EIGHTY-FIFTH DAY

St. Paul, Minnesota, Tuesday, March 4, 2008

The Senate met at 11:00 a.m. and was called to order by the President.

CALL OF THE SENATE

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

Prayer was offered by Senator Gary W. Kubly.

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

Anderson	Erickson Ropes	Larson	Pappas	Sheran
Berglin	Fischbach	Latz	Pariseau	Sieben
Betzold	Foley	Limmer	Pogemiller	Skoe
Bonoff	Frederickson	Lourey	Prettner Solon	Skogen
Carlson	Gimse	Lynch	Rest	Sparks
Clark	Higgins	Marty	Robling	Stumpf
Cohen	Ingebrigtsen	Metzen	Rosen	Tomassoni
Dahle	Johnson	Michel	Rummel	Torres Ray
Day	Koch	Murphy	Saltzman	Vandeveer
Dibble	Koering	Olseen	Saxhaug	Wergin
Dille	Kubly	Olson, G.	Scheid	Wiger
Doll	Langseth	Olson, M.	Senjem	

The President declared a quorum present.

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

EXECUTIVE AND OFFICIAL COMMUNICATIONS

The following communications were received.

February 28, 2008

The Honorable James P. Metzen
President of the Senate

Dear Senator Metzen:

The Subcommittee on Committees of the Committee on Rules and Administration met on February 20, 2008 and noted that the following are serving by virtue of their position:

Pursuant to Minnesota Statutes 2006

Section 3.97: Legislative Audit Commission - Senator Gimse to replace Senator Neuville upon his resignation from the Senate. Senator Gimse is to serve for an indefinite term, serving until replaced or no longer a member of the Senate.

Section 243.93: Correctional Facility Site Selection Committee - Senator Ingebrigtsen to replace Senator Neuville upon his resignation from the Senate. Senator Ingebrigtsen serves at the pleasure of the appointing authority.

Sincerely,
Lawerence J. Pogemiller, Chair
Subcommittee on Committees

February 29, 2008

The Honorable James P. Metzen
President of the Senate

Dear President Metzen:

Please be advised that I have received, approved, signed and deposited in the Office of the Secretary of State, S.F. No. 2428.

Sincerely,
Tim Pawlenty, Governor

February 29, 2008

The Honorable Margaret Anderson Kelliher
Speaker of the House of Representatives

The Honorable James P. Metzen
President of the Senate

I have the honor to inform you that the following enrolled Act of the 2008 Session of the State Legislature has been received from the Office of the Governor and is deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

S.F. No.	H.F. No.	Session Laws Chapter No.	Time and Date Approved 2008	Date Filed 2008
2428		153	February 28 10:05 p.m.	February 29

Sincerely,
Mark Ritchie
Secretary of State

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following House Files, herewith transmitted: H.F. Nos. 2788 and 3201.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted March 3, 2008

FIRST READING OF HOUSE BILLS

The following bills were read the first time.

H.F. No. 2788: A bill for an act relating to the city of Nashwauk; increasing the membership of the Nashwauk Public Utilities Commission from three to five members.

Referred to the Committee on State and Local Government Operations and Oversight.

H.F. No. 3201: A bill for an act relating to financing and operation of government in this state; making policy, technical, administrative, payment, enforcement, collection, proceeds distribution, refund, and other changes to income, franchise, property, state and local sales and use, motor vehicle sales, minerals, estate, cigarette and tobacco products, gasoline, liquor, insurance premiums, mortgage and deed, healthcare gross revenues, and wheelage taxes, and other taxes and tax-related provisions; conforming to certain changes in the Internal Revenue Code; changing accelerated sales tax payments; providing for licensure of assessors; changing provisions relating to the sustainable forest resource management incentive program; providing for aids to local governments; providing for state debt collection; changing border city allocation, tax increment financing, and economic development, provisions, powers, and incentives; authorizing and providing terms and conditions related to the issuance of obligations and the financing of public improvements and services; changing and imposing powers, duties, and requirements on certain local governments and authorities and on the commissioner of revenue and other state departments and agencies; extending the time for certain publications of notices; requiring notices and publication of information; extending a petrofund fee exemption; providing for purchase of forest lands; authorizing and validating trusts to pay certain public postemployment benefits; providing for iron range higher education grants; changing revenue recapture, local impact notes, and data practices provisions; providing penalties; appropriating money; amending Minnesota Statutes 2006, sections 3.987, subdivision 1; 3.988, subdivision 3; 3.989, subdivisions 2, 3; 16A.103, subdivision 2; 16D.04, subdivisions 1, 2; 16D.11, subdivisions 2, 7; 62I.06, subdivision 6; 71A.04, subdivision 1; 97A.061, subdivision 2; 118A.03, subdivision 3; 123B.61; 127A.48, subdivision 2; 216B.1646; 270.071, subdivision 7; 270.072, subdivisions 2, 3, 6; 270.074, subdivision 3; 270.076, subdivision 1; 270.41, subdivisions 1, 2, 3, 5, by adding a subdivision; 270.44; 270.45; 270.46; 270.47; 270.48; 270.50; 270A.03, subdivision 2; 270A.10; 270C.306; 270C.34, subdivision 1; 270C.446, subdivision 2; 270C.56, subdivision 1; 270C.63, subdivision 9; 272.02, by adding subdivisions; 272.115, subdivision 1; 273.05, by adding a subdivision; 273.111, subdivision 3; 273.117; 273.121; 273.124, subdivision 13, by adding a subdivision; 273.125, subdivision 8; 273.128, subdivision 1; 273.13, subdivisions 22, 24, 25, by adding a subdivision; 273.1315; 273.1398, subdivision

4; 273.33, subdivision 2; 273.37, subdivision 2; 273.371, subdivision 1; 274.01, subdivision 1; 274.13, subdivision 1; 275.025, subdivision 3; 275.065, subdivision 5a, by adding a subdivision; 275.066; 275.067; 275.61, subdivision 1; 276.04, subdivision 2, by adding a subdivision; 276A.01, subdivision 3; 276A.04; 277.01, subdivision 2; 278.05, subdivision 6; 279.01, subdivision 1; 279.37, subdivision 1a; 280.39; 287.22; 287.2205; 289A.02, subdivision 7; 289A.08, subdivision 11; 289A.09, subdivision 2; 289A.12, subdivisions 4, 14; 289A.18, subdivision 1; 289A.20, subdivision 4; 289A.38, subdivision 7; 289A.40, subdivision 2; 289A.56, by adding a subdivision; 289A.60, subdivisions 8, 12, 15, 25, 27, by adding subdivisions; 290.01, subdivisions 19a, 19c, 19d; 290.06, subdivisions 2c, 33; 290.067, subdivision 2b; 290.0671, subdivision 7; 290.0677, subdivision 1; 290.091, subdivisions 2, 3; 290.0921, subdivision 3; 290.10; 290.17, subdivision 2; 290.191, subdivision 8; 290.92, by adding a subdivision; 290A.03, subdivision 7; 290B.03, subdivision 2; 290C.02, subdivision 3; 290C.04; 290C.05; 290C.07; 290C.11; 291.005, subdivision 1; 291.215, subdivision 1; 295.52, subdivisions 4, 4a; 295.54, subdivision 2; 296A.18, subdivision 4; 297A.61, subdivisions 3, 4, 7, 10, 24, by adding subdivisions; 297A.63, subdivision 1; 297A.665; 297A.668, by adding a subdivision; 297A.669, subdivisions 3, 13, 14, by adding subdivisions; 297A.67, subdivisions 7, 8, 9; 297A.68, subdivisions 11, 16, 35; 297A.69, subdivision 2; 297A.70, subdivision 7, by adding a subdivision; 297A.72; 297A.90, subdivision 2; 297A.99, subdivision 1; 297B.035, subdivision 1; 297F.06, subdivision 4; 297F.09, subdivision 10; 297F.21, subdivision 3; 297F.25, by adding a subdivision; 297G.09, subdivision 9; 297I.06, subdivisions 1, 2; 297I.15, by adding a subdivision; 297I.20, subdivision 2; 297I.40, subdivision 5; 298.22, by adding a subdivision; 298.2214, subdivision 2; 298.24, subdivision 1; 298.25; 298.28, subdivisions 4, 5, by adding a subdivision; 298.282, subdivision 1; 298.292, subdivision 2; 298.296, subdivision 2; 298.2961, subdivisions 4, 5; 298.75, subdivisions 1, 3, 7, by adding a subdivision; 331A.05, subdivision 2; 360.031; 365A.02; 365A.04; 365A.08; 365A.095; 373.01, subdivision 3; 373.40, subdivision 4; 375B.09; 383A.80, subdivision 4; 383A.81, subdivisions 1, 2; 383B.117, subdivision 2; 383B.77, subdivisions 1, 2; 383B.80, subdivision 4; 410.32; 412.301; 435.193; 453A.02, subdivision 3; 469.169, by adding a subdivision; 469.1734, subdivision 6; 469.174, subdivisions 10, 10a; 469.175, subdivisions 1, 3; 469.176, subdivisions 1, 2, 4l, 7; 469.1761, subdivision 1; 469.1763, subdivision 2; 469.177, subdivision 1; 469.178, subdivision 7; 469.1791, subdivision 3; 473.39, by adding subdivisions; 475.51, subdivision 4; 475.52, subdivision 6; 475.53, subdivision 1; 475.58, subdivisions 1, 3b; 477A.011, subdivision 36; 477A.013, subdivisions 8, 9; Minnesota Statutes 2007 Supplement, sections 270A.03, subdivision 5; 272.02, subdivision 64; 273.124, subdivision 14; 275.065, subdivision 3; 290.01, subdivisions 19, 19b, 31; 290A.03, subdivision 15; 424A.10, subdivision 3; Laws 1973, chapter 393, section 1, as amended; Laws 1980, chapter 511, section 1, subdivision 2, as amended; Laws 1988, chapter 645, section 3, as amended; Laws 1989, chapter 211, section 8, subdivision 4, as amended; Laws 1993, chapter 375, article 9, section 45, subdivisions 2, as amended, 3, as amended, 4, as amended; Laws 1994, chapter 587, article 9, section 14, subdivisions 1, 2, 3; Laws 1995, chapter 264, article 5, sections 44, subdivision 4, as amended; 45, subdivision 1, as amended; Laws 1999, chapter 243, article 4, section 18, subdivisions 1, 3, 4; Laws 2003, chapter 128, article 1, section 172, as amended; Laws 2005, First Special Session chapter 3, article 5, section 39; article 10, section 23, as amended; Laws 2006, chapter 259, article 11, section 3; proposing coding for new law in Minnesota Statutes, chapters 270; 270C; 273; 274; 290C; 297A; 360; 383C; 383D; 383E; 471; 475; repealing Minnesota Statutes 2006, sections 16A.1522; 163.051, subdivision 5; 270.073; 270.41, subdivision 4; 270.43; 270.51; 270.52; 270.53; 295.60; 297A.61, subdivision 20; 297A.668, subdivision 6; 297A.67, subdivision 22; 469.174, subdivision 29; Laws 1973, chapter 393, section 2; Laws 1994, chapter 587, article 9, section 8, subdivision 1, as amended; Laws 1998, chapter 389, article 11, section 18.

Referred to the Committee on Taxes.

REPORTS OF COMMITTEES

Senator Pogemiller moved that the Committee Reports at the Desk be now adopted, with the exception of the report pertaining to the appointment. The motion prevailed.

Senator Prettner Solon from the Committee on Energy, Utilities, Technology and Communications, to which was referred

S.F. No. 1918: A bill for an act relating to telecommunications; setting certain goals; providing for a broadband policy director and advisory board; amending Minnesota Statutes 2006, sections 237.011; 237.082; 237.16, subdivision 9; proposing coding for new law in Minnesota Statutes, chapter 237.

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

Delete everything after the enacting clause and insert:

"Section 1. **ULTRA HIGH-SPEED BROADBAND GOAL TASK FORCE.**

Subdivision 1. **Establishment; membership.** (a) The governor shall convene an Ultra High-Speed Broadband Task Force to make recommendations to the governor and the legislature regarding the creation of a state ultra high-speed broadband goal and a plan to implement that goal.

(b) The Ultra High-Speed Broadband Task Force consists of:

(1) one member representing higher educational systems, and one member representing K-12 institutions or consortia;

(2) one member representing health care institutions located in the metropolitan area, and one member representing health care institutions located in rural areas;

(3) one member representing telephone companies located in the metropolitan area, and one member representing telephone companies located in rural areas;

(4) one member representing cable communications systems providers located in the metropolitan area, and one member representing cable communications systems providers located in rural areas;

(5) one member representing Internet service providers;

(6) one member representing metropolitan area Minnesota counties, and one member representing rural area Minnesota counties;

(7) two members representing Minnesota cities, including one member representing metropolitan area cities, and one member representing rural area Minnesota cities;

(8) four citizen-at-large members representing Internet users, equally divided between business and residential users;

(9) one member representing a labor organization representing communications workers;

(10) the commissioner of commerce or the commissioner's designee;

(11) the commissioner of employment and economic development or the commissioner's designee; and

(12) the commissioner of administration or the commissioner's designee.

For the purposes of this paragraph, "metropolitan area" means the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, and "rural area" means an area outside of the metropolitan area.

(c) The governor shall appoint the members described in paragraph (b), clauses (1) to (9) and shall designate one of the citizen-at-large members to serve as chair of the task force who shall convene the first meeting after all members have been appointed.

(d) The Department of Commerce shall provide logistical and administrative support to the task force.

(e) By November 1, 2009, the task force shall submit a report to the governor and the chairs and ranking minority members of the senate and house committees with primary jurisdiction over telecommunications policy containing recommendations, including possible legislation, for the development of a comprehensive statewide plan designed to achieve a state ultra high-speed broadband goal that the task force considers appropriate. The report must include, at a minimum:

(1) a description of the policies and actions necessary to achieve the goal, including the elimination of obstacles to investment;

(2) a description of the opportunities for the public and private sectors to cooperate to achieve the goal;

(3) an evaluation of strategies, financing methods, and financial incentives used in other states and countries to support the deployment of high-speed broadband;

(4) an evaluation and recommendation of the security, vulnerability, and redundancy actions necessary to ensure the reliability of ultra high-speed broadband;

(5) a description of economic development opportunities made possible by the wide dissemination of ultra high-speed broadband; and

(6) an evaluation of how access to ultra high-speed broadband can benefit educational institutions, healthcare institutions, community-based organizations, and government institutions.

Subd. 2. **Expiration.** This section expires March 1, 2010.

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

Delete the title and insert:

"A bill for an act relating to telecommunications; creating the Ultra High-Speed Broadband Task Force."

And when so amended the bill do pass and be re-referred to the Committee on State and Local Government Operations and Oversight. Amendments adopted. Report adopted.

Senator Prettner Solon from the Committee on Energy, Utilities, Technology and Communications, to which was referred

S.F. No. 2939: A bill for an act relating to telecommunications; modifying provisions relating to alternative regulation plans; amending Minnesota Statutes 2006, section 237.766, by adding a subdivision.

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

Page 2, after line 4, insert:

"(f) Within 30 days of the electing company filing notice to the commission, interested parties may file comments identifying any aspect of the adoption that the party believes is contrary to the public interest. Reply comments may be filed within 45 days following the notice to the commission. The commission shall accept the adoption unless it finds adoption of the existing plan by the electing telephone company is not in the public interest, in which case it may reject or modify the election to opt into the provisions of the existing plan. If the commission modifies the election, the electing company may withdraw its proposed adoption of the existing plan by filing notice with the commission within 30 days of the commission's modification order."

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

Senator Prettner Solon from the Committee on Energy, Utilities, Technology and Communications, to which was referred

S.F. No. 2262: A bill for an act relating to telecommunications; repealing certain obsolete rules; repealing Minnesota Rules, parts 7810.0800; 7810.1000; 7810.2700; 7810.2800; 7810.4000; 7810.4100; 7810.4300; 7810.5000; 7810.5100; 7810.5200; 7810.5300; 7810.5400; 7810.5500; 7810.5700; 7810.5800; 7810.5900; 7810.6200; 7810.6300; 7810.6400; 7810.6500; 7810.6600; 7810.6800.

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

Delete everything after the enacting clause and insert:

"Section 1. **REPEALER.**

Minnesota Rules, parts 7810.0800; 7810.1300; 7810.2700; 7810.4000; 7810.5700; 7810.6200; 7810.6300; and 7810.6500, are repealed."

Amend the title numbers accordingly

And when so amended the bill do pass and be placed on the Consent Calendar. Amendments adopted. Report adopted.

Senator Moua from the Committee on Judiciary, to which was re-referred

S.F. No. 2988: A bill for an act relating to pupil transportation; establishing qualifications for type III school bus drivers; providing criminal penalties; authorizing rulemaking; amending Minnesota Statutes 2006, sections 169.454, subdivision 13; 169A.31; 171.02, by adding subdivisions.

