits	54,300	13,100	41,200	10,500
Above income limits	25,200	8,700	16,500	6,100

Insured Employees / Dependents

	Total Persons	Single Individuals Covered	Individuals with Family Coverage
All	249,500	7,700	241,800
Within income limits	64,700	1,100	63,600
Above income limits	184,800	6,600	178,200

Employed by Small Employer (2-50) Not Offering Health Coverage
Total of
Insured Employees / Dependents and
Uninsured Employees / Dependents

	Total Persons	Single Individuals	Family Members
All	329,000	29,500	299,500
Within income limits	119,000	14,200	104,800
Above income limits	210,000	15,300	194,700

"Healthy New York", a generally similar program experienced an enrollment rate after three years equal to 2.9% of the number of employees in small firms not offering coverage. MinnesotaCare offers more comprehensive coverage, but the cost to employers, assuming 50% of the full cost premium, is about 50% higher than in Healthy New York.

Based on this experience, we assume an average enrollment rate of 3.0% from the total population of uninsured or insured employees and dependents of small firms not offering health coverage, phased in over three years.

We assume relatively higher enrollment by families with children, and relatively higher enrollment by the more subsidized group within MinnesotaCare income limits. We assume 5.5% enrollment by family members and 3.3% enrollment by individuals in the more subsidized group within MinnesotaCare income limits. Enrollment by the group above MinnesotaCare income limits is projected at one-third of the rates for those within the limits.

The effective date is assumed to be January 1, 2009 (following HealthMatch implementation).

	Total Persons	Single Individuals	Family Members
Enrollment Rates			
All	3.03%	2.16%	3.12%
Within income limits	5.24%	3.30%	5.50%
Above income limits	1.78%	1.10%	1.83%
Enrollment			
All	9,970	637	9,334
Within income limits	6,233	469	5,764
Above income limits	3,738	168	3,570

		FY 2006	FY 2007	FY 2008	FY 2009
Families with Children					
Average number of enrollees:					
	Pregnant women	0	0	0	18
	Under age 2	0	0	0	50
	Other children & parents	0	0	0	1,098
	Total	0	0	0	1,167
Avg. monthly payment					
	Pregnant women	$459.78	$506.70	$538.85	$557.30
	Under age 2	$300.90	$312.45	$343.47	$402.72
	Other children & parents	$236.62	$251.49	$286.14	$319.42
Total payments					
	Pregnant women	$0	$0	$0	$122,496
	Under age 2	$0	$0	$0	$241,880

Other children & parents	$0	$0	$0	$4,209,964
Total	$0	$0	$0	$4,574,339
Adults without children				
Average number of enrollees	0	0	0	80
Avg. monthly payment	$386.00	$424.49	$518.92	$556.40
Total payments	$0	$0	$0	$531,560
Revenue				
Family enrollees @ 50% of full premium	0	0	0	721
Family enrollees charged @ 50% of full premium	0	0	0	721
Individual enrollees @ 50% of full premium	0	0	0	59
Total enrollees charged @ 50% of full premium	0	0	0	779
Family enrollees @ full premium	0	0	0	446
Family enrollees charged @ full premium	0	0	0	446
Individual enrollees @ full premium	0	0	0	21
Total enrollees charged @ full premium	0	0	0	467
Half of full premium	$119	$126	$143	$160
Full premium (=avg. pmt. for children and parents)	$237	$251	$286	$319
Revenue @ 50% of full premium	$0	$0	$0	$1,491,150
Revenue @ full premium	$0	$0	$0	$1,788,537
Total revenue	$0	$0	$0	$3,279,687
Net Cost of small employer option	$0	$0	$0	$1,826,212

FISCAL SUMMARY	FY 2006	FY 2007	FY 2008	FY 2009
		(in thousands)		
Pharmacy program (transfer)	$0	$0	$594	$1,389
Self-employed farm income	$0	$0	$0	$542
Eliminate MLB	$0	$0	$0	$3,277
Increase inpatient cap	$0	$0	$0	$1,561
Dental copays and inpatient cap for parents	$0	$0	$0	$1,608
Adults to 190% FPG	$0	$0	$0	$1,044
Small employer option	$0	$0	$0	$1,826
Grand total state budget cost	$0	$0	$594	$11,247

Long-Term Fiscal Considerations

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Local Government Costs

References/Sources

I have reviewed the content of this fiscal note and believe it is a reasonable estimate of the expenditures and revenues associated with this proposed legislation.

Fiscal Note Coordinator Signature: _____ Date: _____

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Senate

State of Minnesota

S.F. No. 2725 - Health Care (First Engrossment)

Author: Senator Linda Berglin

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

Date: March 22, 2006

S.F. No. 2725 establishes the prescription drug discount program and makes the following changes in the MinnesotaCare program: eliminates the limited benefit set; increases the income eligibility for single adults; raises the inpatient hospital annual cap; modifies the definition of income for self-employed farmers; and establishes a small employer buy-in option.

Section 1 (256.9545) establishes the Prescription Drug Discount program.

Subdivision 1 authorizes the Commissioner of Human Services to establish and administer the Prescription Drug Discount program.

Subdivision 2 requires the commissioner to administer a drug rebate program for drugs purchased by enrollees of the program. The commissioner shall execute a rebate agreement from all manufacturers who choose to participate in the program for those drugs covered under the medical assistance program. The rebate amount shall be equal to the basic rebate provided through the federal rebate program.

Subdivision 3 defines the terms: "commissioner," "participating manufacturer," "covered prescription drug," "health carrier," "participating pharmacy," and "enrolled individual."

Subdivision 4 establishes eligibility requirements for the program.

Paragraph (a) states that an applicant must:

(1) be a permanent resident of Minnesota;

(2) not be enrolled in medical assistance, general assistance medical care, or MinnesotaCare;

(3) not be enrolled in prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in prescription drug coverage under a Medicare supplemental policy.

Paragraph (b) states that notwithstanding paragraph (a), an individual enrolled in a Medicare Part D prescription drug plan or Medicare Advantage plan is eligible but only for drugs that are not covered under the Part D plan or for drugs that are covered under the plan, but pursuant to the terms of the plan, the individual is responsible for 100 percent of the cost of the prescription drug.

Subdivision 5, paragraph (a), requires applications and information on the program to be available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Requires individuals to submit any information deemed necessary by the commissioner to verify eligibility to the county social services agencies. Requires the commissioner to determine eligibility within 30 days from receiving the application. Upon approval, the applicant must submit the enrollment fee established under **subdivision 10**. Eligibility begins the month after the enrollment fee is received.

Paragraph (b) requires an enrollee's eligibility to be renewed every 12 months.

Paragraph (c) requires the commissioner to develop an application that does not exceed one page in length and requires information necessary to determine eligibility.

Subdivision 6 requires participating pharmacies to sell a prescription drug to an enrolled individual at the medical assistance rate until January 1, 2008. After January 1, 2008, the prescription drug must be sold at the medical assistance rate, minus an amount equal to the rebate described in **subdivision 8**, plus any switch fee established by the commissioner. Requires a participating pharmacy to provide the commissioner with any information the commissioner determines necessary to administer the program, including information on sales to enrolled individuals and usual and customary retail prices.

Subdivision 7 requires the commissioner to notify the participating manufacturers on a quarterly basis or on a schedule established by the commissioner of the amount of rebate owed on the prescription drugs sold by a participating pharmacy to enrolled individuals.

