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# Senate

State of Minnesota

2725  
**S.F. No. XXXX - Health Care**

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

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

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

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

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

**Subdivision 4** establishes eligibility requirements for the program.

**Paragraph (a)** states that an applicant must:

- (1) be a permanent resident of Minnesota;

- (2) not be enrolled in medical assistance, general assistance medical care, or MinnesotaCare;
- (3) not be enrolled in prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and
- (4) not be enrolled in prescription drug coverage under a Medicare supplemental policy.

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

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

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

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

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

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

**Subdivision 8** requires a participating manufacturer to provide a rebate equal to the rebate provided under the medical assistance program for each prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. Requires the manufacturer to provide full payment within 38 days of receipt of the state invoice for the rebate or according to a schedule established by the commissioner. Requires

the commissioner to deposit all rebates received into the prescription drug dedicated fund. Requires the manufacturers to provide the commissioner with any information necessary to verify the rebate determined per drug.

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

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

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

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

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

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

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

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

**Section 7 (256L.07, subdivision 1)** contains a change related to the income eligibility limit increase.

**Section 8 (256L.20)** establishes the small employer option for MinnesotaCare.

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

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

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

- (1) agree to contribute toward the cost of the premium for the employee and the employee's dependent;
- (2) certify that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;
- (3) offer coverage to all eligible employees and the dependents of those employees; and
- (4) not have provided employer subsidized health coverage as an employee benefit during the previous 12 months.

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

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

**Subdivision 6** states that upon the payment of the premium, eligible employees and their dependents shall be enrolled in the MinnesotaCare program. States that the insurance barrier of Minnesota Statutes, section 256L.07, subdivisions 2 and 3, do not apply. Authorizes the commissioner to require eligible employees to provide income verification to determine premiums.

**Section 9** repeals the limited benefit set for single adults and households without children.

**Section 10** provides an effective date.

KC:ph

Senators Berglin, Koering, Solon and Johnson, D.E. introduced--

S.F. No. 2725: Referred to the Committee on Health and Family Security.

A bill for an act

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

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

Section 1. [256.9545] PRESCRIPTION DRUG DISCOUNT PROGRAM.

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

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

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

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

(b) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section

2.1 256B.0625, subdivision 13, and that is provided by a participating manufacturer that has a  
 2.2 fully executed rebate agreement with the commissioner under this section and complies  
 2.3 with that agreement.

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

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

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

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

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

2.21 (1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision  
 2.22 4;

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

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

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

2.34 (b) Notwithstanding paragraph (a), clause (3), an individual who is enrolled in a  
 2.35 Medicare Part D prescription drug plan or Medicare Advantage plan is eligible for the  
 2.36 program but only for drugs that are not covered under the Medicare Part D plan or for

3.1 drugs that are covered under the plan, but according to the conditions of the plan, the  
3.2 individual is responsible for 100 percent of the cost of the prescription drug.

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

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

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

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

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

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

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

3.32 Subd. 8. Provision of rebate. To the extent that a participating manufacturer's  
3.33 prescription drugs are prescribed to a resident of this state, the manufacturer must provide  
3.34 a rebate equal to the rebate provided under the medical assistance program for any  
3.35 prescription drug distributed by the manufacturer that is purchased at a participating  
3.36 pharmacy by an enrolled individual. The participating manufacturer must provide full

4.1 payment within 38 days of receipt of the state invoice for the rebate, or according to  
4.2 a schedule to be established by the commissioner. The commissioner shall deposit all  
4.3 rebates received into the Minnesota prescription drug dedicated fund established under  
4.4 subdivision 11. The manufacturer must provide the commissioner with any information  
4.5 necessary to verify the rebate determined per drug.

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

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

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

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

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

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

4.33 Subd. 4. Gross individual or gross family income. (a) "Gross individual or gross  
4.34 family income" for nonfarm self-employed means income calculated for the six-month  
4.35 period of eligibility using the net profit or loss reported on the applicant's federal income

5.1 tax form for the previous year and using the medical assistance families with children  
 5.2 methodology for determining allowable and nonallowable self-employment expenses and  
 5.3 countable income.