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

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2007 Supplement, section 169.443, subdivision 9, is amended to read:

Subd. 9. **Personal cellular phone call prohibition.** (a) As used in this subdivision, "school bus" has the meaning given in section 169.01, subdivision 6. In addition, the term includes type III school buses as described in section 169.01, subdivision 6, clause (5), when driven by employees or agents of school districts for nonscheduled or nonregular transportation.

(b) A school bus driver may not operate a school bus while communicating over, or otherwise operating, a cellular phone for personal reasons, whether hand-held or hands free, when the vehicle is in motion.

EFFECTIVE DATE. This section is effective August 1, 2008, and applies to crimes committed on or after that date.

Sec. 2. Minnesota Statutes 2006, section 169A.03, subdivision 23, is amended to read:

Subd. 23. **School bus.** "School bus" has the meaning given in section 169.01, subdivision 6. In addition, the term includes type III school buses as described in section 169.01, subdivision 6, clause (5), when driven by employees or agents of school districts for nonscheduled or nonregular transportation.

EFFECTIVE DATE. This section is effective August 1, 2008, and applies to crimes committed on or after that date.

Sec. 3. Minnesota Statutes 2006, section 171.02, is amended by adding a subdivision to read:

Subd. 2b. **Exception for type III school bus drivers.** (a) Notwithstanding subdivision 2, paragraph (c), the holder of a class D driver's license, without a school bus endorsement, may operate a type III school bus described in section 169.01, subdivision 6, clause (5), under the conditions in paragraphs (b) through (n).

(b) The operator is an employee of the entity that owns, leases, or contracts for the school bus.

(c) The operator's employer has adopted and implemented a policy that provides for annual training and certification of the operator in:

(1) safe operation of a type III school bus;

(2) understanding student behavior, including issues relating to students with disabilities;

(3) encouraging orderly conduct of students on the bus and handling incidents of misconduct appropriately;

(4) knowing and understanding relevant laws, rules of the road, and local school bus safety policies;

(5) handling emergency situations;

(6) proper use of seat belts and child safety restraints;

(7) performance of pretrip vehicle inspections; and

(8) safe loading and unloading of students, including, but not limited to:

(i) utilizing a safe location for loading and unloading students at the curb, on the nontraffic side of the roadway, or at off-street loading areas, driveways, yards, and other areas to enable the student to avoid hazardous conditions;

(ii) refraining from loading and unloading students in a vehicular traffic lane, on the shoulder, in a designated turn lane, or a lane adjacent to a designated turn lane;

(iii) avoiding a loading or unloading location that would require a pupil to cross a road, or ensuring that the driver or an aide personally escort the pupil across the road if it is not reasonably feasible to avoid such a location; and

(iv) placing the type III school bus in "park" during loading and unloading.

(d) A background check or background investigation of the operator has been conducted that meets the requirements under section 122A.18, subdivision 8, or 123B.03 for school district employees; section 144.057 or chapter 245C for day care employees; or section 171.321, subdivision 3, for all other persons operating a type A or type III school bus under this subdivision.

(e) Operators shall submit to a physical examination as required by section 171.321, subdivision 2.

(f) The operator's employer has adopted and implemented a policy that provides for mandatory drug and alcohol testing of applicants for operator positions and current operators, in accordance with section 181.951, subdivisions 2, 4, and 5.

(g) The operator's driver's license is verified annually by the entity that owns, leases, or contracts for the school bus.

(h) A person who sustains a conviction, as defined under section 609.02, of violating section 169A.25, 169A.26, 169A.27, or 169A.31, or whose driver's license is revoked under sections 169A.50 to 169A.53 of the implied consent law, or who is convicted of or has their driver's license revoked under a similar statute or ordinance of another state, is precluded from operating a type III school bus for five years from the date of conviction.

(i) A person who has ever been convicted of a disqualifying offense as defined in section 171.3215, subdivision 1, paragraph (c), may not operate a type III school bus under this subdivision.

(j) A person who sustains a conviction, as defined under section 609.02, of a moving offense in violation of chapter 169 within three years of the first of three other moving offenses is precluded from operating a type III school bus for one year from the date of the last conviction.

(k) An operator who sustains a conviction as described in paragraph (h), (i), or (j) while employed by the entity that owns, leases, or contracts for the school bus, shall report the conviction to the employer within ten days of the date of the conviction.

(l) Students riding the type III school bus must have training required under section 123B.90, subdivision 2.

(m) Documentation of meeting the requirements listed in this subdivision must be maintained under separate file at the business location for each type III school bus operator. The business manager, school board, governing body of a nonpublic school, or any other entity that owns, leases, or contracts for the type III school bus operating under this subdivision is responsible for maintaining these files for inspection.

(n) The type III school bus must bear a current certificate of inspection issued under section 169.451.

(o) An operator employed by a school or school district, whose normal duties do not include operating a type III school bus, who holds a class D driver's license without a school bus endorsement, may operate a type III school bus and is exempt from paragraphs (d), (e), (f), (g), and (k).

EFFECTIVE DATE. This section is effective September 1, 2008.

Sec. 4. Minnesota Statutes 2006, section 171.02, is amended by adding a subdivision to read:

Subd. 2c. **Rulemaking.** The commissioner may adopt rules regarding the qualifications and requirements for drivers of type III school buses.

EFFECTIVE DATE. This section is effective August 1, 2008."

Delete the title and insert:

"A bill for an act relating to pupil transportation; establishing qualifications for type III school bus drivers; providing criminal penalties; authorizing rulemaking; amending Minnesota Statutes 2006, sections 169A.03, subdivision 23; 171.02, by adding subdivisions; Minnesota Statutes 2007 Supplement, section 169.443, subdivision 9."

And when so amended the bill do pass and be re-referred to the Committee on State and Local Government Operations and Oversight. Amendments adopted. Report adopted.

Senator Moua from the Committee on Judiciary, to which was referred

S.F. No. 2790: A bill for an act relating to corrections; authorizing deferral of judgment for certain drug offenses; repealing the sunset on early release of nonviolent controlled substance offenders; requiring the commissioner of corrections to develop a marketing plan for MINNCOR industries; defining long-term homelessness to include persons released from incarceration for purposes of receiving supportive services; granting the Department of Corrections access to DEED preconfinement data on inmates; providing a tax credit to employers that employ persons with criminal records; requiring the commissioner of corrections to study re-entry facilities and programming; increasing funding for chemical and mental health treatment for inmates and probationers; creating a certificate of rehabilitation; establishing a task force to study and recommend approaches for developing a re-entry court pilot program; establishing a controlled substance law working group; requiring the commissioner of corrections to conduct an internal review of parole and supervised release procedures and sanctions; appropriating money; amending Minnesota Statutes 2006, sections 152.18, subdivision 1; 241.27, by adding a subdivision; 256K.26, subdivision 3; 290.06, by adding a subdivision; 611A.06, subdivision 1a; Minnesota Statutes 2007 Supplement, section 268.19, subdivision 1; proposing coding for new law in Minnesota Statutes,

chapter 364; repealing Minnesota Statutes 2006, section 244.055, subdivision 11.

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

Page 3, delete sections 3 and 4

Page 5, delete section 5 and insert:

"Sec. 3. Minnesota Statutes 2006, section 364.03, subdivision 3, is amended to read:

Subd. 3. **Evidence of rehabilitation.** (a) A person who has been convicted of a crime or crimes which directly relate to the public employment sought or to the occupation for which a license is sought shall not be disqualified from the employment or occupation if the person can show competent evidence of sufficient rehabilitation and present fitness to perform the duties of the public employment sought or the occupation for which the license is sought. Sufficient evidence of rehabilitation may be established by the production of a certificate of good conduct under section 364.20 or:

(1) a copy of the local, state, or federal release order; and

(2) evidence showing that at least one year has elapsed since release from any local, state, or federal correctional institution without subsequent conviction of a crime; and evidence showing compliance with all terms and conditions of probation or parole; or

(3) a copy of the relevant Department of Corrections discharge order or other documents showing completion of probation or parole supervision.

(b) In addition to the documentary evidence presented, the licensing or hiring authority shall consider any evidence presented by the applicant regarding:

(1) the nature and seriousness of the crime or crimes for which convicted;

(2) all circumstances relative to the crime or crimes, including mitigating circumstances or social conditions surrounding the commission of the crime or crimes;

(3) the age of the person at the time the crime or crimes were committed;

(4) the length of time elapsed since the crime or crimes were committed; and

(5) all other competent evidence of rehabilitation and present fitness presented, including, but not limited to, letters of reference by persons who have been in contact with the applicant since the applicant's release from any local, state, or federal correctional institution.

Sec. 4. Minnesota Statutes 2006, section 364.09, is amended to read:

364.09 EXCEPTIONS.

(a) This chapter does not apply to the licensing process for peace officers~~;~~, to law enforcement agencies as defined in section 626.84, subdivision 1, paragraph (f)~~;~~, or to fire protection agencies~~;~~. Sections 364.01 to 364.10 do not apply to eligibility for a private detective or protective agent license; to the licensing and background study process under chapters 245A and 245C; to eligibility for school bus driver endorsements; to eligibility for special transportation service endorsements; to eligibility for a commercial driver training instructor license, which is governed by section 171.35

and rules adopted under that section; to emergency medical services personnel, or to the licensing by political subdivisions of taxicab drivers, if the applicant for the license has been discharged from sentence for a conviction within the ten years immediately preceding application of a violation of any of the following:

(1) sections 609.185 to 609.21, 609.221 to 609.223, 609.342 to 609.3451, or 617.23, subdivision 2 or 3;

(2) any provision of chapter 152 that is punishable by a maximum sentence of 15 years or more; or

(3) a violation of chapter 169 or 169A involving driving under the influence, leaving the scene of an accident, or reckless or careless driving.

This chapter also shall not apply to eligibility for juvenile corrections employment, where the offense involved child physical or sexual abuse or criminal sexual conduct.

(b) ~~This chapter does~~ Sections 364.01 to 364.10 do not apply to a school district or to eligibility for a license issued or renewed by the Board of Teaching or the commissioner of education.

(c) Nothing in this section precludes the Minnesota Police and Peace Officers Training Board or the state fire marshal from recommending policies set forth in this chapter to the attorney general for adoption in the attorney general's discretion to apply to law enforcement or fire protection agencies.

(d) ~~This chapter does~~ Sections 364.01 to 364.10 do not apply to a license to practice medicine that has been denied or revoked by the Board of Medical Practice pursuant to section 147.091, subdivision 1a."

Page 8, line 12, after "professional" insert "or occupational"

Page 10, line 8, delete "chair"

Page 10, delete line 9

Page 10, line 10, delete "Budget Division" and insert "speaker of the house of representatives and the Subcommittee on Committees of the senate Rules and Administration Committee, taking into consideration the recommendations of the chairs and ranking minority members of the senate and house committees and divisions having jurisdiction over criminal justice and policy funding,"

Page 10, line 14, delete "two" and insert "three" and after "associations" insert ", including one sheriff, one chief of police, and one member of the Minnesota Police and Peace Officers Association"

Page 10, line 16, delete "two representatives" and insert "one representative" and delete "and" and insert "or"

Page 10, line 17, delete "two experts" and insert "one expert"

Page 10, line 18, delete "three individuals who are" and insert "one individual who is"

Page 10, line 19, delete "have" and insert "has"

Page 10, line 21, delete "two" and insert "four" and delete "an area" and insert "areas"

Page 11, line 18, delete "chair of the house Public Safety Finance Division and the chair of"

Page 11, line 19, delete "the senate Public Safety Budget Division" and insert "chairs and ranking minority members of the house of representatives and senate committees and divisions having jurisdiction over criminal justice policy and funding"

Page 11, line 30, delete "December 1, 2008" and insert "February 1, 2009"

Page 12, delete section 12

Renumber the sections in sequence

Amend the title as follows:

Page 1, line 5, delete everything after the semicolon

Page 1, delete lines 6 to 8

Page 1, line 9, delete everything before "requiring"

Page 1, line 15, delete "appropriating money;"

Amend the title numbers accordingly

And when so amended the bill do pass and be re-referred to the Committee on State and Local Government Operations and Oversight. Amendments adopted. Report adopted.

Senator Moua from the Committee on Judiciary, to which was re-referred

S.F. No. 2369: A bill for an act relating to education; requiring criminal history background checks; amending Minnesota Statutes 2006, section 123B.03, subdivision 1.

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

Page 2, line 36, delete "elects" and insert "is hired"

Page 3, line 1, delete everything after "district" and insert a period

Page 3, delete lines 2 to 4

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

Senator Moua from the Committee on Judiciary, to which was re-referred

S.F. No. 1965: A bill for an act relating to human services; expanding the situations in which the commissioner of human services must consider granting a variance from a licensure disqualification; amending Minnesota Statutes 2006, section 245C.24, subdivision 2.

Reports the same back with the recommendation that the bill do pass. Report adopted.

Senator Pogemiller, from the Committee on Rules and Administration, to which was referred

H.F. No. 3055 for comparison with companion Senate File, reports the following House File was found identical and recommends the House File be given its second reading and substituted for

its companion Senate File as follows:

GENERAL ORDERS		CONSENT CALENDAR		CALENDAR	
H.F. No.	S.F. No.	H.F. No.	S.F. No.	H.F. No.	S.F. No.
3055	2766				

and that the above Senate File be indefinitely postponed.

Pursuant to Rule 45, this report was prepared and submitted by the Secretary of the Senate on behalf of the Committee on Rules and Administration. Report adopted.

Senator Moua from the Committee on Judiciary, to which was referred the following appointment:

BOARD ON JUDICIAL STANDARDS
Randy R. Staver

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

Senator Pogemiller moved that the foregoing committee report be laid on the table. The motion prevailed.

Senator Marty from the Committee on Health, Housing and Family Security, to which was referred

S.F. No. 3099: A bill for an act relating to public health; increasing affordability and continuity of care for state health care programs; modifying health care provisions; establishing a public health access fund; increasing the tobacco impact fees; providing subsidies for employee share of employer-subsidized insurance; establishing the Minnesota Health Insurance Exchange; requiring certain employers to offer Section 125 Plan; creating an affordability standard; requiring mandated reports; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2006, sections 16A.725, subdivision 1; 62A.65, subdivision 3; 62E.141; 62L.12, subdivisions 2, 4; 256.01, by adding a subdivision; 256.9658, subdivisions 3, 9; 256B.061; 256B.69, by adding a subdivision; 256D.03, by adding a subdivision; 256L.05, by adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivision 3; 256L.15, by adding a subdivision; Minnesota Statutes 2007 Supplement, sections 13.46, subdivision 2; 256B.056, subdivision 10; 256L.03, subdivisions 3, 5; 256L.04, subdivisions 1, 7; 256L.05, subdivision 3a; 256L.07, subdivision 1; 256L.15, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 16A; 145; 256B; proposing coding for new law as Minnesota Statutes, chapter 62U; repealing Minnesota Statutes 2006, section 256L.15, subdivision 3.

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

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

PUBLIC HEALTH

Section 1. **[16A.726] HEALTH IMPROVEMENT FUND.**

Subdivision 1. **Health improvement fund.** There is created in the state treasury a public health improvement fund to which must be credited revenue from the health improvement assessment under section 145.9865. The fund is a direct appropriated special revenue fund. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the health improvement fund not currently needed shall be credited to the public health improvement fund.

Subd. 2. **Fund reimbursements.** Money in the health improvement fund shall be appropriated for the statewide health improvement program under section 145.986.

Sec. 2. **[145.986] STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

Subdivision 1. **Goals.** It is the goal of the state to substantially reduce the percentage of Minnesotans who are obese or overweight, use tobacco, or misuse alcohol.

Subd. 2. **Grants to local communities.** (a) Beginning January 1, 2009, the commissioner of health shall award grants to community health boards established pursuant to section 145A.09, and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight, use tobacco, or misuse alcohol.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, worksite, and health care settings; and

(5) be focused on policy, systems, and environmental changes that support healthy behaviors.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. The funding phases for grants shall be:

(1) initiation phase, during which the grant recipient will complete a community needs assessment, establish a community leadership team, identify community consortium members, and complete a staffing plan;

(2) planning phase, during which the grant recipient will complete a community action plan and an evaluation plan, and will identify strengths and weaknesses, technical assistance needs, partners, and additional funding resources; and

(3) implementation phase, during which the grant recipient will implement the community action plan, evaluate the effectiveness of the interventions, and modify or discontinue interventions found to be ineffective.

Grant recipients shall not receive funding at the planning phase level until all the activities of the initiation phase have been completed and approved by the commissioner. Grant recipients shall not receive funding at the implementation phase level until all activities at the planning phase have been completed and approved by the commissioner.