Subdivision 8 requires a participating manufacturer to provide a rebate equal to the rebate provided under the medical assistance program for each prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. Requires the manufacturer to provide full payment within 38 days of receipt of the state invoice for the rebate or according to a schedule established by the commissioner. Requires the commissioner to deposit all rebates received into the prescription drug dedicated fund. Requires the manufacturers to provide the commissioner with any information necessary to verify the rebate determined per drug.

Subdivision 9 requires the commissioner to distribute on a biweekly basis an amount equal to the amount collected under **subdivision 8** to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals on or after January 1, 2008.

Subdivision 10 authorizes the commissioner to establish an annual enrollment fee that covers the expenses of enrollment, processing claims, and distributing rebates. This subdivision also requires the commissioner to establish a switch fee to cover the expenses incurred by participating pharmacies in formatting for the electronic submission of claims for prescription drugs.

Subdivision 11 establishes a prescription drug dedicated fund as an account in the state treasury. Requires the Commissioner of Finance to credit the fund with the rebates and any appropriations designated for the fund, and any federal funds received for the program. Requires the money in the fund to be appropriated to the commissioner to reimburse participating pharmacies for prescription drugs discounts and for other administrative costs related to the program.

Section 2 (256L.01, subdivision 4) eliminates the add back of depreciation for farm self-employed income for purposes of determining income eligibility under MinnesotaCare.

Section 3 (256L.03, subdivision 1) contains a change related to eliminating the limited benefit set for single adults in MinnesotaCare.

Section 4 (256L.03, subdivision 3) contains a change related to the increase of the income eligibility limit to 190 percent of the federal poverty guideline (FPG) for single adults and increases the inpatient hospitalization annual limit from $10,000 to $20,000 in MinnesotaCare.

Section 5 (256L.03, subdivision 5) contains changes related to the income eligibility limit increase and the inpatient hospitalization limit increase.

Section 6 (256L.04, subdivision 7) increases the income eligibility limit from 175 percent to 190 percent of FPG for single adults and households without children in MinnesotaCare.

Section 7 (256L.04, subdivision 14) requires the commissioner to award grants to organizations to provide information regarding the MinnesotaCare program in areas of the state with high uninsured populations.

Section 8 (256L.07, subdivision 1) contains a change related to the income eligibility limit increase.

Section 9 (256L.20) establishes the small employer option for MinnesotaCare.

Subdivision 1 defines the following terms: "dependent," "eligible employer," "eligible employee," "participating employer," and "program."

Subdivision 2 authorizes enrollment in MinnesotaCare coverage for all eligible employees and their dependents, if the eligible employer meets the requirements of **subdivision 3.**

Subdivision 3 states that to participate, an eligible employer must:

(1) agree to contribute toward the cost of the premium for the employee and the employee's dependent;

(2) certify that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;

(3) offer coverage to all eligible employees and the dependents of those employees; and

(4) not have provided employer subsidized health coverage as an employee benefit during the previous 12 months.

Subdivision 4 requires the employer to pay 50 percent of the premium for eligible employees without dependents with income equal to or less than 175 percent of FPG and for eligible employees with dependents with income equal to or less than 275 percent of FPG. States that for eligible employees without dependents with income over 175 percent of FPG and eligible employees with dependents with income over 275 percent of FPG, the employer must pay the full cost of the maximum premium. Permits employer to require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the total cost. If the employee is required to pay a portion of the premium, the payment shall be made to the employer. Requires the commissioner to collect the premiums from the participating employers.

Subdivision 5 states that the coverage provided shall be the MinnesotaCare covered services with all applicable co-pays and coinsurance.

Subdivision 6 states that upon the payment of the premium, eligible employees and their dependents shall be enrolled in the MinnesotaCare program. States that the insurance barrier of Minnesota Statutes, section 256L.07, subdivisions 2 and 3, do no apply. Authorizes the commissioner to require eligible employees to provide income verification to determine premiums.

Section 10 repeals the limited benefit set for single adults and households without children.

Section 11 provides an effective date.

KC:ph

ATTACHMENT "A"

Senator ..... moves to amend S.F. No. 2725 as follows:

Page 9, after line 3, insert:

"Sec. 9. Minnesota Statutes 2004, section 256L.11, subdivision 1, is amended to read:

Subdivision 1. **Medical assistance rate to be used.** Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to 6, and section 256L.115.

Sec. 10. **[256L.115] ASSISTANCE TO FINANCIALLY STRESSED SAFETY NET HEALTH CARE CENTERS AND CLINICS.**

Subdivision 1. **Definitions.** For purposes of this section:

(a) "Federally qualified health center" or "center" means an entity, which is receiving a grant under United States Code, title 42, section 245b, or, based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the secretary to meet the requirements for receiving such a grant.

(b) "Safety net community clinic" or "safety net clinic" means an entity that is not a federally qualified health center, but is certified by the Minnesota Department of Health as being eligible to receive a grant under section 145.9268 and more than 25 percent of its patients were uninsured for the most recent calendar year for which data is available.

Subd. 2. **Rate enhancement.** Within the limits of money appropriated for this purpose, when setting rates for federally qualified health centers and safety net clinics, the commissioner shall provide an additional rate increase for federally qualified health centers and safety net clinics for services provided on or after July 1, 2006, to MinnesotaCare enrollees. The commissioner shall determine the rate increase for each qualifying federally qualified health care center or safety net clinic in proportion to each federally qualified health center's or safety net clinic's share of the number of uninsured patients to the total number of patients served in federally qualified health centers and safety net clinics statewide. To qualify for a rate enhancement, a federally qualified health center or safety net clinic must submit to the commissioner, on a form and in the manner specified by the commissioner, the federally qualified health center's or safety net clinic's payor mix with the percentage of uninsured patients and verification of the clinic's status as either a federally qualified health center or a safety net clinic.

Subd. 3. **Disease management, information technology, and disparities grants.** The commissioner shall award MinnesotaCare ~~administrative grants to~~ federally qualified health centers and safety net clinics to be used for any of the following purposes:

Page 10, line 32, before "$....." insert "(a)"

Page 10, after line 33, insert:

"(b) $..... is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for the following purposes:

(1) $..... for rate enhancement for federally qualified health centers and safety net community clinics as provided in Minnesota Statutes, section 256L.115, subdivision 2; and

(2) $..... for rate enhancement for the coordinated safety net care network pilot project as provided in Minnesota Statutes, section 256L.115, subdivision 4, paragraph (a).

(c) $300,000 is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for a grant to the coordinated safety net care network pilot project as provided in Minnesota Statutes, section 256L.115, subdivision 4, paragraph (b). This appropriation is a onetime appropriation and shall not be added to the budget base.

(d) $..... is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for administrative grants to federally qualified health centers and safety net community clinics as provided in Minnesota Statutes, section 256L.115, subdivision 3. This appropriation is a onetime appropriation and shall not be added to the budget base."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "B"

Senator ..... moves to amend S.F. No. 2725 as follows:

Page 4, after line 33, insert:

"Sec. 2. Minnesota Statutes 2004, section 256B.76, is amended to read:

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(i) potential to successfully increase access to an underserved population;

(ii) the ability to raise matching funds;

(iii) the long-term viability of the project to improve access beyond the period of initial funding;

(iv) the efficiency in the use of the funding; and

(v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after ~~January 1, 2002~~ July 1, 2006, the commissioner ~~may, within the limits of available appropriation,~~ shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. ~~Reimbursement to a critical access dental provider may be increased~~ by not more than 50 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to health plan companies shall be adjusted to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

(e) Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVUs). This change shall be budget neutral and the cost of implementing RVUs will be incorporated in the established conversion factor."