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

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

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

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

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

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

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

5.33 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include  
 5.34 inpatient hospital services, including inpatient hospital mental health services and inpatient

6.1 hospital and residential chemical dependency treatment, subject to those limitations  
 6.2 necessary to coordinate the provision of these services with eligibility under the medical  
 6.3 assistance spenddown. ~~Prior to July 1, 1997, the inpatient hospital benefit for adult~~  
 6.4 ~~enrollees is subject to an annual benefit limit of \$10,000.~~ The inpatient hospital benefit for  
 6.5 adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under  
 6.6 section 256L.04, subdivisions 1 and 2, with family gross income that exceeds ~~175~~ 190  
 6.7 percent of the federal poverty guidelines and who are not pregnant, is subject to an annual  
 6.8 limit of ~~\$10,000~~ \$20,000.

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

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

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

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

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

6.23 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,  
 6.24 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and  
 6.25 \$3,000 per family;

6.26 (2) \$3 per prescription for adult enrollees;

6.27 (3) \$25 for eyeglasses for adult enrollees;

6.28 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an  
 6.29 episode of service which is required because of a recipient's symptoms, diagnosis, or  
 6.30 established illness, and which is delivered in an ambulatory setting by a physician or  
 6.31 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,  
 6.32 audiologist, optician, or optometrist;

6.33 (5) \$6 for nonemergency visits to a hospital-based emergency room; and

7.1 (6) 50 percent of the fee-for-service rate for adult dental care services other than  
 7.2 preventive care services for persons eligible under section 256L.04, subdivisions 1 to 7,  
 7.3 with income ~~equal to or less~~ greater than ~~175~~ 190 percent of the federal poverty guidelines.

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

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

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

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

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

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

7.25 Sec. 7. Minnesota Statutes 2005 Supplement, section 256L.07, subdivision 1, is  
 7.26 amended to read:

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

8.1 of the employer-subsidized health coverage program as described in Laws 1998, chapter  
8.2 407, article 5, section 45, who have family gross incomes that are equal to or less than 150  
8.3 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to  
8.4 be eligible for MinnesotaCare.

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

8.14 (c) Notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare  
8.15 if ten percent of their gross individual or gross family income as defined in section  
8.16 256L.01, subdivision 4, is less than the premium for a six-month policy with a \$500  
8.17 deductible available through the Minnesota Comprehensive Health Association. Children  
8.18 who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month  
8.19 notice period from the date that ineligibility is determined before disenrollment. The  
8.20 premium for children remaining eligible under this clause shall be the maximum premium  
8.21 determined under section 256L.15, subdivision 2, paragraph (b).

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

8.25 **Sec. 8. [256L.20] MINNESOTACARE OPTION FOR SMALL EMPLOYERS.**

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

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

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

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

9.1 (e) "Maximum premium" has the meaning given under section 256L.15, subdivision  
9.2 2, paragraph (b), clause (3).

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

9.6 (g) "Program" means the MinnesotaCare program.

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

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

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

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

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

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

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

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

9.29 (c) For eligible employees without dependents with income over 175 percent of the  
9.30 federal poverty guidelines and for eligible employees with dependents with income over  
9.31 275 percent of the federal poverty guidelines, the participating employer shall pay the  
9.32 full cost of the premium established under paragraph (a) for the eligible employee, the  
9.33 employee's spouse, and any dependents, if applicable. The participating employer may  
9.34 require the employee to pay a portion of the cost of the premium so long as the employer  
9.35 pays 50 percent. If the employer requires the employee to pay a portion of the premium,  
9.36 the employee shall pay the portion of the cost to the employer.

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

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

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

10.15 **Sec. 9. REPEALER.**

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

10.17 **Sec. 10. EFFECTIVE DATE.**

10.18 Sections 1 to 9 are effective August 1, 2006, or upon the implementation of  
10.19 HealthMatch, whichever is later.

APPENDIX  
Repealed Minnesota Statutes: 06-6192

**256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.**

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to \$1,000 and subject to an annual limitation of \$10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay; outpatient hospital services; freestanding ambulatory surgical center services; chiropractic services; lab and diagnostic services; diabetic supplies and equipment; and prescription drugs; subject to the following co-payments:

(i) \$50 co-pay per emergency room visit;

(ii) \$3 co-pay per prescription drug; and

(iii) \$5 co-pay per nonpreventive visit.