(d) Grant recipients in the initiation and planning phases shall receive funding at a standard base amount to be established by the commissioner. Grant recipients in the implementation phase shall receive the standard base amount and a standard per capita amount to be established by the commissioner. By January 15, 2011, the commissioner of health shall recommend whether any funding should be distributed to community health boards and tribal governments based on health disparities demonstrated in the populations served.

(e) Grant recipients in all phases shall report their activities and their progress towards the outcomes established under subdivision 3 to the commissioner in a format and at a time specified by the commissioner.

(f) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 3. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

Subd. 3. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet the goals specified in subdivision 1, and annually review the progress of grant recipients in meeting the outcomes.

(b) The commissioner shall measure current public health status, using existing measures and data collection systems when available, to determine baseline data against which progress shall be monitored.

Subd. 4. **Technical assistance and oversight.** The commissioner shall provide content expertise, technical expertise, and training to grant recipients. The commissioner shall ensure that the statewide health improvement program meets the outcomes established under subdivision 3 by conducting a comprehensive statewide evaluation and assisting grant recipients to modify or discontinue interventions found to be ineffective.

Subd. 5. **Evaluation.** Using the outcome measures established in subdivision 3, the commissioner shall conduct a biennial evaluation of the statewide health improvement program funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation.

Subd. 6. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010.

Subd. 7. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs that work to reduce the percentage of Minnesotans who are obese or overweight, use tobacco, or misuse alcohol, or replace discontinued state or federal funds previously used to reduce the percentage of Minnesotans who are obese or overweight, use tobacco, or misuse alcohol. Funds must not be used to supplant current state or local funding to community health boards or tribal governments used to reduce the percentage of Minnesotans who are obese or overweight, use tobacco, or misuse alcohol.

Sec. 3. **[145.9865] PUBLIC HEALTH IMPROVEMENT ASSESSMENT.**

Subdivision 1. **Hospital assessment.** (a) By June 1, 2009, each Minnesota hospital, except facilities of the federal Indian Health Service and regional treatment centers, shall contribute ... percent of net patient revenue excluding net Medicare revenue for calendar year 2008 as reported by that hospital to the health care cost information system under section 144.698 to the health improvement fund established under section 16A.726.

(b) By June 1, 2010, and each June 1 thereafter, each Minnesota hospital, except facilities of the federal Indian Health Service and regional treatment centers, shall contribute an equal percentage, as determined by the commissioner, of net patient revenue excluding net Medicare revenue for the previous calendar year as reported by that hospital to the health care cost information system to the health improvement fund. The commissioner shall annually adjust this percentage to ensure a total of $40,000,000 in annual contributions from hospitals under this subdivision and nonprofit health plan companies under subdivision 2.

(c) The commissioner shall notify each hospital by May 1 of each year of the contribution due by June 1. If for any year, data needed to determine actual net patient revenue for the previous calendar year is not available in time to determine the contribution due, the commissioner may estimate net patient revenue for the purposes of this section until actual data is available, and any necessary adjustments shall be made.

(d) The contributions shall be collected by the commissioner and deposited in the health improvement fund established under section 16A.726. Any contributions under this section may be applied toward a hospital's community benefit as reported under section 144.669.

(e) Notwithstanding the Medicare cost findings and allowable cost principles, the public health improvement assessment is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

Subd. 2. **Health plan company assessment.** (a) By June 1, 2009, each nonprofit health plan company shall contribute ... percent of the total premium revenues of the nonprofit health plan company for calendar year 2008 as reported to the commissioner.

(b) By June 1, 2010, and each June 1 thereafter, each nonprofit health plan company shall contribute an equal percentage, as determined by the commissioner, of the total premium revenues of the nonprofit health plan company for the previous calendar year. The commissioner shall annually adjust this percentage to ensure a total of $40,000,000 in annual contributions from nonprofit health plan companies under this subdivision and hospitals under subdivision 1.

(c) The commissioner shall notify each nonprofit health plan company by May 1 of each year of the contribution due by June 1. If for any year, data needed to determine actual total premium revenue for the previous calendar year is not available in time to determine the contribution due, the commissioner may estimate total premium revenue for the purposes of this section until actual data is available, and any necessary adjustments shall be made.

(d) The contributions shall be collected by the commissioner and deposited in the health improvement fund established under section 16A.726. Any contributions under this section may be applied toward a nonprofit health plan company's community benefit requirements.

(e) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a nonprofit health plan company from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wrap-around subscribers for health benefits which supplement Medicare coverage; and

(3) Medicare revenue, as a result of an arrangement between a nonprofit health plan company and the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time.

(f) For purposes of this section, "nonprofit health plan company" includes a health maintenance organization operating under chapter 62D and a nonprofit health service plan corporation operating under chapter 62C.

Subd. 3. **Expiration.** This section expires July 1, 2013.

Sec. 4. **[145.987] BMI MONITORING IN CHILDREN AND YOUTH.**

By July 1, 2009, the commissioner of health shall establish and implement a program to monitor the trends of children who are overweight and obese in the state by collecting and analyzing Body Mass Index data. To the extent possible, in establishing this Body Mass Index monitoring program, the commissioner shall use existing child and youth monitoring systems or surveys. The Body Mass Index data collected shall be used to measure progress in reducing the percentage of overweight and obese children in the state, and shall be used to accurately target intervention and prevention services throughout the state. To the extent necessary for implementation and analysis, the Department of Health may share data collected under this program with the Department of Education, consistent with the requirements in Minnesota Statutes, chapter 13. Analysis of the data collected and trends of children who are overweight and obesity shall be reported annually to the legislature by the commissioner of health, beginning January 15, 2011.

Sec. 5. **APPROPRIATION.**

(a) $20,000,000 is appropriated in fiscal year 2009 from the health improvement fund to the commissioner of health for the statewide health improvement plan in Minnesota Statutes, section 145.986. Subject to the availability of funding, beginning January 1, 2009, the commissioner of health shall make grants to community health boards to implement local public health programs.

(b) $40,000,000 is appropriated in fiscal year 2010, and annually thereafter, from the health improvement fund to the commissioner of health for the statewide health improvement plan in Minnesota Statutes, section 145.986.

ARTICLE 2

HEALTH CARE HOMES

Section 1. **[256B.0431] ENROLLEE REQUIREMENTS RELATED TO HEALTH CARE**

HOMES.

Subdivision 1. **Selection of primary care clinic.** The commissioner, beginning January 1, 2009, shall require state health care program enrollees eligible for services under the fee-for-service system to select a primary care clinic or medical group, within two months of enrollment. The commissioner, beginning July 1, 2009, shall encourage enrollees who have a complex or chronic condition to select a primary care clinic or medical group at which clinicians have been certified as health care homes under section 256B.0751, subdivision 3. The commissioner and county social service agencies shall provide enrollees with lists of primary care clinics, medical groups, and clinicians certified as health care homes, and shall establish a toll-free number to provide enrollees with assistance in choosing a clinic, medical group, or health care home.

Subd. 2. **Initial health assessment.** The commissioner shall encourage state health care program enrollees eligible for services under the fee-for-service system to complete an initial health assessment at their selected primary care clinic or medical group, within one month of selection, in order to identify individuals with, or who are at risk of developing, complex or chronic health conditions, and to identify preventive health care needs.

Subd. 3. **Education and outreach.** The commissioner, beginning January 1, 2009, shall provide patient education and outreach to state health care program enrollees and potential applicants related to the importance of choosing a primary care clinic or medical group and a health care home. Education and outreach must be targeted to underserved or special populations.

Subd. 4. **State health care program.** For purposes of this section, "state health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Sec. 2. **[256B.0751] HEALTH CARE HOMES; DEFINITIONS; ESTABLISHMENT.**

Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0754, the following definitions apply.

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

(c) "Commissioners" means the commissioner of human services and the commissioner of health acting jointly.

(d) "State health care program" means the medical assistance, MinnesotaCare, or general assistance medical care programs.

Subd. 2. **Establishment of health care homes.** The commissioners shall establish health care homes for all state health care program enrollees, beginning first with enrollees who have, or are at risk of developing, complex or chronic health conditions. In establishing health care homes, the commissioners shall consider, and when appropriate incorporate, features of the medical home model developed for the primary care coordination (provider-directed care coordination) program authorized under section 256B.0625, subdivision 51.

Subd. 3. **Certification.** The commissioners shall begin certification of individual clinicians, who participate as providers in state health care programs and meet the requirements of section 256B.0752, as health care homes, by July 1, 2009. Clinicians may enter into collaborative agreements with other clinicians to develop the components of a health care home. Clinician certification as a health care home is voluntary. Clinicians certified as health care homes must

renew their certification annually, in order to maintain their status as health care homes.

Sec. 3. **[256B.0752] HEALTH CARE HOME REQUIREMENTS.**

Subdivision 1. **Requirement.** In order to be certified as a health care home, a clinician must meet the criteria specified in this section.

Subd. 2. **Patient-provider relationship; care teams.** (a) Each patient of a health care home must have an ongoing, long-term relationship with a primary care provider trained as a personal clinician to provide first contact, continuous, and comprehensive care for all of a patient's health care needs. Appropriate specialists and other health care professionals who do not practice in a traditional primary care field, and advanced practice registered nurses, must be allowed to serve as personal clinicians, if they provide care according to this section.

(b) Care must be provided using an interdisciplinary team of individuals who collectively take responsibility for the ongoing care of patients, and who practice to the full extent of their license. The interdisciplinary team must include two patient or parent partners as team members.

Subd. 3. **Care coordination.** The personal clinician and the team are responsible for providing for all the patient's health care needs or for arranging appropriate care with other qualified professionals, as part of a whole-person orientation. Health care must be coordinated across all provider types, all care locations, and the greater community. This requirement applies to care for all stages of life, including preventive care, acute care, chronic care, and end-of-life care. Care coordination must include ongoing planning to prepare for patient transitions across different types of care and provider types. The primary care team must also coordinate with those providing for the social service needs of the individual, if this is necessary to ensure a successful health outcome.

Subd. 4. **Care delivery.** (a) A health care home must provide or arrange for access to care 24-hours a day, seven days a week.

(b) Health care homes must encourage the patient and when authorized and appropriate, the family to actively participate in decision making and in health care home quality improvement initiatives, as a full member of the primary care team. Health care homes must consider patients and families as partners in decision making, and must provide access to a patient-directed, decision-making process, including appropriate decision aids, when available.

(c) Care delivery must be facilitated by the use of health information technology and through systematic patient follow-up using internal clinic patient registries.

(d) Care must be provided in a culturally and linguistically appropriate manner.

(e) Within the context of a system of continuous quality improvement, care delivery, whenever possible, must be based on evidence-based medicine and use clinical decision-support tools.

(f) A health care home must provide enhanced access to care, using methods such as open scheduling, expanded hours, and new communication methods, such as e-mail, phone consultations, and e-consults.

Subd. 5. **Quality of care.** Health care homes must meet process, outcome, and quality standards as developed and specified by the commissioners. Health care homes must measure and publicly report all data necessary for the commissioners to monitor compliance with these standards.

Subd. 6. **Comprehensive health assessment.** Health care homes must encourage enrollees to complete a comprehensive health assessment for each enrollee determined, by the initial health assessment under section 256B.0431, subdivision 2, to have, or be at risk of developing, a complex or chronic health condition. Health care homes must develop and implement a comprehensive care plan to manage complex or chronic conditions based upon the comprehensive health assessment and other information. The comprehensive care plans must meet criteria specified by the commissioners.

Subd. 7. **Care coordinators.** Health care homes must employ care coordinators to manage the care provided to patients with complex or chronic conditions specified by the commissioners. Care coordinators may be social workers, nurses, or other clinicians. Care coordinators are responsible for:

(1) identifying patients with complex or chronic conditions eligible for care coordination;

(2) assisting primary care providers in care coordination and education;

(3) helping patients coordinate their care or access needed services, including preventive care;

(4) communicating the care needs and concerns of the patient to the health care home; and

(5) collecting data on process and outcome measures.

Sec. 4. **[256B.0753] CARE COORDINATION FEE.**

Subdivision 1. **Care coordination fee.** (a) The commissioner shall pay each health care home a per-person per-month care coordination fee for providing care coordination services. The fee must be paid for each fee-for-service state health care program enrollee eligible for a health care home, who is served by a personal clinician certified as a health care home.

(b) Payment of the care coordination fee is contingent on the health care home meeting the criteria specified in this section. The care coordination fee is in addition to reimbursement received by a health care home under the medical assistance fee-for-service payment system for health care services.

Subd. 2. **Amount of fee.** The care coordination fee must not exceed an average of $50 per person per month. The care coordination fee must be determined by the commissioner, and must vary by thresholds of care complexity that include the additional time and resources needed for patients with limited English language skills, cultural differences, or other barriers to health care, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination, such as those with very complex health care needs or several chronic conditions.

Subd. 3. **Cost neutrality.** The commissioner may reduce payment rates for nonprimary care services, if initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner.

Sec. 5. **[256B.0754] DUTIES OF THE COMMISSIONERS.**

Subdivision 1. **Establishment of certification standards and other criteria.** (a) The commissioners, by January 1, 2009, shall establish certification standards for health care homes consistent with the criteria in section 256B.0752.

(b) The commissioners, by January 1, 2009, shall develop care complexity thresholds and

payment amounts for the care coordination fee established under section 256B.0753.

(c) The commissioners, by January 1, 2009, shall identify criteria to determine enrollees eligible for and in need of care coordination, and who would benefit from having a comprehensive care plan for their condition.

(d) The commissioners, by January 1, 2009, shall establish criteria and data collection procedures for evaluating health care homes.

(e) The commissioners, by January 1, 2009, shall develop health care home requirements for managed care plan contracts, performance incentives, and withholds, and shall develop the methodology for identifying and recapturing managed care savings resulting from implementation of the health care home model.

Subd. 2. **Monitoring and evaluation.** The commissioners shall ensure the collection from health care homes of data necessary to monitor implementation of the health care home model, measure and evaluate quality of care and outcomes, measure and evaluate patient experience, and determine cost savings from implementation of the health care home model. The commissioners shall collect and evaluate this data directly, but may contract with an appropriate private sector entity for technical assistance. The commissioners shall provide health care homes with practice profiles measuring utilization, cost, and quality.

Subd. 3. **Care Coordination Advisory Committee.** The commissioners, by July 1, 2008, shall establish a Care Coordination Advisory Committee to assist the Departments of Human Services and Health in administering the health care home model, developing the criteria and standards required under subdivision 1, collecting data, and measuring and evaluating health outcomes and cost savings. The commissioners may satisfy this requirement by continuing the advisory committee established for the provider-directed care coordination (primary care coordination) program. If newly established, the committee must include representatives of: primary care and specialist physicians, advanced practice registered nurses, patients and their families, health plans, the Institute for Clinical Systems Improvement, Minnesota Community Measurement, and other relevant entities.

Subd. 4. **Health care home collaborative.** The commissioners, by July 1, 2009, shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 5. **Patient-directed, decision-making process.** By January 1, 2009, the commissioners, in consultation with the care coordination advisory council and the Institute of Clinical Systems Improvement, shall develop a patient-directed, decision-making support model to be used by health care homes. The commissioners shall:

(1) establish protocols that include identifying the use of a patient-directed, decision-making process and incorporating effectively the use of patient-decision aids, when appropriate;

(2) ensure the quality of the patient-decision aids available to the patient;

(3) ensure accessibility of the patient-decision aids, including the use of translators, when necessary; and

(4) ensure that providers are trained to use patient-decision aids effectively.

Subd. 6. **Annual reports.** Beginning December 15, 2009, and each December 15 thereafter, the commissioners shall report to the legislature on the implementation and administration of the health care home model for state health care program enrollees in both the fee-for-service and managed care sectors. The report must include information on the number of state health care program enrollees in health care homes, the number and characteristics of enrollees with complex or chronic conditions, the number and geographic distribution of health care home providers, the performance and quality of care of health care homes, measures of preventive care, costs related to implementation and payment of care coordination fees, health care home payment arrangements for managed care plans, and estimates of savings from implementation of the health care home model for both the fee-for-service and managed care sectors relative to the health care spending baseline calculated under section 62U.13.

Sec. 6. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 29. **Health care home model.** (a) The commissioner shall require managed care plans, as a condition of contract, to adopt by July 1, 2009, a health care home model for providing care to state health care program enrollees who have or are at risk of developing a complex or chronic health condition. The health care home model must meet the criteria specified in this section and section 256B.0752. The commissioner, in consultation with the commissioner of health, may waive or modify criteria for managed care plans, if the commissioners determine that performance and quality standards would still be met.

(b) The commissioners shall require managed care plans to: (1) collect from health care homes data necessary to monitor implementation of the health care home model, measure and evaluate quality of care and outcomes, measure and evaluate patient experience, and determine cost-savings from implementation of the health care home model; and (2) submit this data to the commissioners. The commissioners shall provide managed care plans and their health care homes with practice profiles measuring utilization, cost, and quality.

