



Section-by-Section Summary Minnesota Health Act (SF 118 / HF 135)

Article 1: General Provisions

Section 1: Health Plan requirements

Lists nine criteria the Minnesota Health Plan must meet, including that it cover all “necessary care,” patients must be free to choose their own doctor, and the program must be financed by premium payments based on ability to pay.

Section 2: Minnesota Health Plan general provisions

States that this chapter shall be called the “Minnesota Health Act.” Defines six terms, including:

- Board-which refers to the Minnesota Health Board, which will act as the governing board for the Minnesota Health Plan
- Institutional provider- it means “an inpatient hospital, nursing facility, rehabilitation facility, and other health care facilities that provide overnight care
- Noninstitutional provider- means group practices and facilities such as imaging centers that do not provide overnight care, as well as individual providers

Outlaws conflicts of interest for the employees of the Minnesota Health Plan, and the Minnesota Health Board.

Section 3: Rulemaking Procedures

Exempts medical expense payment rates from the state’s formal rulemaking requirements because these rates will be negotiated, not set by administrative rule.

Article 2: Eligibility

Section 1: Eligibility

All Minnesota residents are eligible. The board shall provide residents with identification that they can use to confirm their eligibility with health care providers. Residents who are temporarily out of state are covered. Nonresidents who get medical services in Minnesota shall be billed for those services by the board. The board may extend coverage to nonresidents employed in Minnesota who pay premiums on an ability-to-pay basis. All retirees eligible for retiree benefits under a contract with an employer will continue to receive those benefits from the board provided the payments for those benefits are paid to the board.

Article 3: Benefits

Section 1: Benefits

Residents may get their care from any licensed provider. All medically necessary services are covered, including preventive services, prescription drugs, mental health care, dental services, acupuncture, long-term care services, and dialysis. Services that are not covered include:

- Services determined by the board to be not medically necessary
- Cosmetic surgery that is not necessary to correct a congenital defect or a body part damaged by injury, disease or surgery
- Private rooms in inpatient facilities unless a private room is deemed medically necessary by the patient’s provider

- Services provided by unlicensed providers.

Section 2: Care coordination

All patients shall have a primary care provider. A specialist may serve as a patient's primary care provider if the specialist and the patient agree to that arrangement.

Article 4: Funding

Section 1: Minnesota Health Fund

The fund shall receive premium payments and other sources of revenue collected according to this chapter. Money deposited in the fund shall be used exclusively to finance the Minnesota Health Plan. The fund shall be divided into three major accounts: operating, capital, and reserve accounts. The operating account shall be divided into the following accounts: medical services, prevention (meaning community prevention programs as opposed to clinical preventive services such as flu shots), planning and assessment, training and development for health care professionals, and medical research.

Section 2: Revenue sources

The board shall establish premiums for individuals and a health tax for businesses. Individual premiums will be based on ability to pay, with an individual cap. The board shall seek all necessary waivers from the federal government to permit the federal government to make payments for federal programs (such as Medicare and Medicaid) directly to the Minnesota Health Plan.

Section 3: Subrogation

When a resident who is insured under a "collateral source" receives services that are paid for by the board, the board may seek reimbursement from the collateral source. Examples of a collateral source include a health insurance policy of a visitor to Minnesota who is treated here, and a government program like Medicare if the federal government has not permitted it to be integrated into the Minnesota Health Plan.

Article 5: Payments

Section 1: Provider payments

The board shall pay noninstitutional providers according to fee schedules negotiated with providers. The board shall reimburse institutional providers with annual budgets (based on anticipated changes in services provided and prices), which shall in turn consist of operating and capital budgets. Providers (institutional or noninstitutional) who propose to make capital expenditures in excess of \$500,000 must get the approval of the board first. Institutional providers must submit requests for such capital expenditures as part of their proposed annual budget. Noninstitutional providers may submit the request for approval of such capital expenditures at any time. The board shall develop a capital management plan for the state that will serve as a guide in deciding where new capital expenditures are needed and whether to approve capital expenditure requests from particular providers.

Article 6: Governance

Section 1: Contested case procedures

The contested case provisions of the Administrative Procedure Act do not apply to the Minnesota Health Plan.

Section 2: Salary limits

The salary for the executive officer of the Minnesotan Health Plan may not exceed 95 percent of that of the governor.