Page 9, after line 3, insert:

"Sec. 10. Minnesota Statutes 2004, section 256L.11, subdivision 1, is amended to read:

Subdivision 1. **Medical assistance rate to be used.** Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to ~~6~~ 7.

Sec. 11. Minnesota Statutes 2004, section 256L.11, is amended by adding a subdivision to read:

Subd. 7. **Critical access dental providers.** (a) Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2006, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, paragraph (c), by 40 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in this subdivision. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers.

(b) The commissioner shall award special hardship grants to nonprofit dental providers with a high proportion of uninsured patients that equals or exceeds 15 percent of the total number of patients served by that provider and the provider does not receive a financial benefit comparable to other critical access dental providers under the critical access dental provider formula described in paragraph (c). The commissioner shall award a grant to these providers allocated in proportion to each critical access dental provider's ratio of uninsured patients to the total number of patients served by all providers who qualify for a grant under this paragraph."

Page 10, line 32, before "$....." insert "(a)"

Page 10, after line 33, insert:

"(b) $..... is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for critical access dental provider reimbursement rate increases as provided under section 256L.11, subdivision 7, paragraph (a).

(c) $..... is appropriated in fiscal year 2007 from the health care access fund to the commissioner of human services for special hardship grants to nonprofit dental providers as provided in Minnesota Statutes, section 256L.11, subdivision 7, paragraph (b)."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "C"

Senator ..... moves to amend S.F. No. 2725 as follows:

Page 4, after line 33, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2007."

Page 5, after line 13, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2006."

Page 5, after line 34, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2007."

Page 6, after line 20, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2006."

Page 7, after line 21, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2006."

Page 7, after line 25, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2006."

Page 8, after line 4, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2006."

Page 9, after line 3, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2006."

Page 10, after line 30, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2006."

Page 11, after line 1, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2007."

Page 11, delete section 12

ATTACHMENT "D"

Senator ..... moves to amend S.F. No. 2725 as follows:

Page 9, after line 3, insert:

"Sec. 9. Minnesota Statutes 2004, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

(b) This subdivision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

(c) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. ~~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 and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

(d) This subdivision does not apply to children.

EFFECTIVE DATE. This section is effective August 1, 2006, or upon implementation of HealthMatch, whichever is later.

Sec. 10. Minnesota Statutes 2005 Supplement, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal. ~~Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:~~

~~(1) lacks two or more of the following:~~

~~(i) basic hospital insurance;~~

~~(ii) medical-surgical insurance;~~

~~(iii) prescription drug coverage;~~

~~(iv) dental coverage; or~~

~~(v) vision coverage;~~

~~(2) requires a deductible of $100 or more per person per year; or~~

~~(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.~~

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. ~~The requirement of no health coverage~~ This paragraph does not apply to ~~newborns~~ children.

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

(d) Applicants who were recipients of medical assistance or general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2.

(e) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.

EFFECTIVE DATE. This section is effective August 1, 2006, or upon implementation of HealthMatch, whichever is later.

Sec. 11. Minnesota Statutes 2005 Supplement, section 256L.15, subdivision 2, is amended to read:

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

income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. Effective October 1, 2003, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

~~(c) After calculating the percentage of premium each enrollee shall pay under paragraph (a), eight percent shall be added to the premium.~~

EFFECTIVE DATE. This section is effective August 1, 2006, or upon implementation of HealthMatch, whichever is later."

Page 10, line 2, delete everything after "the" and insert "maximum premium regardless of the income of the eligible employee, as defined in section 256L.15, subdivision 2, paragraph (b)."

Page 10, delete line 3

4.1 Renumber the sections in sequence and correct the internal references

4.2 Amend the title accordingly

A bill for an act

relating to employment; requiring certain health cost payments by large employers; proposing coding for new law in Minnesota Statutes, chapter 177.

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

Section 1. **[177.45] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of sections 177.45 to 177.47, the terms defined in this section have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of labor and industry.

Subd. 3. **Employee.** "Employee" means a person who performs services for hire for an employer, and includes all individuals employed at any site in Minnesota owned or operated by an employer. Employee does not include an independent contractor.

Subd. 4. **Employer.** "Employer" means any corporation or other legal entity with more than 10,000 employees in Minnesota including the state or any of its political subdivisions.

Subd. 5. **Health costs.** "Health costs" means the amount paid by an employer to provide health care or health insurance to employees to the extent the costs are deductible by an employer under federal tax law. Health costs include payments for insurance, medical care, prescription drugs, vision care, medical savings accounts, exercise programs, and any other costs to provide health benefits as defined in section 213(d) of the federal Internal Revenue Code of 1986, as amended.

Subd. 6. **Wages.** "Wages" has the meaning provided in section 268.035, subdivision 29.

Wages do not include:

(1) wages paid to any employee in excess of the state median household income as most recently determined by the Department of Housing and Urban Development; and

(2) wages paid to an employee who is enrolled in or eligible for Medicare.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 2. **[177.46] EMPLOYER HEALTH COST PAYMENT.**

Subdivision 1. **When payment required.** An employer that does not spend at least eight percent of the total wages paid in a calendar year to employees for health costs must make a payment to the commissioner equal to the difference between what the employer spends for health costs and eight percent of the total wages paid to employees in the state. The payment must be made by December 31 of the year following the year for which payment is required.

Subd. 2. **Use of payments.** The commissioner shall deposit payments into the health care access fund created under section 16A.724 for the purposes of that fund, except that the commissioner may retain up to five percent of the payment for administrative costs related to sections 177.45 to 177.47.

Subd. 3. **Employee not responsible.** An employer may not deduct any payment made under subdivision 1 from the wages of an employee.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 3. **[177.47] DUTIES OF COMMISSIONER.**

The commissioner shall enforce sections 177.45 to 177.47 and may, in addition to other powers the commissioner may possess:

(1) investigate employers suspected of violating section 177.45, including inspecting the records of employers;

(2) request and receive information from other state agencies to enforce compliance with sections 177.45 to 177.47; and

(3) collect payments not timely made by commencing an action in district court and by any other collection method available, including referring the debt to the commissioner of revenue for collection under the Debt Collection Act.

The Department of Employment and Economic Development shall, upon request of the commissioner, provide the commissioner with unemployment insurance information related to wages and number of employees of an employer.

EFFECTIVE DATE. This section is effective January 1, 2007.

Unemployment Insurance
Minnesota

March 16, 2006

William Wilson
Committee Administrator
Health & Family Security Committee
G-24 Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155-1606

Re: S.F. 2672 - Large Employer Health Cost Payments

Dear Mr. Wilson:

I would like Senator Lourey to be aware that Minnesota Statutes §268.19, subdivision 1, clause 7, gives the Department of Labor & Industry full access to all unemployment insurance data, including all wage records and any other information we obtain on employers. Therefore, lines 29, 30, and 31 on page 2 of the bill are unnecessary. The authority in the bill for data access already exists in the statutes.

If you have any questions, please feel free to contact me at lee.nelson@state.mn.us or at 651-296-6110.