(c) The commissioner, beginning July 1, 2009, shall provide a performance incentive for expenses related to the operation of health care homes that would reimburse upfront costs related to implementation of health care homes after a one-year lag. The commissioners shall establish quality and performance standards for health care homes, and beginning July 1, 2009, these standards shall be subject to the capitation rate withhold under subdivision 5a, paragraph (c).

(d) Managed care plans must encourage state health care program enrollees to complete an initial health assessment within three months from the time of enrollment, in order to identify individuals with, or who are at risk of developing, complex or chronic health conditions, and to identify preventive health care needs.

(e) The commissioner shall require managed care plans, beginning July 1, 2009, to complete a comprehensive health assessment for each enrollee determined, by the initial health assessment required under section 256B.0431, subdivision 2, to have, or be at risk of developing, a complex or chronic health condition. The commissioner shall pay managed care plans a one-time health assessment fee for each enrollee who completes a comprehensive health assessment. Comprehensive health assessments must meet the criteria established for health care homes under section 256B.0752, subdivision 6.

(f) The commissioner, beginning July 1, 2009, shall implement financial arrangements for managed care plans to ensure that plans require each enrollee who has or who is at risk of

developing a complex or chronic health condition to choose a provider to serve as a health care home.

Sec. 7. **[256B.766] PRIMARY CARE PHYSICIAN REIMBURSEMENT RATE INCREASE.**

(a) Effective for physician services rendered on or after January 1, 2009, the commissioner shall increase reimbursements to primary care physicians deemed by the commissioner to meet the requirements in paragraph (b). Reimbursement may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the primary care provider. Payments to health plan companies shall be adjusted to reflect increased reimbursement to primary care physicians as approved by the commissioner.

(b) The commissioner, in collaboration with the Office of Rural Health, shall determine areas of the state in need of primary care physicians. By September 1 of each year, beginning September 1, 2008, the commissioner shall accept applications from primary care physicians who agree to practice in a designated area for a period of no less than five years. The commissioner shall determine participant eligibility based on their suitability for practice serving a designated geographic area.

(c) The commissioner may reconsider the designated areas, as necessary. A primary care physician who agrees to practice in a designated area shall receive the increased reimbursement rates for at least a period of five years, unless the physician discontinues practicing in the designated area during the five-year period.

(d) A health care clinic or medical group may submit applications under this section for primary care physicians who will be hired to fill vacancies, prior to filling the vacant position.

Sec. 8. **APPROPRIATION; PRIMARY CARE EDUCATION INITIATIVES.**

(a) $..... is appropriated in fiscal year 2010 from the health savings reinvestment fund to the board of regents of the University of Minnesota, to expand initiatives under Minnesota Statutes, sections 137.38 to 137.40, to increase the number of graduates of residency programs who practice primary care.

(b) $..... is appropriated in fiscal year 2010 from the health savings reinvestment fund to the Mayo Medical Foundation for medical school initiatives to increase the number of graduates of residency programs who practice primary care.

(c) $..... is appropriated in fiscal year 2010 from the health savings reinvestment fund to the Duluth General Medical Education Council for medical school initiatives to increase the number of graduates of residency programs who practice primary care.

(d) $..... is appropriated in fiscal year 2010 from the health savings reinvestment fund to the Office of Higher Education to provide grants to schools of nursing in Minnesota to increase the number of graduates of advanced practice registered nurse programs.

(e) $..... is appropriated in fiscal year 2010 from the health savings reinvestment fund to the board of regents of the University of Minnesota, to address faculty shortages in primary care medicine.

(f) $..... is appropriated in fiscal year 2010 from the health savings reinvestment fund to the

Mayo Medical Foundation, to address faculty shortages in primary care medicine.

(g) $..... is appropriated in fiscal year 2010 from the health savings reinvestment fund to the Office of Higher Education to provide grants to schools of nursing in Minnesota to address faculty shortages.

(h) $..... is transferred in fiscal year 2009 from the health professional education loan forgiveness program under Minnesota Statutes, section 144.1501, to the commissioner of human services for the reimbursement rate increase described in Minnesota Statutes, section 256B.766. The reduction in the loan forgiveness program shall be taken from the physician loan forgiveness program.

ARTICLE 3

INCREASING ACCESS; CONTINUITY OF CARE

Section 1. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 27. **Automation and coordination for state health care programs.** (a) For purposes of this subdivision, "state health care program" means the medical assistance, MinnesotaCare, or general assistance medical care programs.

(b) By July 1, 2009, the commissioner shall improve coordination between state health care programs and social service programs including, but not limited to WIC, free and reduced school lunch programs, and food stamps, and shall develop and use automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program. The system must also permit enrollees to renew state health care program enrollment through these social services programs. By January 15, 2009, the commissioner shall, as necessary, identify and recommend to the legislature statutory changes to state health care and social service programs necessary to improve coordination and automation of outreach and enrollment efforts.

(c) By January 15, 2009, the commissioner shall establish and implement an automated process to send out state health care program renewal forms in the most common foreign languages, to those state health care program enrollees who request renewal forms in those foreign languages. The commissioner, as part of the initial enrollment process, shall inform applicants of the availability of this option.

(d) Beginning July 1, 2008, the commissioner, county social service agencies, and health care providers shall update state health care program enrollee addresses and related contact information, at the time of each enrollee contact.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 2. Minnesota Statutes 2007 Supplement, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare, medical assistance, or general assistance medical care, the commissioner, within the available appropriation, shall pay the organization a ~~$20~~ $25 application assistance bonus. The organization may provide an applicant a gift certificate or other incentive upon enrollment.

Sec. 3. Minnesota Statutes 2007 Supplement, section 256.962, subdivision 6, is amended to read:

Subd. 6. **School districts.** (a) At the beginning of each school year, a school district shall provide information to each student on the availability of health care coverage through the Minnesota health care programs.

(b) For each child who is determined to be eligible for ~~a~~ the free ~~or~~ and reduced ~~priced~~ school lunch program, the district shall provide the child's family with ~~an application for the Minnesota health care programs and~~ information on how to obtain an application for the Minnesota health care programs and application assistance.

(c) A district shall also ensure that applications and information on application assistance are available at early childhood education sites and public schools located within the district's jurisdiction.

(d) Each district shall designate an enrollment specialist to provide application assistance and follow-up services with families ~~who are eligible for the reduced or free lunch program or~~ who have indicated an interest in receiving information or an application for the Minnesota health care program. A district is eligible for the application assistance bonus described in subdivision 5.

(e) Each school district shall provide on their Web site a link to information on how to obtain an application and application assistance.

Sec. 4. Minnesota Statutes 2007 Supplement, section 256B.056, subdivision 10, is amended to read:

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60-day postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall verify ~~assets and~~ income for all applicants, and for all recipients upon renewal.The commissioner shall verify liquid assets for applicants, and for recipients upon renewal, only if the applicant or recipient is within ten percent of the applicable asset limit. The commissioner may verify nonliquid assets, but is not required to do so.

(d) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period, before being disenrolled.

(e) If there is no change in an enrollee's income or asset information, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. These designated sites shall forward the renewal forms to the commissioner.

EFFECTIVE DATE. The amendments to paragraphs (c) and (e) are effective January 1, 2009. Paragraph (d) is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 5. Minnesota Statutes 2006, section 256B.061, is amended to read:

256B.061 ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS; DELAYED VERIFICATION.

(a) If any individual has been determined to be eligible for medical assistance, it will be made available for care and services included under the plan and furnished in or after the third month before the month in which the individual made application for such assistance, if such individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished. The commissioner may limit, restrict, or suspend the eligibility of an individual for up to one year upon that individual's conviction of a criminal offense related to application for or receipt of medical assistance benefits.

(b) On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application: (1) whose gross income is less than 90 percent of the applicable income standard; (2) whose total liquid assets are less than 90 percent of the asset limit; (3) does not reside in a long-term care facility; and (4) meets all other eligibility requirements, including compliance at the time of application with citizenship or nationality documentation requirements under section 256B.06, subdivision 4. The applicant must provide all required verifications within 60 days' notice of the eligibility determination or eligibility shall be terminated. Applicants who are terminated for failure to provide all required verifications are not eligible to apply for coverage using the delayed verification procedures specified in this paragraph for 12 months.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 6. Minnesota Statutes 2006, section 256D.03, is amended by adding a subdivision to read:

Subd. 7a. **Additional duties of the commissioner.** In administering the general assistance medical care program, the commissioner shall: (1) apply the delayed verification procedure specified in section 256B.061, paragraph (b), to general assistance medical care applicants; and (2) provide general assistance medical care enrollees who fail to submit renewal forms and related documentation necessary to verify continued eligibility with an additional month of eligibility beyond the end of the current eligibility period.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 7. Minnesota Statutes 2007 Supplement, 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. 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 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, 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.

EFFECTIVE DATE. This section is effective January 1, 2009, for enrollees for whom federal funding is not available, and is effective January 1, 2009, or upon federal approval, whichever is later, for enrollees for whom federal funding is available.

Sec. 8. Minnesota Statutes 2007 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; and

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

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, 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.

(f) 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.

EFFECTIVE DATE. This section is effective January 1, 2009, for enrollees for whom federal funding is not available, and is effective January 1, 2009, or upon federal approval, whichever is later, for enrollees for whom federal funding is available.

Sec. 9. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than ~~275~~ 300 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) ~~Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $50,000.~~

~~(e)~~ Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.

EFFECTIVE DATE. The effective date of this section is contingent on meeting the cost containment goals described in section 62U.14 and having sufficient funding for the expansion.

Sec. 10. Minnesota Statutes 2007 Supplement, 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 200 percent of the federal poverty guidelines. Effective ~~July~~ January 1, 2009, 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 ~~215~~ 300 percent of the federal poverty guidelines.

EFFECTIVE DATE. The effective date of this section is contingent on meeting the cost containment goals described in section 62U.14 and having sufficient funding for the expansion.

Sec. 11. Minnesota Statutes 2007 Supplement, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application

is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, the first period of eligibility begins the month the enrollee submitted the application or renewal for general assistance medical care.

(d) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period, before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 12. Minnesota Statutes 2006, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Delayed verification.** On the basis of information provided on the completed application, an applicant whose gross income is less than 90 percent of the applicable income standard and meets all other eligibility requirements, including compliance at the time of application with citizenship or nationality documentation requirements under section 256L.04, subdivision 10, shall be determined eligible beginning in the month of application. The applicant must provide all required verifications within 60 days' notice of the eligibility determination or eligibility shall be terminated. Applicants who are terminated for failure to provide all required verifications are not eligible to apply for coverage using the delayed verification procedures specified in this subdivision for 12 months.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 13. Minnesota Statutes 2006, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective ~~for~~ the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. ~~Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ The commissioner shall waive premiums for coverage provided under this paragraph to persons disenrolled for nonpayment who reapply under section 256L.05, subdivision 3b. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 14. Minnesota Statutes 2007 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.

Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above ~~275~~ 300 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or ~~215~~ 300 percent of the federal poverty guidelines on or after ~~July~~ January 1, 2009, 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.

(b) Notwithstanding paragraph (a), 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 annual premium for a 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).

~~(c) Notwithstanding paragraphs (a) and (b), parents are not eligible for MinnesotaCare if gross household income exceeds $50,000 for the 12-month period of eligibility.~~

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later, except that the effective date for the amendment to paragraph (a) related to the expansion in eligibility to 300 percent of federal poverty guidelines is contingent on meeting the cost containment goals established in section 62U.14 and having sufficient funding for the expansion.

Sec. 15. Minnesota Statutes 2006, 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 does not apply to newborns.

(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)~~ (c) 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 January 1, 2009, or upon federal approval, whichever is later.

Sec. 16. Minnesota Statutes 2007 Supplement, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; 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. Until December 31, 2008, 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. 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) ~~Families~~ Children whose gross income is above ~~275~~ 300 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) Beginning January 1, 2009, MinnesotaCare enrollees shall pay premiums according to the affordability scale established in section 62U.15, subdivision 2, with the exception that children in families with income at or below 150 percent of the federal poverty guidelines shall pay a monthly premium of $4.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval,

whichever is later, except that the effective date to the amendment to paragraph (b) related to the expansion in eligibility to 300 percent of federal poverty guidelines is contingent on meeting the cost containment goals in section 62U.14 and having sufficient funding for the expansion.

Sec. 17. Minnesota Statutes 2006, section 256L.15, is amended by adding a subdivision to read:

Subd. 5. **First month premium exemption.** New enrollee households are exempt from premiums for the first month of MinnesotaCare enrollment. For purposes of this exemption, a "new enrollee household" is a household which has not been enrolled in MinnesotaCare for at least one year prior to application.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later.

Sec. 18. **INSURANCE COVERAGE FOR LONG-TERM CARE WORKERS.**

(a) The commissioner of human services shall study and report to the legislature by December 15, 2008, with recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market. The commissioner shall collect necessary actuarial data, employment data, current coverage data, and other needed information.

(b) The commissioner shall develop cost estimates for three levels of insurance coverage for long-term care workers:

(1) the coverage provided to state employees;

(2) the coverage provided to MinnesotaCare enrollees; and

(3) the benefits provided under an "average" private market insurance product, but with a deductible limited to $100 per person.

Premium cost sharing, waiting periods for eligibility, definitions of full- and part-time employment, and other parameters under the three options must be identical to those under the state employees' health plan.

(c) For purposes of this section, a long-term care worker is a person employed by a nursing facility, an intermediate care facility for persons with mental retardation, or a service provider that:

(1) is eligible under Laws 2007, chapter 147, article 7, section 71; and

(2) provides long-term care services.

The commissioner may recommend a different definition of long-term care worker if this definition presents insurmountable implementation issues.

(d) The recommendations must include measures to:

(1) ensure equitable treatment between employers that currently have different levels of expenditure for employee health insurance costs; and

(2) enforce the requirement that the rate increase be expended for the intended purpose.

Sec. 19. **APPROPRIATION.**

(a) $..... is appropriated from the general fund to the commissioner of human services for the fiscal year beginning July 1, 2008, for the purposes of section 1.

(b) $250,000 is appropriated in fiscal year 2010 from the general fund to the commissioner of human services and $100,000 is appropriated in fiscal year 2010 from the health care access fund to the commissioner of human services for the application assistance bonus in Minnesota Statutes, section 256.962, subdivision 5.

Sec. 20. **REPEALER.**

Minnesota Statutes 2006, section 256L.15, subdivision 3, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval of the amendments to Minnesota Statutes, section 256L.15, subdivision 2, paragraph (c), whichever is later.

ARTICLE 4

HEALTH INSURANCE PURCHASING AND AFFORDABILITY REFORM

Section 1. Minnesota Statutes 2007 Supplement, section 13.46, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Unless the data is summary data or a statute specifically provides a different classification, data on individuals collected, maintained, used, or disseminated by the welfare system is private data on individuals, and shall not be disclosed except:

(1) according to section 13.05;

(2) according to court order;

(3) according to a statute specifically authorizing access to the private data;

(4) to an agent of the welfare system, including a law enforcement person, attorney, or investigator acting for it in the investigation or prosecution of a criminal or civil proceeding relating to the administration of a program;

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to an individual or family across programs; evaluate the effectiveness of programs; assess parental contribution amounts; and investigate suspected fraud;

(6) to administer federal funds or programs;

(7) between personnel of the welfare system working in the same program;

(8) to the Department of Revenue to assess parental contribution amounts for purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax

refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Employment and Economic Development, and when applicable, the Department of Education, for the following purposes:

(i) to monitor the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency;

(ii) to administer any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system;

(iii) to monitor and evaluate the Minnesota family investment program or the child care assistance program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L; and

(iv) to analyze public assistance employment services and program utilization, cost, effectiveness, and outcomes as implemented under the authority established in Title II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999. Health records governed by sections 144.291 to 144.298 and "protected health information" as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code of Federal Regulations, title 45, parts 160-164, including health care claims utilization information, must not be exchanged under this clause;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance or general assistance medical care may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1(c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, general assistance medical care, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public

authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a local board of health as defined in section 145A.02, subdivision 2, when the commissioner or local board of health has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions; ~~or~~

(29) counties operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education; or

(30) according to section 256.01, subdivision 27, between the welfare system and the Minnesota Health Insurance Exchange under section 62U.02, in order to collect premiums from individuals, enrolled in the MinnesotaCare program under chapter 256L, and to administer the individual's and their families' participation in the program, to the extent authorized in section 62U.03.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or

(18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but is not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

Sec. 2. **[16A.727] HEALTH SAVINGS REINVESTMENT FUND.**

A health savings reinvestment fund is created in the state treasury. The fund is a direct appropriated special revenue fund. The commissioner shall deposit to the credit of the fund money made available to the fund.