Section 3: Minnesota Health Board

The Minnesota Health Board shall administer the Minnesota Health Plan. Its powers and duties include: creating the Office of Health Planning and Quality as well as the Minnesota Health Fund; conducting all necessary investigations; establishing and collecting premium payments; approving a statewide budget each year as well as budgets for each of the six regions of the state (see Section 4 below); establishing fee schedules for noninstitutional providers and budgets for institutional providers; implementing eligibility standards; evaluating the performance of the Minnesota Health Plan; ensuring the Plan promotes optimum physical and mental health; annually reporting to the Legislature; and ensuring strong public health services.

The board shall consist of 15 members, serving four-year terms, appointed by the regional boards. Eight of these members will come directly from the regional boards, and seven will be at-large members. Each of the five rural regional boards will appoint one member to the Minnesota Health Board, while the metropolitan regional board will appoint three members for a total of eight. These eight members from the regional boards will in turn appoint the seven at-large members. Two of these at-large members will be consumers, and five will be providers.

The compensation of the Board members shall not exceed the compensation of the Public Utilities Commission members.

The board is responsible for establishing a job placement and retraining program for people losing their jobs due to administrative efficiencies in the MHP. The program will give special attention to retraining and placement into health care related positions to help address the current serious shortage of providers in many health care professions. Displaced workers will receive comprehensive medical care from the MHP.

The board shall establish a Conflict of Interest Committee to ensure that the Board members, providers and medical suppliers disclose all financial interests related to doing business with the Minnesota Health Plan.

Section 4: Health planning regions

The state is divided into six planning regions. The metropolitan region includes the seven metropolitan counties. The boundaries of the five rural planning regions will be determined according to several criteria, including population and patterns of health care service utilization (in other words, where patients tend to be referred for more complex services).

Section 5: Regional health planning board

The board of the metropolitan planning region will consist of two county commissioners from each of the seven metropolitan counties. The boards of the five rural planning regions will consist of one county commissioner from each of the counties within the region. Each regional board appoints its own chair from among its members. Board members serve for four-year terms. The regional boards' duties include recommending regional operating and capital budgets to the Minnesota Health Board, and collaborating with local public health agencies to educate consumers and providers about public health programs.

Section 6: Office of Health Planning and Quality

This office shall be established by the board. This office shall make annual recommendations to the board on all aspects of the effectiveness of the Minnesota Health Plan, including ensuring access to care, improving quality, and ensuring Minnesotan has enough health care professionals and health care facilities. The office

shall also consider additional services that should be covered by the Plan (including alternative medical care services), and it must establish a process by which providers may request authorization to provide services that are not covered by the Plan, including experimental treatments.

Section 7: Ombudsman Office for Patient Advocacy

This office is created to ensure that patients get the health care they are entitled to under the laws administered by the board. The ombudsman shall be appointed by the governor “without regard to political affiliation and must be knowledgeable about and have experience in health care services and administration.” This office is independent of the Minnesota Health Board.

Section 8: Grievance system

The ombudsman shall establish a grievance system to handle all complaints by enrollees in the Minnesota Health Plan. Providers may assist patients in filing grievances without fear of retribution. The ombudsman shall send written notice of the disposition of the complaint to the enrollee within 30 days of the filing of the complaint unless the ombudsman determines that additional time is reasonably necessary to evaluate the complaint. Decisions of the ombudsman may be appealed to a district court.

Section 9: Inspector General for the Minnesota Health Plan

This office is established within the Attorney General’s office. The inspector general is appointed by the Attorney General. The inspector general shall investigate allegations of misconduct by employees and appointees of the Minnesota Health Board and by providers of goods and services paid for by the Plan, and shall investigate “patterns of medical practice that may indicate fraud and abuse.”

Section 10: Examination by Legislative Auditor

The books and policies of the board shall be subject to examination by the legislative auditor.

Article 7: Implementation

Section 1: Appropriation

An unspecified amount is appropriated for the Minnesota Health Fund to implement the provisions of this act.

Section 2: Repealer

Several statutes that will be superseded by this act are repealed.

Section 3: Effective date and transition

The Minnesota Health Plan must be operational within two years from the date of enactment of this act. Health plans may not sell policies for services provided by the Minnesota Health Plan once the Plan is operational. The commissioner of health shall designate the six health planning regions three months after this act is enacted; the regional boards shall be established six months after the date of enactment; and the Minnesota Health Board shall be established nine months after the date of enactment.

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Updated by Lisa Nilles and Laura Blubaugh Feb. 2009.