Sincerely,

Lee B. Nelson/jrw

Lee B. Nelson
Director
Unemployment Insurance Legal Affairs

LBN: jrw

cc: Lynne Batzli

Department of Employment and Economic Development
Unemployment Insurance Legal Affairs
1st National Bank Building • 332 Minnesota Street, Suite E200 - Saint Paul, MN 55101-1351 • USA
651-296-6110 • Fax: 651-284-0170 • TTY: 651-296-3900 • www.uimn.org

Bill Summary | Senate

Senate Counsel & Research | State of Minnesota

S.F. No. 2672 - Health Care Cost Payment by Large Employers

Author: Senator Becky Lourey

Prepared by: John C. Fuller, Senate Counsel (651/296-3914)

Date: March 22, 2006

This bill amends the chapter of Minnesota Statutes related to labor standards and wages. It requires private employers with more than 10,000 employees in Minnesota to pay to the state for deposit in the health care access fund account the difference between eight percent of the wages paid to Minnesota employees and what the employer pays for medical costs of its employees. If the employer pays more than eight percent, there is no payment obligation.

Section 1 contains definitions.

Subdivision 2 defines "commissioner" as the Commissioner of Labor and Industry.

Subdivision 3 defines "employee" and excludes independent contractors from the definition.

Subdivision 4 defines an "employer" as an entity employing more than 10,000 individuals within the state and excludes public employers.

Subdivision 5 defines "health care costs" as those paid for by an employer to provide health care or health insurance and that are deductible by the employer under federal tax law.

Subdivision 6 defines "wages" by reference to the definition of wages contained in the unemployment compensation law. Excluded from wages are those paid to employees enrolled in Medicare and those wages that are in excess of the state median household income.

Section 2 requires employers that pay less than eight percent of wages for health care costs to make a payment to the state for the difference between eight percent and what the employer pays for health care costs. The obligation is enforced on an annual calendar-year basis. The payment must be made to the Commissioner for deposit into the health care access fund. The first year an employer has the obligation is calendar year 2007.

Section 3 requires the Commissioner of Labor and Industry to enforce section 2. The Commissioner is authorized to engage in various activities to ensure compliance with section 2. The Commissioner of Employment and Economic Development is required to cooperate with the Commissioner in providing wage and employment count information.

JCF:cs

Consolidated Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/20/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings	X	
Tax Revenue		X

Agencies: Labor & Industry (03/20/06)
Employee Relations (03/20/06)
Employment & Economic Dev Dept (03/17/06)
Human Services Dept (03/17/06)

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
Health Care Access Fund			163	216	221
Labor & Industry			163	216	221
State Employees Insurance Fund		0	0	0	0
Employee Relations		0	0	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
Health Care Access Fund			163	216	221
Labor & Industry			163	216	221
State Employees Insurance Fund		0	0	0	0
Employee Relations		0	0	0	0
Total Cost <Savings> to the State		0	163	216	221

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Health Care Access Fund			1.20	2.00	2.00
Labor & Industry			1.20	2.00	2.00
Total FTE			1.20	2.00	2.00

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/20/06 Phone: 296-7642

Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/20/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

Agency Name: Labor & Industry

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings	X	
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Health Care Access Fund			163	216	221
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
Health Care Access Fund			163	216	221
Revenues					
-- No Impact --					
Net Cost <Savings>					
Health Care Access Fund			163	216	221
Total Cost <Savings> to the State			163	216	221

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
Health Care Access Fund			1.20	2.00	2.00
Total FTE			1.20	2.00	2.00

Bill Description

This bill requires employers with more than 10,000 employees in Minnesota to make a payment to the Department of Labor and Industry (DLI) if they do not spend at least 8% of total wages paid to employees in a calendar year for health costs. The payment amount would be the difference between the actual amount spent for health care and 8% of total wages paid. The payments would be deposited into the Health Care Access Fund. DLI is allowed to retain up to 5% of the payment amount for administrative costs.

Wages are defined as the wages reported to the Department of Employment and Economic Development (DEED) for unemployment insurance purposes. Wages in excess of the state median household income as determined by the Department of Housing and Urban Development ($68,200 for 2006) and wages paid to an employee who is enrolled in or eligible for Medicare are excluded for the health care cost calculation.

Assumptions

There are approximately 11 employers with over 10,000 employees in Minnesota. DLI would hire two Labor Standards Investigators to develop a reporting process and inspect these employer health care cost records to ensure compliance. It will also require the assistance of a Research Analyst to compare wage detail information from the DEED with Medicare information maintained by the Department of Human Services and determine the aggregate amount of wages to be included in the calculation.

It is assumed that data collection, calculation, and auditing would begin in January 2007 for the calendar year 2006.

It is also assumed that DLI administrative expenditures would be funded from the Health Care Access Fund.

Expenditure and/or Revenue Formula

Revenue:

DLI does not have any information regarding the current health care benefit levels provided by these employers, therefore is unable to estimate the amount of revenue that might be generated under this bill.

Expenditures:

	2007	2008	2009
Personnel	$85,000	$144,000	$148,000
Other Operating	$78,000	$72,000	$73,000
Total	$163,000	$216,000	$221,000

Long-Term Fiscal Considerations

If all defined employers' health care costs exceed the 8% threshold there would be no revenue generated from which to offset DLI's administrative costs.

Local Government Costs

Local governments with more than 10,000 employees could be affected if they are not paying at least 8% of wages for employee health costs.

References/Sources

DLI Assistant Commissioner, Workplace Services
DLI Research Director
Business Journal

FN Coord Signature: CINDY FARRELL
Date: 03/17/06 Phone: 284-5528

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/20/06 Phone: 296-7642

Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/17/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

Agency Name: Human Services Dept

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: SF 2672-1A

Bill Description

As amended, SF 2672 would require employers with 10,000 or more employees who does not spend at least 8% of total wages in a calendar year to employees for health costs to make a payment to the commissioner of labor and industry equal to the difference between what the employer spends for health costs and 8% of total wages paid to employees in the state. The definition of employer includes any corporation or other legal entity with more than 10,000 employees in the state, including the state and any of its political subdivisions.

The payments must be deposited by the commissioner of labor and industry into the Health Care Access Fund. The commissioner of labor and industry is allowed to keep up to 5% of the payment for administrative costs.

The bill is effective January 1, 2007.

The amendments to the bill do not impact DHS.

Assumptions

It is anticipated that there would be no program, systems or administrative impacts attributed to DHS.

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Steve Nelson 651-431-2202
FN Coord Signature: STEVE BARTA
Date: 03/17/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: LISA MUELLER
Date: 03/17/06 Phone: 296-6661

Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/20/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Employee Relations

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
State Employees Insurance Fund		0	0	0	0
Less Agency Can Absorb					
State Employees Insurance Fund		0	0	0	0
Net Expenditures					
State Employees Insurance Fund		0	0	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
State Employees Insurance Fund		0	0	0	0
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

BILL DESCRIPTION:
Senate file 2672-1A requires certain health cost payments by large employers.

BACKGROUND:
The Minnesota Advantage Health Plan is a self-insured health plan offered by the State of Minnesota to state employees and their dependents. Both the employer and the employee make contributions to the cost of premiums. The bill requires large employers (10,000 + employees) who do not spend at least 8% of total wages paid to employees for health costs to make a payment to the Commissioner of Labor and Industry.

Based on 2005 data, The State of Minnesota spent approximately 18% of total wages for health care costs.

ASSUMPTIONS:
DOER has assumed that health care costs will continue to rise at a faster rate than the rate of wage increases.