Sec. 3. Minnesota Statutes 2006, section 62A.65, subdivision 3, is amended to read:

Subd. 3. **Premium rate restrictions.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Except for policies issued under section 62U.03, subdivision 5, paragraph (b), premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) A health carrier may request approval by the commissioner to establish separate geographic regions determined by the health carrier and to establish separate index rates for each such region. The commissioner shall grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) each geographic region must be composed of no fewer than seven counties that create a contiguous region; and

(3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use.

Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

(i) An insurer may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this paragraph. The rating practices guarantee must be in writing and must guarantee that the policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. An insurer that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (c), (f), and (h).

Sec. 4. Minnesota Statutes 2006, section 62E.141, is amended to read:

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

No employee of an employer that offers a group health plan as defined in section 62A.10, under which the employee is eligible for coverage, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under the employer's health plan. This section does not apply to persons enrolled in the Comprehensive Health Association as of June 30, 1993. With respect to persons eligible to enroll in the health plan of an employer that has more than 29 current employees, as defined in section 62L.02, this section does not apply to persons enrolled in the Comprehensive Health Association as of December 31, 1994.

Sec. 5. Minnesota Statutes 2007 Supplement, section 62J.496, is amended by adding a subdivision to read:

Subd. 5. **Interoperable electronic health record requirements.** To meet the requirements of subdivision 1, hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(a) The electronic health record must be certified by the Certification Commission for Healthcare Information Technology, or its successor. This criterion only applies to hospitals and health care providers whose practice setting is a practice setting covered by Certification Commission for Healthcare Information Technology certifications. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(b) A health care provider who is a prescriber or dispenser of controlled substances must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 6. **[62J.497] ELECTRONIC PRESCRIPTION DRUG PROGRAM.**

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(b) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(c) "Electronic media" has the same meaning given this term under Code of Federal Regulations, title 45, part 160.103.

(d) "E-prescribing" means the transmission using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.

(e) "Electronic prescription drug program" means a program that provides for e-prescribing.

(f) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(g) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(h) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(i) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(j) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(k) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005.

(l) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(m) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

(n) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(o) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish and maintain an electronic prescription drug program that complies with the applicable standards in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

(b) Nothing in this section requires providers, group purchasers, prescribers, or dispensers to conduct the transactions described in this section. If transactions described in this section are conducted, they must be done electronically using the standards described in this section. Nothing in this section requires providers, group purchasers, prescribers, or dispensers to electronically conduct transactions that are expressly prohibited by other sections or federal law.

(c) Providers, group purchasers, prescribers, and dispensers must use either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the recipient are part of the same legal entity. If an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard or other applicable standards required by this section. Any pharmacy within an entity must be able to receive electronic prescription transmittals from outside the entity using the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health Insurance Portability and Accountability Act (HIPAA) requirement that may require the use of a HIPAA transaction standard within an organization.

(d) Entities transmitting prescriptions or prescription-related information where the prescriber is required by law to issue a prescription for a patient to a nonprescribing provider that in turn forwards the prescription to a dispenser are exempt from the requirement to use the NCPDP SCRIPT Standard when transmitting such prescriptions or prescription-related information.

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(1) get message transaction;

(2) status response transaction;

(3) error response transaction;

(4) new prescription transaction;

(5) prescription change request transaction;

(6) prescription change response transaction;

(7) refill prescription request transaction;

(8) refill prescription response transaction;

(9) verification transaction;

(10) password change transaction;

(11) cancel prescription request transaction; and/or

(12) cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions in accordance with the requirements of section 62J.536.

Sec. 7. Minnesota Statutes 2007 Supplement, section 62J.81, subdivision 1, is amended to read:

Subdivision 1. **Required disclosure of estimated ~~payment~~ out-of-pocket costs.** ~~(a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. Health plan companies must allow contracted providers, or their designee, to release this information. If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.~~

~~(b)~~ A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for with a specified provider within the network

as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.

EFFECTIVE DATE. This section is effective January 1, 2010.

Sec. 8. Minnesota Statutes 2007 Supplement, section 62J.82, subdivision 1, is amended to read:

Subdivision 1. **Required information.** The Minnesota Hospital Association shall develop a Web-based system, available to the public free of charge, for reporting the following, for Minnesota residents:

(1) hospital-specific performance on the measures of care developed under section 256B.072 for acute myocardial infarction, heart failure, and pneumonia;

(2) by January 1, 2009, hospital-specific performance on the public reporting measures for hospital-acquired infections as published by the National Quality Forum and collected by the Minnesota Hospital Association and Stratis Health in collaboration with infection control practitioners; and

(3) ~~charge~~ cost information, including, but not limited to, number of discharges, average length of stay, average ~~charge~~ cost, average ~~charge~~ cost per day, and median ~~charge~~ cost, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association.

EFFECTIVE DATE. This section is effective January 1, 2010.

Sec. 9. Minnesota Statutes 2006, section 62L.12, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees as required.

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to substitute individual health plans for a group health plan nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

(h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., as amended.

(i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

(j) A health carrier may offer, issue, sell, or renew an individual health plan to persons eligible for an employer group health plan, if the individual health plan is a high deductible health plan for use in connection with an existing health savings account, in compliance with the Internal Revenue Code, section 223. In that situation, the same or a different health carrier may offer, issue, sell, or renew a group health plan to cover the other eligible employees in the group.

(k) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to employees or through the Minnesota Health Insurance Exchange under section 62U.02 to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. Except as provided in section 62U.03, subdivision 5, paragraph (b), the requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the premium and merely collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier or to the Minnesota Health Insurance Exchange under section 62U.02. Except for coverage under section 62A.65, subdivision 5, paragraph (b), or 62E.16, at the request of an employee, the health carrier or the Minnesota Health Insurance Exchange under section 62U.02 may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier or the Minnesota Health Insurance Exchange, as applicable, shall provide a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

The employer must provide a written and signed statement to the health carrier or the Minnesota Health Insurance Exchange, as applicable, stating that the employer is not contributing directly or indirectly to the employee's premiums. The Minnesota Health Insurance Exchange under section 62U.02 shall provide all health carriers with enrolled employees of the employer with a copy of the employer's statement. The health carrier may rely on the employer's statement and is not required to guarantee-issue individual health plans to the employer's ~~other current or future~~ employees.

Sec. 10. Minnesota Statutes 2006, section 62L.12, subdivision 4, is amended to read:

Subd. 4. **Employer prohibition.** A small employer offering a health benefit plan shall not

encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another health carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.

Sec. 11. Minnesota Statutes 2006, section 62Q.735, subdivision 1, is amended to read:

Subdivision 1. **Contract disclosure.** (a) Before requiring a health care provider to sign a contract, a health plan company shall give to the provider a complete copy of the proposed contract, including:

(1) all attachments and exhibits;

(2) operating manuals;

(3) a general description of the health plan company's health service coding guidelines and requirement for procedures and diagnoses with modifiers, and multiple procedures; and

(4) all guidelines and treatment parameters incorporated or referenced in the contract.

~~(b) The health plan company shall make available to the provider the fee schedule or a method or process that allows the provider to determine the fee schedule for each health care service to be provided under the contract.~~

~~(c) Notwithstanding paragraph (b),~~ A health plan company that is a dental plan organization, as defined in section 62Q.76, shall disclose information related to the individual contracted provider's expected reimbursement from the dental plan organization. Nothing in this section requires a dental plan organization to disclose the plan's aggregate maximum allowable fee table used to determine other providers' fees. The contracted provider must not release this information in any way that would violate any state or federal antitrust law.

Sec. 12. **[62U.01] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given, unless otherwise specified.

Subd. 2. **Baskets or baskets of care.** "Basket" or "baskets of care" means a collection of health care services that are paid separately under a fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient.

Subd. 3. **Clinically effective.** "Clinically effective" means that the use of a particular health technology improves patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology demonstrates a clinical advantage over alternative technologies.

Subd. 4. **Commission.** "Commission" means the Health Care Transformation Commission established under section 62U.04.

Subd. 5. **Cost effective.** "Cost effective" means that the economic costs of using a particular service, device, or health technology to achieve improvement in a patient's health outcome are justified given the comparison to both the economic costs and the improvement in patient health outcome resulting from the use of an alternative service, device, or technology, or from not providing the service, device, or technology.

Subd. 6. **Exchange.** "Exchange" means the Minnesota Health Insurance Exchange established in section 62U.02.

Subd. 7. **Group purchaser.** "Group purchaser" has the meaning provided in section 62J.03.

Subd. 8. **Health plan.** "Health plan" means a health plan as defined in section 62A.011.

Subd. 9. **Health plan company.** "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

Subd. 10. **Health technology.** "Health technology" means medical and surgical devices and procedures, medical equipment, and diagnostic tests.

Subd. 11. **Participating provider.** "Participating provider" means a provider who has entered into a service agreement with a health plan company.

Subd. 12. **Provider or health care provider.** "Provider" or "health care provider" means a health care provider as defined in section 62J.03, subdivision 8.

Subd. 13. **Section 125 Plan.** "Section 125 Plan" means a cafeteria or premium-only plan under section 125 of the Internal Revenue Code that allows employees to pay for health insurance premiums with pretax dollars.

Subd. 14. **Service agreement.** "Service agreement" means an agreement, contract, or other arrangement between a health plan company and a provider under which the provider agrees that when health services are provided for an enrollee, the provider shall not make a direct charge against the enrollee for those services or parts of services which are covered by the enrollee's contract, but shall look to the service plan corporation for the payment for covered services, to the extent they are covered.

Subd. 15. **Third-party administrators.** "Third-party administrators" means a vendor of risk-management services or an entity administering a self-insurance or health insurance plan under section 60A.23.

Sec. 13. **[62U.02] MINNESOTA HEALTH INSURANCE EXCHANGE.**

Subdivision 1. **Title; citation.** This section may be cited as the "Minnesota Health Insurance Exchange."

Subd. 2. **Creation; tax exemption.** The Minnesota Health Insurance Exchange is created for the limited purpose of providing individuals with greater access, choice, portability, and affordability of health insurance products. The Minnesota Health Insurance Exchange is a nonprofit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.

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

(a) "Board" means the board of directors of the Minnesota Health Insurance Exchange established under subdivision 12.

(b) "Commissioner" means:

(1) the commissioner of commerce for health plan companies subject to the jurisdiction of the Department of Commerce;

(2) the commissioner of health for health plan companies subject to the jurisdiction of the Department of Health; or

(3) either commissioner's designated representative.

(c) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

(d) "Individual market health plan" means a health plan as defined in section 62A.011.

(e) "Small employer" means a small employer as defined in section 62L.02, subdivision 26.

(f) "Small employer plan" means a small employer health plan as defined in section 62L.02, subdivision 15.

Subd. 4. **Health plan company participation and health plan availability.** (a) All individual market health plans and small employer plans offered by a health plan company licensed to issue health insurance in Minnesota may be made available for purchase through the exchange. The health exchange shall limit the number of health plans to be made available through the exchange. The appropriate number of health plans shall ensure health plan innovation and consumer choice without being so numerous to become unmanageable for consumers using the exchange.

(b) Nothing in this section restricts the sale of individual market health plans and small employer plans outside the exchange. The requirements applicable to issuance, renewal, cancelation, and pricing of coverage are the same for health plans purchased inside and outside the exchange, except as described under section 62U.03, subdivision 5, paragraph (b).

(c) Health plans offered through the Minnesota Comprehensive Health Association as defined in section 62E.10 shall be available for sale through the exchange as determined by the Minnesota Comprehensive Health Association.

(d) Health plans offered through the MinnesotaCare program shall be available through the exchange for individuals and families with children who:

(1) have gross household incomes equal to or greater than 200 percent of federal poverty guidelines;

(2) meet the eligibility requirements of the MinnesotaCare program; and

(3) pay premiums through an employer Section 125 Plan.

(e) Beginning January 1, 2010, any health plan company that issues health plans in the individual or small employer market must offer through the exchange at least three health plans that meet the

standard benefit set and design established by the Health Care Transformation Commission. The health plan may impose varying levels of cost sharing provided it meets the requirements of the standard benefit set and design.

Subd. 5. **Listing of health plans.** The exchange shall create an Internet-based system for listing individual market health plans and small employer health benefit plans offered through the exchange. The system shall consider the variation across health plans in such factors as premiums, deductibles, co-payment and coinsurance requirements, annual out-of-pocket maximum payments, and lifetime benefit limits, and the system shall rank the health plans based on priorities specified by the user.

Subd. 6. **Individual participation and eligibility.** Individuals are eligible to purchase health plans directly through the exchange or through an employer Section 125 Plan under section 62U.03. Nothing in this section requires guaranteed issue of individual market health plans offered through the exchange except as provided under section 62U.03, subdivision 5, paragraph (b). Individuals are eligible to purchase individual market health plans through the exchange if the individual meets one or more of the following qualifications:

(1) the individual is a Minnesota resident, meaning the individual is physically residing on a permanent basis in a place that is the individual's principal residence and from which the individual is absent only for temporary purposes;

(2) the individual is a student attending an institution outside of Minnesota and maintains Minnesota residency;

(3) the individual is not a Minnesota resident but is employed by an employer physically located within the state and the individual's employer is required to offer a Section 125 Plan under section 62U.03; or

(4) the individual is a dependent as defined in section 62L.02, of another individual who is eligible to participate in the exchange.

Subd. 7. **Small employer participation and eligibility.** Small employers, as defined in section 62L.02, may purchase health plans through the exchange.

Subd. 8. **Responsibilities of the exchange.** The exchange may serve as a coordinating entity for enrollment and collection and transfer of premium payments for health plans sold to individuals through the exchange. The exchange shall be responsible for the following functions:

(1) publicize the exchange, including but not limited to its functions, eligibility rules, and enrollment procedures;

(2) provide assistance to employers to establish Section 125 Plans under section 62U.03;

(3) provide education and assistance to employers to help them understand the requirements of Section 125 Plans and compliance with applicable regulations;

(4) create a system to allow individuals to compare and enroll in health plans offered through the exchange, including a system of comparative rating of health plans and benefits set;

(5) create a system to collect and transmit to the applicable plans all premium payments made by individuals, including developing mechanisms to receive and process automatic payroll deductions

for individuals who purchase coverage through employer Section 125 Plans;

(6) for participating employers, bill the employer for the premiums payable by the employer for a small employer health benefit plan;

(7) for individuals purchasing individual market health plans through a Section 125 Plan, bill the individual's employer for premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose;

(8) provide information on public insurance programs to individuals who may qualify for these programs, and provide application assistance, if needed on applying for these programs;

(9) establish a mechanism with the Department of Human Services to transfer premiums paid by Minnesota health care program enrollees from Section 125 Plans;

(10) establish procedures to account for all funds received and disbursed by the exchange; and

(11) make available to the public, within 90 days from the end of each fiscal year, a report of an independent audit of the exchange's accounts.

Subd. 9. **State not liable.** The state of Minnesota shall not be liable for the actions of the Minnesota Health Insurance Exchange.

Subd. 10. **Powers of the exchange.** The exchange shall have the power to:

(1) contract with insurance producers licensed in accident and health insurance under chapter 60K and vendors to perform one or more of the functions specified in subdivision 8;

(2) contract with employers to collect premiums for small employer plans and for individual market health plans purchased through a Section 125 Plan;

(3) establish and assess fees on health plan premiums of small employer plans and individual market health plans to fund the cost of administering the exchange;

(4) seek and directly receive grant funding from government agencies or private philanthropic organizations to defray the costs of operating the exchange;

(5) establish and administer rules and procedures governing the operations of the exchange;

(6) establish one or more service centers within Minnesota;

(7) sue or be sued or otherwise take any necessary or proper legal action;

(8) establish bank accounts and borrow money; and

(9) enter into agreements with the commissioners of commerce, health, human services, revenue, employment and economic development, and other state agencies as necessary for the exchange to implement the provisions of this section.

Subd. 11. **Dispute resolution.** The exchange shall establish procedures for resolving disputes with respect to the eligibility of an individual to participate in the exchange. The exchange does not have the authority or responsibility to intervene in or resolve disputes between an individual and a health plan or health plan company. The exchange shall refer complaints from individuals participating in the exchange to the commissioner to be resolved according to sections 62Q.68 to

62Q.73.

Subd. 12. **Governance.** The exchange shall be governed by a board of directors with 11 members. The board shall convene on or before July 1, 2008, after the initial board members have been selected. The initial board membership consists of the following:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health; and

(4) eight members with knowledge and experience related to health insurance and health insurance markets, appointed to sever three-year terms as follows: two members appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate; two members appointed by the house of representatives; and four members appointed by the governor.

Subd. 13. **Subsequent board membership.** (a) Ongoing membership of the exchange consists of the following effective July 1, 2011:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

(4) two members appointed as follows: one member appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate; and one member appointed by the house of representatives to serve two-year terms; and

(5) four members elected by the membership of the exchange of which two are elected to serve a two-year term and two are elected to serve a three-year term.