DOER has assumed the Employer Contribution formula, as specified by bargaining agreements, will remain relatively stable over the next five years.

DOER therefore concludes the state will continue to spend 18% of wages or more on health care costs, and would not be required to make an additional payment.

EXPENDITURE FORMULA:
Not applicable.

LONG-TERM FISCAL CONSIDERATIONS:
Not applicable.

LOCAL GOVERNMENT COSTS:
Not applicable.

REFERENCES:
- Current premium costs from the Minnesota Advantage Health Plan.
- Current average salary calculated from report PDHR6200, *Executive Branch Appointment and Employment Statistics*, dated July 19, 2005.

Agency Contact Name: Liz Houlding (651-259-3700)
FN Coord Signature: MIKE HOPWOOD
Date: 03/20/06 Phone: 259-3780

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KRISTI SCHROEDL
Date: 03/20/06 Phone: 215-0595

Fiscal Note – 2005-06 Session

Bill #: S2672-1A **Complete Date:** 03/17/06

Chief Author: LOUREY, BECKY

Title: LARGE EMPLOYER HEALTH COST PAYMENTS

Agency Name: Employment & Economic Dev Dept

Fiscal Impact	Yes	No
State		X
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

This agency is not involved in the administration of the program initiated by this bill. The data exchange with this agency, called for on Page 2, lines 29-31, is already authorized under MN Statutes 268.19, Subd. 1(7).

Assumptions

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

FN Coord Signature: MIKE MEYER
Date: 03/17/06 Phone: 297-1978

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/17/06 Phone: 296-7642

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 2672: A bill for an act relating to employment; requiring certain health cost payments by large employers; proposing coding for new law in Minnesota Statutes, chapter 177.

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

Page 2, delete lines 29 to 31

And when so amended that the bill be recommended to pass and be referred to the full committee.

Linda Berglin
(Division Chair)

March 28, 2006
(Date of Division recommendation)

Senate Counsel, Research, and Fiscal Analysis

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Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

S.F. No. 2477 - MinnesotaCare

Author: Senator Charles W. Wiger

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

Date: March 14, 2006

S.F. No. 2477 eliminates premiums for members of the military who enroll in MinnesotaCare within 24 months following the member's tour of active duty. This exemption applies for 12 months so long as the individual or family remains eligible for the program during this period.

KC:ph

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S2477-0 **Complete Date:**

Chief Author: WIGER, CHARLES

Title: MNCARE MIL FAMILY PREMIUM ELIMINATED

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		0	1,930	0	0
Health Care Access Fund		0	0	1,274	1,396
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		0	1,930	0	0
Health Care Access Fund		0	0	1,274	1,396
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		0	1,930	0	0
Health Care Access Fund		0	0	1,274	1,396
Total Cost <Savings> to the State		0	1,930	1,274	1,396

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Preliminary

NARRATIVE: SF 2477/HF 2821

Bill Description

This bill exempts members of the military and their families from payment of premiums for 12 months. Individuals must be otherwise eligible for MinnesotaCare at application and at six-month renewal. The determination of eligibility for MinnesotaCare must be made within 24 months of the end of the member's tour of duty.

Assumptions

The change would need federal approval.

Assume an implementation date of July 2007.

If approved, the MNCare premium will be waived for 12 months for members of the military who have finished their tour of duty and their families.

It will have a large impact on MMIS, total cost is $201,600. State share cost would be $70,560.

The bill would result in a four month HealthMatch delay costing $5,308,000.
State share cost is $1,858,800.

Expenditure and/or Revenue Formula

Fiscal Summary (dollars in thousands)
General Fund

BACT	Description	FY07	FY08	FY09
51-HC Operations	MMIS costs	71	0	0
51-HC Operations	HealthMatch (4 month delay)	1,859	0	0
Total General Fund		1,930	0	0
HCAF				
40-MnCare Grants	Program costs	0	1,274	1,396
Total Cost to State:		1,930	1,274	1,396

Minnesota
MINNESOTACARE
Fiscal Analysis of a Proposal to
Senate File 2477

This bill provides an exemption from MinnesotaCare premiums for military personnel who apply for MinnesotaCare within 24 months of the end of a tour of active duty. The exemption is effective for a period of twelve months and applies to both the individual and their families.

We assume that the use of this exemption will usually occur in the period 12 to 24 months after the end of the tour of active duty because TRICARE coverage is available for the first 18 months.

We project the number of affected people who would be on MinnesotaCare without this legislation, using twice the rate that applies to the general population of ages 20-29. The cost for this group is the loss of their normal premium payments. We also project that an equal number will be added to the program because of the premium exemption. The cost for this group is the cost of their MinnesotaCare coverage.

No effective date is specified in the bill. We assume an implementation date of July 2007 because federal waiver approval is expected to take 12 months.

	FY 2006	FY 2007	FY 2008	FY 2009
Minnesota adults within 12-24 months after a tour of active duty		2,000	3,000	3,000
% projected to be on MinnesotaCare				

in the absence of this legislation:				
as caretakers			3.80%	3.80%
as adults with no kids			3.60%	3.60%
Number projected to be on MinnesotaCare in the absence of this legislation:				
as caretakers		0	114	114
as adults with no kids		0	108	108
kids based on caretaker count		0	228	228

	FY 2006	FY 2007	FY 2008	FY 2009
FAMILIES WITH CHILDREN				
Cost of Reduced Premiums				
Number of eligibles		0	342	342
Avg. monthly revenue		-$27.16	-$27.46	-$27.46
Total revenue	0	0	-112,708	-112,708
Federal share %	55.58%	52.03%	50.88%	50.31%
Federal share	0	0	-57,341	-56,703
State share	0	0	-55,367	-56,006
Cost of Increased Enrollment				
Number of eligibles		0	342	342
Avg. monthly payment	236.62	251.49	286.14	319.42
Avg. monthly revenue		$0.00	$0.00	$0.00
Total payments	0	0	1,174,299	1,310,919
Federal share %	55.58%	52.03%	50.88%	50.31%
Federal share	0	0	597,436	659,513
State share	0	0	576,863	651,405
Total revenue	0	0	0	0
Federal share %	55.58%	52.03%	50.88%	50.31%
Federal share	0	0	0	0
State share	0	0	0	0
Net cost for Families with Children	0	0	1,287,008	1,423,627
Federal share	0	0	654,778	716,216
State share	0	0	632,230	707,411

	FY 2006	FY 2007	FY 2008	FY 2009
ADULTS WITHOUT CHILDREN				
Cost of Reduced Premiums				
Number of eligibles		0	108	108
Avg. monthly revenue		-$17.63	-$15.38	-$15.18
Total revenue	0	0	-19,935	-19,676

Preliminary

Cost of Increased Enrollment				
Number of eligibles		0	108	108
Avg. monthly payment		$401.02	$479.72	$516.05
Avg. monthly revenue		$0.00	$0.00	$0.00
Total payments	0	0	621,715	668,800
Total revenue	0	0	0	0
Net cost for Adults w. No Kids	0	0	641,649	688,476
Total MinnesotaCare cost	0	0	1,928,657	2,112,103
Federal share	0	0	654,778	716,216
State share	0	0	1,273,879	1,395,887

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Senators Wiger, Vickerman and Murphy introduced–

S.F. No. 2477: Referred to the Committee on Health and Family Security.

A bill for an act

relating to MinnesotaCare; eliminating premiums for military personnel and their families; amending Minnesota Statutes 2004, section 256L.15, subdivision 1.

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

Section 1. Minnesota Statutes 2004, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare are exempt from this section and section 256L.06 upon eligibility approval made within 24 months following the end of the member's tour of active duty. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption shall apply for 12 months if the individual or family remains eligible upon six-month renewal.

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Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

S.F. No. 2957 - Family Planning Special Projects Grants

Author: Senator Becky Lourey

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

Date: March 27, 2006

S.F. No. 2957 eliminates the reduction to the family planning special projects grants that was passed last session in the Health and Human Services Omnibus bill. This reduction was to take place beginning fiscal year 2007 but only if full implementation of the family planning project had taken place. The grants were to be reduced by $1.877 million each year.

KC:ph

Senate Health and Human Services Budget Division
March 28, 2006

Madam Chair and Members of the Committee,

My name is Meg Friese, Chief Operating Officer at Planned Parenthood Minnesota, North Dakota and South Dakota.

Thank you for the opportunity to speak on behalf of S.F. 2957, a bill to correct the legislation enacted at the end of the 2005 special session. This 2005 bill will reduce the State Family Planning Special Projects program dramatically upon implementation of the federal 1115 Medicaid family planning demonstration project.

As you know, the Minnesota Legislature established the State Family Planning Special Projects program in 1977 as Minnesota's main legislative effort in reducing unintended pregnancies. Planned Parenthood of Minnesota has always appreciated this senate committee's support of the program.

Planned Parenthood of Minnesota has worked diligently over the decades to serve the reproductive health care needs of over 80,000 men and women annually by maintaining a statewide system of family planning clinics. Combined federal and state funding for family planning needs in our state has always been significantly below the community need for these services. Planned Parenthood has leveraged flat public funding resources with private philanthropic donations and clinic overhead cost efficiencies to remain viable. In recent years we have reluctantly informed both Governor Pawlenty and this legislative body that we may not be able to maintain this system of family planning clinics statewide without significant public funding reforms.

The Minnesota Legislature, working with the Minnesota Department of Health and Human Services, applied in 2002 to the federal Department of Human Services for a Medicaid demonstration project to reduce unintended pregnancies through greater expansion of access to family planning services. This 1115 Medicaid waiver was based on the federal requirement that additional federal funding for family planning services would not supplant current state efforts in this public health area. Indeed, the State Family Planning Program was cited as the state program upon which the federal waiver would build greater access. Continuation of the state effort was implied in the grant application to the U.S. Department of Health and Human Services.

The unfortunate decision at the end of the 2005 special session to reduced FPSP was apparently made without sufficient consideration to the groups of family planning clients who will not be eligible for services through the Medicaid family planning waiver. These groups who would be negatively affected are: 1) Individuals whose income is over 200% above poverty; 2) Undocumented immigrants who utilize all family planning clinics in Minnesota; 3) Teenagers concerned with confidentiality of services, 4) Individuals initially seeking treatment or diagnosis for a sexually transmitted infection.

Additionally all education and outreach efforts will be significantly curtailed with the reduction in the state funding.

Without going into great detail, Planned Parenthood of Minnesota also has concerns with the ongoing delay of implementation of the federal 1115 family planning waiver. Our agency's rural clinic system, financed primarily by the federal government through the Title X program, will not survive into the next decade without this infusion of federal Medicaid funding.

As we ask you to please reverse this body's decision to dramatically cut the state family planning funding, we also respectfully ask you to inquire as to the nature of the delay and planning of the federal 1115 waiver, looking into patient access issues and reasonable funding reimbursement levels for providers.

Family planning providers have always operated with a small financial margin. Reduced FPSP dollars place a financial hardship on all family planning providers throughout the state. Please give strong consideration into the adverse consequences that cutting state funding commitments to family planning providers will have in addition to assuring that the anticipated federally funded waiver program will be quickly and properly implemented

Thank you for your time.

StarTribune.com | MINNEAPOLIS - ST. PAUL, MINNESOTA
Last update: March 26, 2006 – 7:00 PM

Editorial: More support for family planning

State, lawmakers should restore and expand funding.

For every public dollar spent on family planning, government saves $3 in costs for prenatal and newborn care. That's a worthwhile investment, one that Minnesota had been increasing for nearly three decades.

Last year, however, the Legislature cut family-planning support in half, reducing the allocation by more than $3 million. That change, along with delays in accessing a new source of federal funding, threatens the survival of clinics that offer contraception and other services. The Pawlenty administration and the Legislature should make family planning a priority, simplify the system and keep crucial dollars flowing to clinics.

Under the previous two administrations, that commitment grew to $10 million per biennium through the Health Department. During that same period, federal funding flattened and failed to keep pace with rising costs. So in recognition of growing needs, the state applied for funding through Medicare and Medicaid. That was approved in 2004 and channeled through the Human Services Department. Yet the program is not yet officially established, so funds have not been distributed.

Planned Parenthood officials say implementation problems include inadequate computer systems, staffing and training; and a lack of confidentiality safeguards for teens.

At the end of the 2005 legislative session, a compromise deal to preserve MinnesotaCare health care funding resulted in the family planning cuts -- with the idea that those funds would be covered upon full use of the federal program. Trouble is, "full use" is not well-defined. And switching the program from health to human services along with folding in Medicaid/Medicare procedures has complicated and slowed down the transfers.

Recent federal action could make matters worse. Congress passed a budget reconciliation bill that allows states to charge co-pays and to opt out of some Medicaid-supported programs. If states use those options, services will be even further out of reach for poor families.

Combined, these changes make it harder to access birth control and other family planning services -- particularly for younger, lower-income and immigrant people. That's exactly the wrong direction to go. Only about 40 percent of Minnesota women and teens who need publicly supported contraceptive services receive them. That's an argument to expand, not diminish, access to programs.

Minnesota was on the path to progress in providing these important services. Now is no time to regress. State agencies should streamline and simplify

eligibility and get waiting federal funds to providers. And lawmakers should restore and increase state support for family planning.

Minnesota
SAFPlan
Statewide Association for Family Planning

Prevention Works -- Family Planning prevents abortions and saves Minnesota Taxpayers Money

Fully Fund Family Planning at 2004 Levels

THE MEDICAID WAIVER IS GOOD NEWS

- More women will have access to family planning services. This will save money the government now spends on the consequences of unintended pregnancy.

AND BAD NEWS

- The reimbursement rate under the waiver may covers only 50% of a family planning clinic visit.
- A couple earning over $25,000 does not qualify for the waiver. (That equates to $9.20/hour.)
- The price of contraceptives is often more than these couples can afford.

WE NEED STATE FAMILY PLANNING MONEY TO COMPLEMENT THE WAIVER

- Last year family planning funding was cut 48% in anticipation that the waiver would cover costs.
- Some smaller clinics filling the health disparities gap may be forced out of business.
- The waiver will not fund: Educational outreach, the Hot Line at the Family Tree serving more than 5,000 callers a year, new populations of legal immigrants here for less than five years, undocumented immigrants, translation services for hearing and vision impaired.