(b) Elected members may serve more than one term. At least one of the elected members must represent a small employer, and at least one member must be a person who purchases an individual market health plan through the exchange.

Subd. 14. **Operations of the board.** Officers of the board of directors are elected by members of the board and serve one-year terms. Six members of the board constitutes a quorum, and the affirmative vote of six members of the board is necessary and sufficient for any action taken by the board. Board members serve without pay, but are reimbursed for actual expenses incurred in the performance of their duties. Expenses shall be compensated in accordance with section 15.0575.

Subd. 15. **Operations of the exchange.** The board of directors shall appoint an exchange director who shall:

(1) be a full-time employee of the exchange;

(2) administer all of the activities and contracts of the exchange; and

(3) hire and supervise the staff of the exchange.

Subd. 16. **Insurance producers.** An individual has the right to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an

individual market health plan through the exchange. When a producer licensed in accident and health insurance under chapter 60K enrolls an eligible individual in the exchange, the health plan company chosen by the individual may pay the producer a commission.

Subd. 17. **Implementation.** Health plan coverage through the exchange begins on July 1, 2009. The exchange must be operational to assist employers and individuals by January 1, 2009, and be prepared for enrollment by June 1, 2009.

Subd. 18. **Exemption from administrative procedures.** To carry out the purposes of this section, the board may adopt rules under chapter 14. The board is exempt from rulemaking requirements to the extent rules are necessary for the operation of the exchange. The board may use the provisions of section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.

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

Sec. 14. **[62U.03] SECTION 125 PLANS.**

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Employee" means an employee currently on an employer's payroll other than a retiree or disabled former employee.

(b) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on such employed person or persons.

(c) "Exchange director" means the appointed director of the Minnesota Health Insurance Exchange under section 62U.03, subdivision 15.

Subd. 2. **Section 125 Plan requirement.** (a) Effective January 1, 2009, all employers with 11 or more current employees shall establish a Section 125 Plan to allow their employees to purchase individual market or employer-based health plan coverage with pretax dollars. Nothing in this section requires employers to offer or purchase group health insurance coverage for their employees. Employers with no employees who are eligible to participate in a Section 125 Plan are exempt from this section.

(b) Employers that offer a Section 125 Plan may enter into an agreement with the exchange to administer the employer's Section 125 Plan.

(c) Notwithstanding paragraph (a), an employer that has been certified by a licensed insurance broker as having received education and information on the benefits and advantages of offering Section 125 Plans is not required to establish a Section 125 Plan. This paragraph expires January 1, 2010.

Subd. 3. **Tracking compliance.** By July 1, 2010, the exchange, in consultation with the commissioners of commerce, health, employment and economic development, and revenue shall establish a method for tracking employer compliance with the Section 125 Plan requirement.

Subd. 4. **Employer requirements.** (a) Employers that do not offer a group health insurance plan as defined in section 62A.10 and are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase an individual market health plan for themselves and their dependents;

(2) allow employees to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an individual market health plan;

(3) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the health plan or the exchange; and

(4) provide notice to employees that individual market health plans purchased by employees through payroll deduction are not employer-sponsored or administered.

(b) Employers shall be held harmless from any and all liability claims related to the individual market health plans purchased by employees under a Section 125 Plan.

Subd. 5. **Health plan company requirements.** (a) Individuals who are eligible to use an employer Section 125 Plan to pay for an individual market health plan purchased through the exchange may enroll in any health plan offered through the exchange for which the individual is eligible, including the individual market health plans, MinnesotaCare, and the Minnesota Comprehensive Health Association, to the extent authorized under section 62U.02, subdivision 4.

(b) Individuals who purchase an individual market health plan through a Section 125 Plan may purchase coverage on a guaranteed issue basis during an annual open enrollment period that coincides with the open enrollment period for their employer's Section 125 Plan or upon experiencing a qualifying event as defined in United States Code, chapter 43, section 4980B. Nothing in this section precludes a health plan company from issuing coverage with preexisting condition exclusions as authorized in law. Health plan companies may not charge higher or lower premiums based on health status for individuals who purchase coverage on a guaranteed issue basis under this section, except for variations in premium that are allowable based on health behaviors such as tobacco use.

Sec. 15. **[62U.04] HEALTH CARE TRANSFORMATION COMMISSION.**

Subdivision 1. **Creation.** The Health Care Transformation Commission is created for the purpose of coordinating the health care transformation activities within Minnesota.

Subd. 2. **Members.** (a) The Health Care Transformation Commission shall consist of ten members who are appointed as follows:

(1) three members appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate, one of which shall be a legislator;

(2) three members appointed by the house of representatives, one of which shall be a legislator; and

(3) four members appointed by the governor, two of which shall be state commissioners from the agencies listed in section 15.01.

(b) The appointed members who are not legislators or commissioners must:

(1) have expertise in health care financing, health care delivery, health care quality improvement,

health economics, actuarial science, or business operations;

(2) not be state employees or employees of a political subdivision; and

(3) not have a direct financial interest in the outcome of the commission's business, other than as an individual consumer of health care services.

(c) If a member is no longer able or eligible to perform the required duties, a new member shall be appointed by the entity that appointed the outgoing member.

Subd. 3. **Operations of the commission.** (a) The commission shall convene on or before July 1, 2008, following the initial appointment of the members. The commission members may convene prior to confirmation by the senate.

(b) The commission shall elect a chair among its members.

(c) The commission members shall not be compensated for commission activities except for actual expenses incurred in the performance of their duties. Expenses shall be compensated in accordance with section 15.0575.

Subd. 4. **Immunity of liability.** No member of the commission shall be held civilly liable for an act or omission by that member if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

Subd. 5. **Responsibilities of the commission.** (a) The commission shall develop a design and implementation plan for health care payment restructuring system within the parameters described in this chapter. The plan must provide for the full implementation of the payment restructuring system by January 1, 2011. Included in the design and plan, the commission must:

(1) develop uniform definitions for the baskets of care and a comprehensive set of services as required under section 62U.10;

(2) establish a mechanism for soliciting and accepting payment bids from health care providers and health care systems as required under section 62U.10. The mechanism must ensure that the bids from different providers and care systems can be compared by consumers on both quality and cost;

(3) develop procedures to facilitate providers in participating in the payment system and, if needed, provide technical assistance to providers in assembling bids, contracting with other providers in order to assemble or submit bids, or otherwise participate in the payment system; and

(4) develop a method for monitoring, measuring, and evaluating the effectiveness of the payment restructuring system and for making adjustments, as necessary, to address any barriers or unintended consequences.

(b) In developing the payment restructuring system described in this chapter, the commission shall consult and coordinate with the commissioners of health and human services, health care providers, health plan companies, organizations that work to improve health care quality in Minnesota, consumers, and employers.

(c) By July 1, 2009, the commission must make recommendations on how to incorporate Medicare into the payment restructuring system. In developing these recommendations, the commission shall negotiate with the Centers for Medicare and Medicaid Services and with the

Minnesota congressional delegation and explore participation in a demonstration project or advocate for changes in federal law to enable the transformation of the health care system to succeed.

(d) The commission may contract with other organizations and entities to carry out any of the duties described in this chapter, including evaluating the effectiveness of the payment restructuring system.

Subd. 6. **Standard benefit set and design.** (a) Based on the recommendations submitted by the Health Benefit Set and Design Advisory Committee, the commission shall establish a standard benefit set and design by July 1, 2009.

(b) The standard health benefit set and design must meet the requirements described in section 62U.06.

(c) Prior to establishing the standard benefit set and design, the commission shall convene public hearings throughout the state.

Subd. 7. **Reports.** The commission shall submit an annual report to the governor and legislature, beginning January 15, 2010, on the following:

(1) the extent to which health care providers have reduced their costs and fees;

(2) the extent to which costs and cost growth are likely to be maintained or reduced in future years;

(3) the extent to which the quality of health care services has improved;

(4) the extent to which all Minnesotans have access to quality, affordable health care; and

(5) recommendations on additional actions that are needed in order to successfully achieve health care transformation in Minnesota.

Subd. 8. **Sunset.** The commission shall expire June 30, 2012. Upon expiration, the duties of the commission shall transfer to the Health Care Value Reporting Organization.

Sec. 16. **[62U.05] HEALTH CARE VALUE REPORTING ORGANIZATION.**

Subdivision 1. **Creation.** The Health Care Transformation Commission shall solicit proposals from organizations and collaborations of organizations such as the Minnesota Community Measurement and Stratis Health to serve as the Health Care Value Reporting Organization.

Subd. 2. **Duties.** (a) The Health Care Value Reporting Organization shall be responsible for collecting, analyzing, and disseminating data on health care quality.

(b) The Health Care Value Reporting Organization shall:

(1) establish the standards for measuring health care outcomes;

(2) establish a system for providers to report outcomes and processes associated with patient care. In establishing these standards and system, the Health Care Value Reporting Organization shall work with other organizations that are developing quality measurement and reporting systems to establish a single system for collection and reporting of data on provider quality;

(3) collect standardized electronic information outcomes and processes from health care providers;

(4) establish a system for risk adjusting the measures reported by providers January 1, 2010; and

(5) issue annual public reports on provider quality using the data submitted by providers, adjusted for patient complexity beginning July 1, 2010.

Sec. 17. **[62U.06] STANDARD BENEFIT SET AND DESIGN.**

Subdivision 1. **Creation.** The Health Care Transformation Commission shall convene a health benefit and design advisory committee to make recommendations to the commission on a standard benefit set and design. The advisory committee shall consist of seven members. The members shall be appointed by the commission and must have expertise in benefit design and development, actuarial analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits.

Subd. 2. **Operations of the committee.** (a) The advisory committee shall convene on or before September 1, 2008, upon the appointment of the initial committee and must meet at least once a year, and at other times as necessary.

(b) The commission shall provide office space, equipment and supplies, and technical support to the committee.

(c) The committee shall be governed by section 15.059, except the committee shall not expire. Upon the expiration of the Health Care Transformation Commission, the Benefit Set and Design Committee shall continue to exist under the oversight of the Health Care Value Reporting Organization.

Subd. 3. **Immunity of liability.** No member of the committee shall be held civilly liable for an act or omission by that member if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

Subd. 4. **Duties of the committee.** (a) By January 1, 2009, the committee shall develop and submit to the commission an initial cost-effective benefit set and design that provides individuals access to a broad range of health care services, including preventive health care, including dental care, comprehensive mental health services, chemical dependency treatment, vision care, language interpreter services, emergency transportation, and prescription drugs without incurring severe financial loss as a result of serious illness or injury. The benefit set must include necessary evidence-based health care services, procedures, and diagnostic tests that are scientifically proven to be both clinically effective and cost effective. In establishing the initial benefit set, the committee may contract with the Institute for Clinical Systems Improvement (ICSI) to assemble existing scientifically based practice standards. The committee shall consider cultural, ethnic, and religious values and beliefs to ensure that the health care needs of all Minnesota residents will be addressed in the benefit set.

(b) The benefit set must identify and include preventive services, chronic care coordination services, and early diagnostic tests, that, if included in the benefit set, with minimal or no cost-sharing requirements, would result in savings that are equal to or greater than the cost of providing the services.

(c) The benefit set must include ICSI-designated evidence-based outpatient care for asthma, heart disease, diabetes, and depression with no cost-sharing requirements, or with minimal cost-sharing requirements that would not impose an economic barrier to accessing the care.

(d) The benefit design must establish a maximum deductible for in-network benefits and for prescription drugs coverage and a maximum out-of-pocket costs.

Subd. 5. **Continued review.** The committee shall review the benefit set and design on an ongoing periodic basis and shall adjust the benefit set and design, as necessary to ensure that the benefit set and design continues to be safe, effective, and scientifically based.

Sec. 18. **[62U.07] HEALTH TECHNOLOGY ASSESSMENT.**

Subdivision 1. **Technology Advisory Committee.** (a) The Health Care Transformation Commission shall convene an advisory committee to make recommendations to the commission regarding the inclusion of new and existing health technologies to the standard benefit set and design.

(b) The advisory committee shall be made up of 11 members appointed by the commission, in consultation with the Institute for Clinical Systems Improvement, the Health Services Advisory Council, and the University of Minnesota. The members shall consist of:

(1) six practicing physicians licensed under chapter 147; and

(2) five other practicing health care professionals who use health technology in their scope of practice.

(c) No member of the advisory committee shall have a substantial financial interest in a health technology company or be employed by or under contract with a health technology manufacturer during their term or for 18 months before their appointment.

(d) The members shall be immune from civil liability for any official acts performed in good faith as members of the committee.

(e) The advisory committee shall be governed under section 15.059, except that the committee shall not expire. Upon the expiration of the Health Care Transformation Commission, the Health Technology Assessment Committee shall continue to exist under the oversight of the Health Care Value Reporting Organization.

Subd. 2. **Technology selection process.** The commission, in consultation with the advisory committee, shall select existing and new health technologies to be reviewed by the committee. In making a selection, priority shall be given to any technology for which:

(1) there are concerns about its safety, efficacy, or cost effectiveness;

(2) actual or expected expenditures are high due to demand for the technology, its cost or both; and

(3) there is adequate evidence available to conduct a complete review.

Subd. 3. **Technology review.** (a) Upon the selection of a health technology for review, the committee shall contract for a systematic evidence-based assessment of the technology's safety,

efficacy, and cost effectiveness. The contract shall be with an evidence-based practice center designated as such by the federal agency for health care research and quality, or another appropriate entity as designated by the committee.

(b) The committee shall provide notification to the public when a health technology has been selected for review. The notification must indicate when that review is to be initiated and how an interested party may submit evidence or provide public comment for consideration during the review.

Subd. 4. **Committee determination.** (a) Upon reviewing the completed assessment and any other evidence submitted regarding the safety, efficacy, and cost effectiveness of the technology, the committee shall recommend to the commission:

(1) the conditions, if any, under which the health technology should be included as a covered benefit; and

(2) if covered, the criteria to be used to decide whether the technology is medically necessary, or proper and necessary treatment.

(b) The commissioners of human services, employee relations, and corrections may use the committee's recommendation in making coverage and reimbursement decisions unless the recommendation conflicts with an applicable federal statute or regulation.

Sec. 19. **[62U.08] PAYMENT RESTRUCTURING: INCENTIVE PAYMENTS BASED ON QUALITY AND EFFICIENCY OF CARE.**

Subdivision 1. **Development.** (a) By November 15, 2008, the Health Care Transformation Commission shall develop a system of quality and efficiency incentive payments to providers that meets the criteria listed in subdivision 2. The system must incorporate payments to primary care physicians, speciality care physicians, health care clinics, and hospitals eligible for these incentive payments.

(b) The requirements of section 62Q.101 do not apply under this incentive payment system.

Subd. 2. **Payment system criteria.** The quality and efficiency incentive payment system shall meet the following criteria:

(1) providers meeting specified targets, or who demonstrate a significant amount of improvement over time, shall be eligible for quality and efficiency incentive payments;

(2) priority shall be placed on measures of health care outcomes, rather than processes, wherever possible;

(3) quality measures for primary care providers shall include preventive services, coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, and depression;

(4) quality measures for specialty care shall be initially based on quality indicators measured and reported publicly by specialty societies;

(5) hospital measures shall be initially based on existing quality and efficiency measures; and

(6) other indicators of care quality and efficiency may be incorporated where appropriate. These

indicators may include care infrastructure, collection and reporting of results, measures of efficiency for specific procedures, and measures of overall cost of care for individuals.

Subd. 3. **Implementation.** By January 1, 2009:

(1) the commissioner of human services shall implement this incentive payment system for all enrollees in the state's public health care programs;

(2) the commissioner of employee relations shall implement this incentive payment system for all participants in the state employee group insurance program; and

(3) all health plan companies shall implement this incentive payment system for all participating providers.

Sec. 20. **[62U.09] PAYMENT RESTRUCTURING: CARE COORDINATION PAYMENTS.**

Subdivision 1. **Development.** By July 1, 2009, the Health Care Transformation Commission shall develop a system that provides care coordination payments to health care providers. In order to be eligible for a care coordination payment, a health care provider must be certified as a health care home by the commissioner of health based on the certification standards for health care homes established under section 256B.0754.

Subd. 2. **Care coordination fee.** (a) Under the care coordination payments, health care homes shall receive a per-person per-month care coordination fee for providing care coordination services and employing care coordinators. For purpose of this section, the specifications of care coordination and care coordinators are described in section 256B.0752, subdivisions 3 and 7, respectively.

(b) The care coordination fee must not exceed an average of $50 per person per month. The care coordination fee must be determined by the Health Care Transformation Commission and may vary by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination, such as those with very complex health care needs or several chronic conditions.

(c) In developing the system of care coordination fees, the commission shall consider the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care.

(d) Care coordination fees must be phased-in, and must be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions.