FUNDING BIRTH CONTROL SAVES MONEY AND PREVENTS ABORTIONS

* $1 spent on family planning saves over $3 in public pregnancy and medical costs.
* Nearly half of all pregnancies are unintended, half of which end in abortion.
* Preventing unintended pregnancies reduces the need for abortion.
* More than 90% of women at risk of unintended pregnancy use a contraceptive method. But nearly 50% of unintended pregnancies occur to 7% of women who are not using a contraceptive.
* Over half of women at or below 200% of the poverty level become unintentionally pregnant.
* Women age 20-34 account for most unintended pregnancies. Contraception is critical to helping these women realize their family size goals.

In Minnesota, 158 publicly funded clinics provide contraceptive care to 103,880 women helping to prevent 20,900 unintended pregnancies each year. More than 253,000 additional women are in need of publicly supported family planning services.

State Family Planning money does NOT pay for abortion or abortion referral service.

Information from Alan Guttmacher Institute, 2004 www.guttmacher.org and the MN Dept. of Health, www.health.state.mn.us/divs/fh/mch/familyplanning

Minnesota SAFPlan, 1619 Dayton Ave, St. Paul, MN 55104 651-645-0478

Senators Lourey, Kelley, Cohen, Kiscaden and Pogemiller introduced–

S.F. No. 2957: Referred to the Committee on Finance.

A bill for an act

relating to health; eliminating the reduction of the family planning special projects grants; amending Laws 2005, First Special Session chapter 4, article 9, section 3, subdivision 2.

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

Section 1. Laws 2005, First Special Session chapter 4, article 9, section 3, subdivision 2, is amended to read:

Subd. 2. **Community and Family Health Improvement**

Summary by Fund

General	40,413,000	40,382,000
State Government Special Revenue	141,000	128,000
Health Care Access	3,510,000	3,516,000
Federal TANF	6,000,000	6,000,000

~~[FAMILY PLANNING BASE REDUCTION.] Base level funding for the family planning special projects grant program is reduced by $1,877,000 each year of the biennium beginning July 1, 2007, provided that this reduction shall only take place upon full implementation of~~

~~the family planning project section of the 1115 waiver. Notwithstanding Minnesota Statutes, section 145.925, the commissioner shall give priority to community health care clinics providing family planning services that either serve a high number of women who do not qualify for medical assistance or are unable to participate in the medical assistance program as a medical assistance provider when allocating the remaining appropriations. Notwithstanding section 15, this paragraph shall not expire.~~

[SHAKEN BABY VIDEO.] Of the state government special revenue fund appropriation, $13,000 in 2006 is appropriated to the commissioner of health to provide a video to hospitals on shaken baby syndrome. The commissioner of health shall assess a fee to hospitals to cover the cost of the approved shaken baby video and the revenue received is to be deposited in the state government special revenue fund.

Sec. 2. **TITLE; CITATION.**

This act may be cited as the "Putting Prevention First Act of 2006."

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 2534 - Brainerd Regional Treatment Center

Author: Senator Paul E. Koering

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 22, 2006

Section 1 requires the commissioner of human services to maintain or expand laundry services that are provided by the laundry unit at Brainerd Regional Treatment Center until January 2010.

Section 2 requires the commissioner of human services to allow the Brainerd Regional Treatment Center employees and service units to bid on state contracting opportunities, specifically the contracts to provide services to the new community-based inpatient psychiatric hospitals.

JW:mvm

Fiscal Note – 2005-06 Session

Bill #: S2534-1A **Complete Date:** 03/27/06

Chief Author: KOERING, PAUL

Title: BRNRD LNDRY. SRVC MAINT; BID AUTH

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		0	2,795	0	0
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		0	2,795	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		0	2,795	0	0
Total Cost <Savings> to the State		0	2,795	0	0

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: SF 2534-1A

Bill Description

The bill seeks to require the Commissioner of Human Services to continue or expand laundry services provided by the Brainerd Regional Human Service Center until January, 2010. The second section requires the Commissioner to allow the state employees and service units to bid on state contracting opportunities for the new community based inpatient hospitals.

Assumptions

For the last several months, the City of Brainerd and Crow Wing County under a joint powers agreement with the State have been completing a master re-use plan for the Brainerd Regional Human Services campus. This re-use plan is required under language passed during the 2003 legislative session and will provide direction for the use of the campus as the DHS adult mental health services moves into community-based sites. With this re-use planning and relocation of services to the community, DHS plan to discontinue use of the campus. For any remaining services, renovation of current structures and purchase of equipment may be necessary..

The laundry service at the Brainerd Regional Treatment Center provides services to both State Operated Services programs as an internal laundry and for private/other governmental organizations under a shared service income contract arrangement. The private/other non-State Operated Services contract laundry accounts for 54% of the pounds of laundry done by the facility. The large equipment used for this service is approximately 20 years old and will require replacement. To continue to operations, the laundry would require the replacement of:

- Boiler - $150,000
- Tunnel Washer – $250,000
- Water Softener – $175,000
- Delivery Trucks – $66,000/truck

The current average cost of laundry done at the facility is $ .74 per pound before the additional depreciation cost that will be incurred with the new equipment. To be competitive in the market place, the service would need to reduce costs to a level were the average cost is $ .38 per pound. In order to reduce the costs of the service, 4.75 FTEs of the current 9.5 FTEs would need to be reduced.

To retain a cost competitive Dietary services on the BRHSC campus, renovation of the current dietary building at a cost of $1.15 million with equipment replacement cost of $450,000 would be required. This renovation and equipment purchase would create a dietary service capable of preparing 450 meals per day which would exceed the current need for meals for all State Operated Services within the Brainerd area. Based upon a current market analysis, a competitive meal service rate would need to average $6.30/meal based on volume and staffing costs. The current cost per meal at the campus (before the additional depreciation cost that will be incurred with the remodeling and new equipment) is $7.58/per meal. In order to reduce the cost of the service to allow for a competitive bid, the service would need to reduce staffing from the current level of 17.26 FTEs to 6.33 FTEs.

Expenditure and/or Revenue Formula

It is assumed that both services would run as enterprise and would require 120 days of cash flow to open as an enterprise service.

Laundry Service

- 120 day of cash flow: Estimated pounds of laundry of 2,375,000 * .38/pound= $902,500
  $902,500 / 365 * 120 Days= $296,712
- Equipment (as outlined above) = $641,000

Dietary Service

- 120 days of cash flow: Estimated meals of 124,381 * $6.30 = $783,600
  $783,600 / 365 * 120 Days = $257,622
- Renovations = $1,150,000 (based on estimated design costs)
- Equipment = $450,000 (based on estimated design costs)

Long-Term Fiscal Considerations

DHS –SOS appropriations have been reduced in anticipation of the sale and/or transfer of the campuses to the local units of government or private entities. To continue to operate these services once the disposition of the

campus has occurred will require the State to pay for lease costs of the property as well as to maintain the buildings and the equipment as long as the services operate. There is also no mention in this bill as to whether the services will be covered under an appropriation or whether they will be required to operate based on the revenues generated for the services provided.

Local Government Costs

None.

References/Sources

Agency Contact Name: Shirley Jacobson 431-3696
FN Coord Signature: STEVE BARTA
Date: 03/22/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/27/06 Phone: 282-5065

Senators Koering, Berglin, Foley and Lourey introduced–

S.F. No. 2534: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; requiring the Brainerd Regional Treatment Center laundry services to be maintained or expanded; allowing Brainerd Regional Treatment Center employees and service units to bid on certain service contracts.

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

Section 1. **LAUNDRY SERVICES AT BRAINERD REGIONAL TREATMENT CENTER.**

The commissioner of human services shall maintain or expand laundry services that are provided by the laundry unit at the Brainerd Regional Treatment Center until January 2010.