Subd. 3. **Quality and efficiency-based payments.** The care coordination fees paid under this section are in addition to the quality and efficiency incentive payments in section 62U.08. Providers whose quality or efficiency does not allow them to qualify for payments under section 62U.08 are not be eligible to receive care coordination fees.

Subd. 4. **Implementation.** (a) By July 1, 2009:

(1) the commissioner of human services shall implement the care coordination payments for enrollees in the state's public health care programs;

(2) the commissioner of employee relations shall implement the care coordination payments for

participants in the state employee group insurance program; and

(3) all health plan companies shall implement this care coordination payments for enrollees.

(b) The commissioners of human services and employee relations and health plan companies may begin implementing this care coordination payments for enrollees and participants who have or are at risk of developing complex and chronic health conditions.

Sec. 21. **[62U.10] PAYMENT RESTRUCTURING: PROVIDER INNOVATION TO IMPROVE COSTS AND QUALITY.**

Subdivision 1. **Development.** By January 1, 2010, the Health Care Transformation Commission shall develop a payment system that encourages provider innovation to improve costs and quality.

Subd. 2. **Encounter data.** (a) Beginning September 1, 2008, and every three months thereafter, all health plan companies and third-party administrators shall submit encounter data to the Health Care Transformation Commission. The data shall be submitted in a form and manner specified by the commission subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commission shall only use the data submitted under paragraph (a) for the purpose of carrying out its responsibilities in designing and implementing a payment restructuring system. If the commission contracts with other organizations or entities to carry out any of its duties or responsibilities described in this chapter, the contract must require that the organization or entity maintain that data that it receives according to the provisions of this section.

(c) The commission shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commission shall not publish analyses or reports that identify or could potentially identify individual patients.

(e) The commission may publish analyses and reports that identify specific providers but only after the provider has been provided the opportunity by the commission to review the data and submit comments. The provider shall have 21 days to review and comment, after which time the commission may release the data along with any comments submitted by the provider.

Subd. 3. **Utilization on health care costs.** (a) The commission shall develop a method of calculating the relative utilization and health care costs of providers. The method must include risk adjustments to reflect the differences in the demographics, health, and special needs of the providers' patient population. The risk adjustment must be developed in accordance with generally accepted risk adjustment methodologies.

(b) By April 1, 2009, the commission shall disseminate information to providers on their utilization and cost in comparison to an appropriate peer group.

(c) The commission shall develop a system to index providers based on their total risk-adjusted resource use per person and on quality of care. In developing this system, the commission shall consult and coordinate with health care providers, health plan companies, and the Health Care Value Reporting Organization.

Subd. 4. **Total care bids.** (a) The commission shall develop a standard method and format for providers to use for submitting a bid under this subdivision. This method shall be published in the State Register and must be made available to all providers.

(b) Beginning July 1, 2009, and annually thereafter, using the information developed in subdivision 3, providers may submit bids to the commission for total costs of providing care based on their disclosed prices under section 62U.11 combined with their actual risk-adjusted resource use for the most recent analytic period. The bid submitted must reflect the providers' commitment to manage their risk-adjusted patient population within this total cost.

(c) A provider who does not want to submit a bid as part of a care system may submit a bid on the services that the provider offers. The bid must be included in a bid for total care that may be compiled by the provider, the commission, or another entity.

(d) Until January 1, 2012, no provider shall submit a bid for risk-adjusted total cost of care that represents an increase of more than the increase in the previous calendar year's Consumer Price Index for all urban consumer plus two percentage points or a decrease of more than 15 percent below the provider's risk-adjusted total cost of care calculated based on their average pricing levels for the previous calendar year.

(e) Beginning January 1, 2010, the commission shall annually publish the results of the process described in paragraph (b), and shall include only providers who choose to submit bids. The results that are published must be on a risk-neutral basis. Effective January 1, 2011, the published results shall include all providers.

Subd. 5. **Provider assistance.** The commission shall provide education and technical assistance to providers on how to calculate and submit bids for the total risk-adjusted cost of care per patient.

Subd. 6. **Payments.** The commission shall establish a method by which providers who have submitted a bid shall be paid for their total cost of care, with periodic adjustments to the payment they receive to reflect their actual risk-adjusted cost relative to their submitted bid price. Providers who choose not to bid shall be paid based on the prices they have established under section 62U.11.

Subd. 7. **Implementation.** By January 1, 2010:

(1) the commissioner of human services shall implement this payment system for all enrollees in the state's public health care programs;

(2) the commissioner of employee relations shall implement this payment system for all participants in the state employee group insurance program;

(3) all political subdivisions as defined in section 13.02, subdivision 11, that offer health benefits to their employees must implement this payment system or purchase a health plan that uses this

payment system;

(4) all health plan companies shall use the information and methods developed under this section to develop health plans that encourage consumers to use high-quality, lost-cost providers; and

(5) health plan companies that issue health plans in the individual market or the small employer market must offer at least one health plan that uses the information developed under subdivision 3 to establish financial incentives for consumers to choose high-quality, low-cost providers through enrollee cost-sharing or selective provider networks.

Sec. 22. **[62U.11] PROVIDER PRICE AND QUALITY DISCLOSURE.**

(a) By January 1, 2009, and annually thereafter, each health care provider shall establish a list of prices for each health care procedure, service, or basket of care the provider provides and provide this information electronically to the Health Care Transformation Commission in the form and manner specified by the commission, and shall be provided to the public at no cost upon request.

(b) By January 1, 2009, each health care provider shall submit standardized electronic information on the outcomes and processes associated with patient care to the Health Care Value Reporting Organization.

Sec. 23. **[62U.12] PROVIDER PRICING.**

(a) No health care provider shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser.

(b) This section does not apply to a variation based upon a payer being a governmental entity.

(c) This section does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

Sec. 24. **[62U.13] HEALTH SAVINGS REINVESTMENT ASSESSMENT.**

Subdivision 1. **Projected spending baseline.** (a) The commissioner of health shall calculate the annual projected total health care spending for the state and establish a health care spending baseline beginning for the calendar year 2008 and for the next ten years based on the annual projected growth in spending.

(b) In establishing the health care spending baseline, the commissioner shall use the Center of Medicare and Medicaid Services forecast for total growth in national health care expenditures, and adjust this forecast to reflect the demographics, health status, and other factors deemed necessary by the commissioner. The commissioner shall contract with an actuarial consultant to make recommendations as to the adjustments needed to specifically reflect projected spending for Minnesota residents.

(c) The commissioner may adjust the projected baseline as necessary, to reflect any updated federal projections or account for unanticipated changes in federal policy.

(d) Medicare spending shall not be included in the calculations required under this section.

Subd. 2. **Actual spending.** (a) By June 1 of each year, beginning June 1, 2010, the commissioner shall determine the actual private and public health care expenditures for the calendar year preceding the current calendar year based on data collected under chapter 62J and shall determine the difference between the projected spending as determined under subdivision 1 and the actual spending for that year. The actual spending must be certified by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner shall determine an aggregate savings offset amount not to exceed 33 percent of the difference.

(b) Based on this calculation, the commissioner shall determine annually a savings offset amount to be paid by health plan companies and third-party administrators. The aggregate savings reinvestment amount may not exceed 33 percent of the aggregate savings reflected in the difference between the actual spending and the projected spending.

Subd. 3. **Publication of spending.** The commissioner shall publish in the State Register by June 15 of each year, beginning June 15, 2010, the projected spending baseline, including any adjustments, and the actual spending for the preceding year.

Subd. 4. **Savings reinvestment assessments.** (a) Health plan companies and third-party administrators shall pay a health savings reinvestment assessment. The commissioner shall calculate the savings reinvestment assessments as a percentage of paid claims as follows:

(1) for health plan companies, the health savings reinvestment assessment may not exceed four percent of annual paid health care claims on policies that insure residents of this state; and

(2) for third-party administrators, the health savings reinvestment assessment may not exceed four percent of annual paid claims for health care for residents of this state.

(b) A health plan company shall not be required to pay a health savings reinvestment assessment on policies or contracts insuring federal employees.

(c) Health savings reinvestment assessments shall apply to claims paid for plan years beginning on or after January 1, 2010.

(d) Health savings reinvestment assessments must be made quarterly to the commissioner of revenue within 60 days of the close of each quarter, beginning June 15, 2010.

Subd. 5. **Deposit of assessments.** The commissioner of revenue shall deposit the revenue derived from the assessments into the health savings reinvestment fund established under section 16A.727.

Sec. 25. **[62U.14] COST CONTAINMENT GOALS; CONTINGENT EXPANSION TO MINNESOTA CARE.**

Subdivision 1. **Cost containment goals.** Based on the projected spending baseline calculated under section 62U.13, subdivision 1, the following annual cost containment goals for public and private spending on health care services for Minnesota residents are established:

(1) for calendar year 2009, the cost containment goal is the baseline projected spending growth for 2009 established in section 62U.13 less one percentage point;

(2) for calendar year 2010, the cost containment goal is the baseline projected spending growth for 2010 less 1.5 percentage points;

(3) for calendar years 2011 and 2012, the cost containment goal is the baseline projected spending growth for 2011 and 2012 less two percentage points; and

(4) for calendar years after 2012, the cost containment goal is the projected baseline spending for 2013 less 2.5 percentage points.

Subd. 2. **Contingent expansion of MinnesotaCare.** (a) By June 1, 2010, the commissioner of health shall report to the commissioner of human services and the legislature on whether the cost containment goal for 2009 was met. If the goal was met, the commissioner of human services shall implement the eligibility expansion to the MinnesotaCare program for individuals and families with children up to 300 percent of federal poverty guidelines, to be effective July 1, 2010.

(b) If the cost containment goal has not been met, the legislature shall consider an eligibility expansion to the MinnesotaCare program based on available funding.

(c) The commissioner of health shall submit a plan to the legislature by January 15, 2013, if the cost containment goals established in this section have been met and the uninsured rate for Minnesota residents is greater than three percent. The plan must include efforts that will increase coverage to at least 97 percent insured, including an individual responsibility requirement.

Sec. 26. **[62U.15] AFFORDABILITY STANDARD.**

Subdivision 1. **Definition of affordability.** For purposes of this section, coverage is "affordable" if the sum of premiums, deductibles, and other out-of-pocket costs paid by an individual or family for health coverage does not exceed the applicable percentage of the individual or family's gross monthly income specified in subdivision 2.

Subd. 2. **Incomes up to 300 percent of the federal poverty guidelines.** The following affordability standard is established for individuals and households with gross family incomes of 300 percent of the federal poverty guidelines or less:

AFFORDABILITY STANDARD

Federal Poverty Guideline Range	**Percent of Average Gross Monthly Income**
0-33%	minimum
33-54%	1.1%
55-81%	1.4%
82-109%	1.9%
110-136%	2.6%
137-164%	3.4%
165-191%	4.4%
192-219%	5.2%
220-248%	5.9%
248-274%	6.5%

275-300%	7.0%

Subd. 3. **Incomes greater than 300 percent but not exceeding 400 percent of the federal poverty guidelines.** For purposes of determining affordability, the affordability standard for individuals and households with gross family incomes greater than 300 percent but not exceeding 400 percent of the federal poverty guidelines shall be based on a continuation of the sliding scale specified in subdivision 2, with the percentage of average gross monthly income rising proportionately at each income range, to a maximum of 10.0 percent.

Sec. 27. **[62U.16] EMPLOYEE SUBSIDIES FOR EMPLOYER-SUBSIDIZED HEALTH COVERAGE.**

Subdivision 1. **Establishment of subsidy program.** The commissioner of human services shall establish a subsidy program for eligible employees with access to employer-subsidized health coverage. For purposes of this section, employer-subsidized health coverage has the meaning provided in section 256L.07, subdivision 2, paragraph (c).

Subd. 2. **Eligible employees.** In order to be eligible for a subsidy under this section, an employee must:

(1) be covered by employer-subsidized health coverage that meets or is actuarially equivalent to the benefit set and design established by the Health Care Transformation Commission; and

(2) meet all eligibility criteria for the MinnesotaCare program established under chapter 256L, except for the requirements related to:

(i) no access to employer-subsidized coverage under section 256L.07, subdivision 2; and

(ii) no other health coverage under section 256L.07, subdivision 3.

Subd. 3. **Amount of subsidy.** The subsidy shall equal the amount the employee is required to pay for health coverage, including premiums, deductibles, and other cost sharing, minus an amount based on the affordability standard specified in section 62U.15. The maximum subsidy shall not exceed the amount of the subsidy that would have been provided under the MinnesotaCare program, if the employee and any dependents were eligible for that program.

Subd. 4. **Payment of subsidy.** The commissioner shall pay the subsidy amount for an employee and any dependents to the Minnesota Health Insurance Exchange, and this payment shall be credited towards the employee's share of premium. Any additional amount paid by the commissioner to the Minnesota Health Insurance Exchange that exceeds the employee's share of premium shall be credited first towards the employee deductible and then towards any employee cost-sharing obligation.

EFFECTIVE DATE. This section is effective July 1, 2010.

Sec. 28. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 27. **Exchange of data.** An entity that is part of the welfare system as defined in section 13.46, subdivision 1, paragraph (c), and the Minnesota Health Insurance Exchange under section 62U.02 may exchange private data about individuals without the individual's consent in order to collect premiums from individuals in the MinnesotaCare program under chapter 256L. This

subdivision only applies if the entity that is part of the welfare system and the Minnesota Health Insurance Exchange have entered into an agreement that complies with the requirements in Code of Federal Regulations, title 45, section 164.314.

Sec. 29. **APPROPRIATION.**

$20,000,000 is appropriated in fiscal year 2009 from the health care access fund to the Health Care Transformation Commission. This is a onetime appropriation.

Sec. 30. **REPEALER.**

Minnesota Statutes 2006, sections 62A.63; 62A.64; 62Q.49; 62Q.65; and 62Q.736, are repealed.

EFFECTIVE DATE. This section is effective January 1, 2010."

Delete the title and insert:

"A bill for an act relating to health care; establishing a statewide health improvement program; monitoring child obesity; establishing a health improvement fund; establishing a public health improvement assessment; establishing health care homes; increasing continuity of care; modifies outreach efforts; establishing primary care education initiatives; increasing affordability and continuity of care with public health care programs; creating a health insurance exchange; establishing Section 125 Plans; creating a Health Care Transformation Commission; restructuring the health care payment system; creating a savings reinvestment fund; establishing a savings recapture assessment; establishing cost containment goals; specifying an affordability standard; providing subsidies for employer-subsidized coverage; requiring providers to list prices; establishing an electronic prescription drug program; requiring mandated reports; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2006, sections 62A.65, subdivision 3; 62E.141; 62L.12, subdivisions 2, 4; 62Q.735, subdivision 1; 256.01, by adding a subdivision; 256B.061; 256B.69, by adding a subdivision; 256D.03, by adding a subdivision; 256L.05, by adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivision 3; 256L.15, by adding a subdivision; Minnesota Statutes 2007 Supplement, sections 13.46, subdivision 2; 62J.496, by adding a subdivision; 62J.81, subdivision 1; 62J.82, subdivision 1; 256.962, subdivisions 5, 6; 256B.056, subdivision 10; 256L.03, subdivisions 3, 5; 256L.04, subdivisions 1, 7; 256L.05, subdivision 3a; 256L.07, subdivision 1; 256L.15, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 16A; 62J; 145; 256B; proposing coding for new law as Minnesota Statutes, chapter 62U; repealing Minnesota Statutes 2006, sections 62A.63; 62A.64; 62Q.49; 62Q.65; 62Q.736; 256L.15, subdivision 3."

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

SECOND READING OF SENATE BILLS

S.F. Nos. 2939, 2262, 2369 and 1965 were read the second time.

SECOND READING OF HOUSE BILLS

H.F. No. 3055 was read the second time.

MOTIONS AND RESOLUTIONS

Senator Murphy moved that his name be stricken as chief author, and the name of Senator Stumpf be added as chief author to S.F. No. 996. The motion prevailed.

Senator Olson, G. moved that the name of Senator Ingebrigtsen be added as a co-author to S.F. No. 2313. The motion prevailed.

Senator Higgins moved that the name of Senator Erickson Ropes be added as a co-author to S.F. No. 2908. The motion prevailed.

Senator Olseen moved that the name of Senator Erickson Ropes be added as a co-author to S.F. No. 2909. The motion prevailed.

Senator Prettner Solon moved that the name of Senator Sheran be added as a co-author to S.F. No. 3182. The motion prevailed.

Senator Prettner Solon moved that S.F. No. 2372 be withdrawn from the Committee on Commerce and Consumer Protection and re-referred to the Committee on Health, Housing and Family Security. The motion prevailed.

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate proceeded to the Order of Business of Introduction and First Reading of Senate Bills.

INTRODUCTION AND FIRST READING OF SENATE BILLS

The following bills were read the first time.