Sec. 2. **BRAINERD REGIONAL TREATMENT CENTER SERVICES.**

The commissioner of human services shall allow the Brainerd Regional Treatment Center employees and service units to bid on state contracting opportunities, specifically the contracts to provide services for the new community-based inpatient psychiatric hospitals.

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 3095 - Delaying Certain Personal Care Assistant Documentation Requirements

Author: Senator Linda Berglin

Prepared by: David Giel, Senate Research (296-7178)

Date: March 27, 2006

Section 1 (256B.0655, subdivision 2) delays for one year, until July 1, 2007, the application of certain documentation and reporting requirements to providers of personal care assistant (PCA) services using pooled or shared hours and to service providers who pool PCA hours in order to have staff available 24 hours per day.

The delay applies to the following documenting and reporting requirements:

- that documentation be maintained specifying the day, month, year, and arrival and departure times for all services provided to the recipient;
- that documentation be maintained of all notices to the recipient regarding PCA use exceeding authorized hours;
- that the provider communicate with the recipient about the schedule for use of authorized hours and notify the recipient and the county in advance if the monthly number of hours is likely to be exceeded; and
- that the provider comply with an ongoing audit process to be established by the Department of Human Services (DHS), which must include a requirement that providers document hours of care provided as attested by the PCA.

This section directs DHS to work with providers given a compliance delay to develop reasonable documentation requirements or options for alternative services for affected recipients. The results of that effort must be reported to the 2007 Legislature.

DG:rdr

Fiscal Note – 2005-06 Session

Bill #: S3095-0 **Complete Date:** 03/24/06

Chief Author: BERGLIN, LINDA

Title: DELAY PERS CARE ASST DOC IMPLEMENT

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		787	2,631	0	0
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		787	2,631	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		787	2,631	0	0
Total Cost <Savings> to the State		787	2,631	0	0

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: HF 3557/SF 3095

Bill Description

Section 1, subd. 2)h) of the bill suspends the documentation and reporting requirements of certain providers of personal care assistant services who provide services, using pooled or shared hours in corporate foster care or other settings. It requires the commissioner to work with these providers to develop reasonable and appropriate documentation requirements and report to the legislature by January 15, 2007. The effective date of the section is March 1, 2006.

The PCA documentation provisions referenced in the bill were passed by the 2005 legislature to correct deficiencies in program integrity for PCA services.

Assumptions

1. The current statute is consistent with federal requirements, the Medicaid State Plan, Minnesota Statutes and Rules which require documentation of actual services to individual clients for all PCA services. This is required for all Medicaid reimbursable services.
2. About 25% of the affected recipients are on waivers and can get their supervision paid for using different service codes. PCA providers of shared care already comply with the documentation requirements of (iv) & (v).
3. A suspension of the documentation requirements could result in potential federal disallowances for services to the class of recipients affected by the suspension. A loss of federal funding for this entire class of recipients would approach $20 million in SFY 2007.
4. It is estimated that as many as 800 client's PCA services are being billed in this manner. It is assumed that at least 10% of the payments to these types of providers are not appropriate.

Expenditure and/or Revenue Formula

	FY2006	FY2007	FY2008	FY2009
Estimated PCA spending (2/06 Forecast)	$276,094,677	$307,470,128		
% of Budget Affected-Actual Pooled Care*	8.9%	8.9%		
% of Budget-Affected-Additional Pooled Care*	8.2%	8.2%		
Total % of Budget*	17.1%	17.1%		
Percent of Year Affected	33.3%	100.0%		
Total Budget Affected	$15,747,828	$52,612,243		
Estimated Difference in Payment	10%	10%		
Total MA Cost	$1,574,783	$5,261,224		
State Share (50%)	$787,391	$2,630,612		
State Budget (000's) MA Waivers and Homecare	787	2,631	$0	$0

*Percent of budget is based on actual CY reports of the number of recipients and total costs of providers of shared or pooled care compared to total PCA expenditures. In CY 2006 there were 1,674 recipients receiving 44,648,335 dollars of PCA services in congregate settings. Total PCA expenditures for CY 2005 were $260,928,402.

Long-Term Fiscal Considerations

None, due to the effective dates of the bill.

Local Government Costs

None

References/Sources

February 2006 Forecast
Health Care Operations
Continuing Care Research and Analysis

Agency Contact Name: Vicki Kunerth 431-2618
FN Coord Signature: STEVE BARTA
Date: 03/23/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/24/06 Phone: 286-5618

Senator Berglin introduced–

S.F. No. 3095: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; delaying implementation of certain personal care assistant documentation and reporting requirements; amending Minnesota Statutes 2005 Supplement, section 256B.0655, subdivision 2.

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

Section 1. Minnesota Statutes 2005 Supplement, section 256B.0655, subdivision 2, is amended to read:

Subd. 2. **Personal care assistant services.** (a) The personal care assistant services that are eligible for payment are services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivisions 3 and 4, and sections 256B.0651, subdivisions 4 to 12, and 256B.0654, subdivision 2.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

(1) services provided without a physician's statement of need as required by section 256B.0625, subdivision 19c, and included in the personal care provider agency's file for the recipient;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) homemaker services that are not an integral part of a personal care assistant services;

(11) home maintenance or chore services;

(12) services not specified under paragraph (a); and

(13) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

(f) In order to be paid for personal care assistant services, personal care provider organizations, and personal care assistant choice providers are required:

(1) to maintain a recipient file for each recipient for whom services are being billed that contains:

(i) the current physician's statement of need as required by section 256B.0625, subdivision 19c;

(ii) the service plan, including the monthly authorized hours, or flexible use plan;

(iii) the care plan, signed by the recipient and the qualified professional, if required or designated, detailing the personal care assistant services to be provided;

(iv) documentation, on a form approved by the commissioner and signed by the personal care assistant, specifying the day, month, year, arrival, and departure times, with

AM and PM notation, for all services provided to the recipient. The form must include a notice that it is a federal crime to provide false information on personal care service billings for medical assistance payment; and

(v) all notices to the recipient regarding personal care service use exceeding authorized hours; and

(2) to communicate, by telephone if available, and in writing, with the recipient or the responsible party about the schedule for use of authorized hours and to notify the recipient and the county public health nurse in advance and as soon as possible, on a form approved by the commissioner, if the monthly number of hours authorized is likely to be exceeded for the month.

(g) The commissioner shall establish an ongoing audit process for potential fraud and abuse for personal care assistant services. The audit process must include, at a minimum, a requirement that the documentation of hours of care provided be on a form approved by the commissioner and include the personal care assistant's signature attesting that the hours shown on each bill were provided by the personal care assistant on the dates and the times specified.

(h) The commissioner shall not implement until July 1, 2007, the documentation and reporting requirements in paragraph (f), clause (1), items (iv) and (v), and clause (2), and paragraph (g), for providers that employ personal care assistants using pooled or shared hours in corporate foster care or other settings or for providers serving recipients who choose to pool personal care assistant hours in order to have staff available 24 hours per day. This paragraph applies to all personal care assistants employed by providers that use shared or pooled hours. The commissioner shall work with providers covered by this paragraph to develop reasonable and appropriate documentation requirements or options for alternative services for affected recipients and report the results of that effort to the legislature by January 15, 2007.

EFFECTIVE DATE. This section is effective retroactive to March 1, 2006.