Senators Lynch, Saltzman and Lourey introduced–

S.F. No. 3420: A bill for an act relating to education; providing for full funding of kindergarten milk; amending Minnesota Statutes 2006, section 124D.118, subdivision 4.

Referred to the Committee on Finance.

Senator Lynch introduced–

S.F. No. 3421: A bill for an act relating to education finance; establishing funding for voluntary, full-day kindergarten; amending Minnesota Statutes 2007 Supplement, section 126C.05, subdivision 1.

Referred to the Committee on Finance.

Senator Betzold introduced–

S.F. No. 3422: A bill for an act relating to retirement; providing coverage in the public employees police and fire plan for fire inspectors; amending Minnesota Statutes 2006, section 353.64, by adding a subdivision.

Referred to the Committee on State and Local Government Operations and Oversight.

Senator Moua introduced–

S.F. No. 3423: A bill for an act relating to health; requiring the commissioner of health to establish a registry of health care interpreter services; appropriating money; amending Minnesota Statutes 2006, section 295.52, subdivisions 1, 1a, 2; proposing coding for new law in Minnesota Statutes, chapter 144.

Referred to the Committee on Health, Housing and Family Security.

Senator Hann introduced–

S.F. No. 3424: A bill for an act relating to commerce; regulating unlawful trade practices, deceptive trade practices, consumer fraud, and false statements in advertising; modifying private remedies; providing for the application and construction of these acts; amending Minnesota Statutes 2006, sections 8.31, subdivision 3a, by adding a subdivision; 325D.09; 325D.16; 325D.46, subdivision 1; 325D.47; 325F.67; 325F.69, by adding subdivisions.

Referred to the Committee on Commerce and Consumer Protection.

Senators Chaudhary, Saxhaug, Skogen and Pariseau introduced–

S.F. No. 3425: A bill for an act relating to game and fish; modifying report requirements for game and fish fund; modifying disposition of pheasant habitat improvement account; modifying wild turkey management account; modifying hunting and fishing licensing and taking provisions; authorizing rulemaking; amending Minnesota Statutes 2006, sections 97A.015, by adding a subdivision; 97A.055, subdivision 4b; 97A.075, subdivisions 4, 5; 97A.311, subdivision 5; 97A.431, subdivision 2; 97A.433, subdivision 2; 97A.434, subdivision 2; 97A.475, subdivision 5; 97A.485, subdivision 6; 97B.015, subdivision 5; 97B.071; 97B.106, subdivision 1; 97B.211, subdivision 1; 97B.301, subdivision 6; 97B.721; 97C.355, subdivisions 4, 7a; 97C.401, subdivision 2; Minnesota Statutes 2007 Supplement, sections 97A.055, subdivision 4; 97A.405, subdivision 2; 97A.441, subdivision 7; 97A.475, subdivisions 2, 3, 11, 12; 97B.328; 97C.355, subdivisions 2, 8; proposing coding for new law in Minnesota Statutes, chapter 97B; repealing Minnesota Statutes 2006, section 97A.411, subdivision 2; Minnesota Rules, parts 6232.0200, subpart 4; 6232.0300, subpart 4.

Referred to the Committee on Environment and Natural Resources.

Senators Chaudhary, Saxhaug and Skogen introduced–

S.F. No. 3426: A bill for an act relating to game and fish; allowing crossbow hunting of bear and turkey during regular firearms seasons; amending Minnesota Statutes 2007 Supplement, section 97B.036.

Referred to the Committee on Environment and Natural Resources.

Senator Hann introduced–

S.F. No. 3427: A bill for an act relating to health; changing licensing requirements for certain health professions; amending Minnesota Statutes 2006, sections 148.512, subdivisions 10b, 20;

148.5161, subdivisions 2, 3; 148.5175; 148.519, subdivision 3; 148.5194, subdivisions 7, 8; 148.5195, subdivision 3; 148.6425; 148.6428; 148.6440; 148.6443, subdivisions 1, 3; 148.6445, subdivision 11; 153A.13, subdivision 4; 153A.14, subdivisions 2i, 4a, 11; 153A.175; Minnesota Statutes 2007 Supplement, section 148.515, subdivision 2.

Referred to the Committee on Health, Housing and Family Security.

Senator Stumpf introduced–

S.F. No. 3428: A bill for an act relating to natural resources; reinstating an exemption from the Wetland Conservation Act for approved development; amending Minnesota Statutes 2006, section 103G.2241, by adding a subdivision.

Referred to the Committee on Environment and Natural Resources.

Senators Saltzman, Foley and Murphy introduced–

S.F. No. 3429: A bill for an act relating to health; providing an exception to hospital construction moratorium; amending Minnesota Statutes 2006, section 144.551, subdivision 1.

Referred to the Committee on Health, Housing and Family Security.

Senator Olson, M., by request, introduced–

S.F. No. 3430: A bill for an act relating to health-related licensing boards; modifying the membership and authority of the Board of Veterinary Medicine; amending Minnesota Statutes 2006, sections 156.01, subdivision 1; 156.127, subdivision 1, by adding a subdivision.

Referred to the Committee on Agriculture and Veterans.

Senators Gimse, Day and Ingebrigtsen introduced–

S.F. No. 3431: A bill for an act relating to public safety; making technical correction to provision relating to financing the statewide public safety radio system; amending Minnesota Statutes 2006, section 373.47, subdivision 1.

Referred to the Committee on Finance.

Senators Lynch and Hann introduced–

S.F. No. 3432: A bill for an act relating to education; providing full funding for transportation of nonpublic students; amending Minnesota Statutes 2006, section 123B.92, subdivision 9.

Referred to the Committee on Finance.

Senators Bakk; Saxhaug; Sheran; Olson, G. and Senjem introduced–

S.F. No. 3433: A bill for an act relating to natural resources; modifying provisions relating to permits to harvest or destroy aquatic plants; requiring rulemaking; amending Minnesota Statutes 2006, sections 103G.005, by adding a subdivision; 103G.615, subdivision 3, by adding subdivisions.

Referred to the Committee on Environment and Natural Resources.

Senators Wergin and Saxhaug introduced–

S.F. No. 3434: A bill for an act relating to game and fish; modifying fish house licensing requirements; amending Minnesota Statutes 2006, section 97C.355, subdivisions 4, 7a; Minnesota Statutes 2007 Supplement, section 97C.355, subdivision 2.

Referred to the Committee on Environment and Natural Resources.

Senator Sparks introduced–

S.F. No. 3435: A bill for an act relating to taxation; providing that certain property of nonprofit outdoor recreation organizations is exempt from taxation; amending Minnesota Statutes 2006, section 272.02, by adding a subdivision.

Referred to the Committee on Taxes.

Senators Doll and Rummel introduced–

S.F. No. 3436: A bill for an act relating to education; appropriating money to the Department of Education for a grant to the Minnesota Historical Society to provide professional development for teachers.

Referred to the Committee on Finance.

Senators Ingebrigtsen and Hann introduced–

S.F. No. 3437: A bill for an act relating to state lands; permitting local units of government to petition for a public hearing when additions to the state park system are proposed; amending Minnesota Statutes 2006, section 85.0115.

Referred to the Committee on State and Local Government Operations and Oversight.

Senators Ortman, Robling and Olson, G. introduced–

S.F. No. 3438: A bill for an act relating to capital investment; authorizing spending to acquire and better public land and buildings and other improvements of a capital nature; authorizing the issuance of state bonds; appropriating money for Carver County to acquire property for the Lake Waconia Regional Park.

Referred to the Committee on Finance.

Senator Ortman introduced–

S.F. No. 3439: A bill for an act relating to taxes; exempting certain motor vehicles from the motor vehicle sales tax; amending Minnesota Statutes 2006, section 297B.03.

Referred to the Committee on Taxes.

Senator Moua introduced–

S.F. No. 3440: A bill for an act relating to crimes; including possession of machine guns and short-barreled shotguns to list of crimes against a person for registration under the Predatory Offender Registration Law; amending Minnesota Statutes 2007 Supplement, section 243.167, subdivision 1.

Referred to the Committee on Judiciary.

Senator Moua introduced–

S.F. No. 3441: A bill for an act relating to courts; limiting testimony of domestic abuse advocates without consent of victims; amending Minnesota Statutes 2007 Supplement, section 595.02, subdivision 1.

Referred to the Committee on Judiciary.

Senator Moua introduced–

S.F. No. 3442: A bill for an act relating to crime; modifying law on expungement of criminal records; amending Minnesota Statutes 2006, sections 609A.01; 609A.02, subdivision 3; 609A.03, subdivisions 2, 5, 6, 7, 8; proposing coding for new law in Minnesota Statutes, chapter 609A; repealing Minnesota Statutes 2006, section 609A.02.

Referred to the Committee on Judiciary.

Senator Koering introduced–

S.F. No. 3443: A bill for an act relating to veterans; designating July 27 as Korean War Veterans Day; proposing coding for new law in Minnesota Statutes, chapter 197.

Referred to the Committee on Agriculture and Veterans.

Senator Olson, M. introduced–

S.F. No. 3444: A bill for an act relating to state auditor; requiring employees and officers of local public pension plans to report unlawful actions; amending Minnesota Statutes 2006, section 609.456, subdivision 1.

Referred to the Committee on State and Local Government Operations and Oversight.

Senators Sheran, Koering, Lynch and Doll introduced–

S.F. No. 3445: A bill for an act relating to human services; modifying the phase-in of rebased nursing facility operating cost payment rates; amending Minnesota Statutes 2007 Supplement, section 256B.441, subdivisions 1, 55.

Referred to the Committee on Finance.

Senators Saltzman, Scheid and Vandeveer introduced–

S.F. No. 3446: A bill for an act relating to insurance; requiring certain health insurers to offer small employers the option to purchase certain flexible benefits plans; amending Minnesota Statutes 2006, section 62L.056.

Referred to the Committee on Commerce and Consumer Protection.

Senator Rest introduced–

S.F. No. 3447: A bill for an act relating to firefighters; adding duties to the Board of Firefighter Standards and Training; authorizing rulemaking; creating licensing standards; amending Minnesota Statutes 2006, sections 299F.012, subdivision 2; 299N.01; 299N.02, as amended; proposing coding for new law in Minnesota Statutes, chapter 299N.

Referred to the Committee on State and Local Government Operations and Oversight.

Senators Berglin and Torres Ray introduced–

S.F. No. 3448: A bill for an act relating to human services; allowing counties to contract with hospitals to provide chemical use assessments; amending Minnesota Statutes 2007 Supplement, section 254A.19, subdivision 3, by adding a subdivision.

Referred to the Committee on Health, Housing and Family Security.

Senator Latz introduced–

S.F. No. 3449: A bill for an act relating to state lands; requiring private sale of certain surplus state land bordering public water in Cass County.

Referred to the Committee on Environment and Natural Resources.

Senators Prettner Solon, Saxhaug, Vickerman, Tomassoni and Lourey introduced–

S.F. No. 3450: A bill for an act relating to veterans; authorizing and regulating state veterans cemeteries; amending Minnesota Statutes 2006, section 197.236.

Referred to the Committee on Agriculture and Veterans.

MOTIONS AND RESOLUTIONS - CONTINUED

Pursuant to Rule 26, Senator Pogemiller, Chair of the Committee on Rules and Administration, designated S.F. No. 3295 a Special Order to be heard immediately.

SPECIAL ORDER

S.F. No. 3295: A bill for an act relating to capital improvements; authorizing spending to acquire and better public land and buildings and other improvements of a capital nature with

certain conditions; establishing new programs and modifying existing programs; authorizing the sale of state bonds; canceling and modifying previous appropriations; appropriating money; amending Minnesota Statutes 2006, sections 16B.32, by adding a subdivision; 16B.325; 116.155, subdivisions 2, 3; 119A.45; 136F.10; 136F.60, subdivision 5; 136F.64, subdivision 1, by adding a subdivision; 136F.98, subdivision 1; 462A.21, by adding a subdivision; Laws 2003, First Special Session chapter 20, article 1, section 12, subdivision 3; Laws 2005, chapter 20, article 1, sections 7, subdivision 21; 17; 20, subdivision 3; 21, subdivision 2; 23, subdivisions 3, 8, 16; Laws 2006, chapter 258, sections 4, subdivision 4; 7, subdivisions 3, as amended, 7, 11, 22; 16, subdivision 5; 17, subdivision 8; 21, subdivisions 6, 15; 23, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 116; 137; 462A.

CALL OF THE SENATE

Senator Langseth imposed a call of the Senate for the balance of the proceedings on S.F. No. 3295. The Sergeant at Arms was instructed to bring in the absent members.

Senator Pappas moved to amend S.F. No. 3295 as follows:

Page 10, line 29, delete "12,500,000" and insert "13,500,000"

Page 46, after line 7, insert:

"(c) **Como Zoo Gorilla Exhibits** 11,000,000

For a grant to the city of St. Paul to construct, furnish, and equip Phase 2 renovation of the polar bear and gorilla exhibits at the Como Zoo."

Page 46, line 8, delete "(c)" and insert "(d)"

Page 46, delete lines 14 to 18

Page 59, line 20, delete "5,500,000" and insert "7,000,000"

Page 59, delete lines 29 to 34

Page 60, delete lines 1 to 16

Page 60, line 17, delete "(c)" and insert "(b)"

Correct the section totals and the appropriation summary

The motion prevailed. So the amendment was adopted.

Senator Wergin moved to amend S.F. No. 3295 as follows:

Page 62, line 12, after the period, insert "In future biennia, the commissioner of finance shall likewise schedule the sale of general obligation bonds so that, during the biennium, an amount equal to no more than three percent of general fund revenue for the biennium will need to be transferred from the general fund to the state bond fund to pay principal and interest due and to become due on outstanding state general obligation bonds."

The motion prevailed. So the amendment was adopted.

Senator Murphy moved to amend S.F. No. 3295 as follows:

Page 41, line 22, delete "135,620,000" and insert "131,617,000"

Page 41, line 25, delete "20,675,000" and insert "16,672,000"

Page 41, delete lines 26 to 31

Page 41, line 32, delete "(b)" and insert "(a)"

Page 42, line 3, delete "(c)" and insert "(b)"

Page 42, line 10, delete "(e)" and insert "(c)"

Adjust amounts accordingly

The motion prevailed. So the amendment was adopted.

S.F. No. 3295 was read the third time, as amended, and placed on its final passage.

The question was taken on the passage of the bill, as amended.

The roll was called, and there were yeas 51 and nays 7, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Latz	Prettner Solon	Skoe
Berglin	Foley	Lourey	Rest	Skogen
Betzold	Frederickson	Lynch	Robling	Sparks
Bonoff	Gimse	Marty	Rosen	Stumpf
Carlson	Higgins	Metzen	Rummel	Tomassoni
Clark	Ingebrigtsen	Murphy	Saltzman	Wergin
Cohen	Johnson	Olseen	Saxhaug	Wiger
Dahle	Koering	Olson, M.	Scheid	
Day	Kubly	Pappas	Senjem	
Dibble	Langseth	Pariseau	Sheran	
Dille	Larson	Pogemiller	Sieben	

Those who voted in the negative were:

Doll	Koch	Michel	Vandeveer
Fischbach	Limmer	Olson, G.	

So the bill, as amended, was passed and its title was agreed to.

Senator Pogemiller moved that S.F. No. 3295 be laid on the table. The motion prevailed.

GENERAL ORDERS

The Senate resolved itself into a Committee of the Whole, with Senator Metzen in the chair.

After some time spent therein, the committee arose, and Senator Betzold reported that the committee had considered the following:

S.F. Nos. 2908, 2909, 2471, 2511, 2377, 2796 and 2418, which the committee recommends to pass.

S.F. No. 3154, which the committee recommends to pass with the following amendment offered by Senator Scheid:

Page 4, line 35, after "resources" insert "or sole reliance on any single item listed above"

The motion prevailed. So the amendment was adopted.

S.F. No. 2881, which the committee recommends to pass with the following amendment offered by Senator Scheid:

Page 10, line 12, delete "Sections 1, 2, and 5 are" and insert "Section 2 is" and after the second period, insert "Sections 1 and 5 are effective January 1, 2009."

The motion prevailed. So the amendment was adopted.

On motion of Senator Pogemiller, the report of the Committee of the Whole, as kept by the Secretary, was adopted.

MEMBERS EXCUSED

Senators Bakk, Chaudhary, Gerlach, Hann, Jungbauer, Moua, Ortman and Vickerman were excused from the Session of today. Senator Torres Ray was excused from the Session of today from 11:00 to 11:50 a.m.

ADJOURNMENT

Senator Pogemiller moved that the Senate do now adjourn until 11:00 a.m., Wednesday, March 5, 2008. The motion prevailed.

Patrick E. Flahaven, Secretary of the Senate

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Tuesday, March 4, 2008

EXECUTIVE AND OFFICIAL COMMUNICATIONS

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