The services covered under this section may be provided by a physician, physician ancillary, chiropractor, psychologist, or licensed independent clinical social worker if the services are within the scope of practice of that health care professional.

For purposes of this section, "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 any health care provider identified in this paragraph.

Enrollees are responsible for all co-payments in this section.

(b) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the \$20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (c).

(c) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

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

1.2 Page 7, after line 24, insert:

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

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

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

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

1.11 (2) the ability to raise matching funds; and

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

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

1.16 Page 10, after line 14, insert:

1.17 "Sec. 10. APPROPRIATION.

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

1.20 Renumber the sections in sequence and correct the internal references

1.21 Amend the title accordingly



**STATEMENT OF  
AARP MINNESOTA  
BEFORE  
THE SENATE HEALTH AND FAMILY SECURITY COMMITTEE  
MINNESOTA STATE SENATE**

**March 2, 2006**

Good Morning. My name is Christeen Stone, a volunteer with AARP Minnesota, representing 650,000 people throughout the state. Madame Chair, Senator Berglin, and Committee members, we thank you for the opportunity to testify today about Senate File 2724.

AARP Minnesota supports Section 1 of Senate File 2724, as well as proposals by the Governor and others that reduce the costs of prescription drugs for all Minnesotans. We believe it makes common sense to harness the purchasing power of consumers and the state to bring down drug prices.

Despite efforts at the federal level to introduce the new Medicare drug benefit, and efforts here in Minnesota to help consumers access lower-cost prescription drugs, the fact remains that prescription drug prices are still rising.

AARP's research shows that over the 12-month period ending March 2005, manufacturers raised the price they charge for 195 brand-name drugs most commonly used by older Americans, on average, by 6.6 percent. That's more than double the rate of inflation.

For consumers across the state – especially those without insurance coverage, the high costs of prescription drugs can be debilitating to household budgets, and forces too many people to lessen their quality of life – or even put their health in danger. Prescription drug costs simply cannot continue to rise at their current rate. Millions of Americans can no longer afford the vital drug therapies they need. Drugs have become so expensive that many people don't even fill their prescriptions. Others are forced to take drastic measures such as splitting pills or skipping doses. Still others have been driven to selling their possessions in a desperate attempt to pay for the medications they need.

It makes common sense for the state to use its purchasing power, and the power of Minnesota's collective consumers who pay out-of-pocket for their prescriptions. AARP strongly believes that this legislation will be a step toward truly making a difference in the pocketbooks of those who continue to struggle to pay for their prescriptions.

Thank you .

*Jim Meffert-Nelson*

February 22, 2006



Governor Tim Pawlenty  
State Capitol  
St Paul, MN 55155

Governor Pawlenty,

When created in 2003, the MinnesotaCare Limited Benefit Program included the services that optometrists provide, but did not allow them to deliver them to their established patients. This unique limitation created barriers to continuity in care which increased costs and delayed important care in addition to disrupting well established care patterns that utilize optometrists as the primary care provider for eye trauma, acute care, and basic eye care delivery.

Since that time our association has worked with the administration, members of the legislature, and health plans to fix problems associated with this program. We have introduced specific legislation, worked with the Department of Human Services, and delivered amendments for inclusion in omnibus bills. Each time we have worked to fix this program in fiscally responsible ways. While DHS has enabled individuals within this program to receive care for acute and chronic eye conditions, these patients continue to be informed that they cannot go to their optometrist for services covered under this program.

Each legislative session since, we have been told that this problem will be fixed. Each legislative session has passed without a fix. The most frustrating aspect for both patients and optometrists is that the money is in the Health Care Access Fund to solve this problem. For the optometrists, writing the check to pay the sick tax and being told they cannot see some of the individuals within the MinnesotaCare program add insult to injury.

It is time to restore the cuts to MinnesotaCare. Using the surplus in the access fund will have no effect on the overall budget. Restoring access to services will have an effect on the health of individuals in this program. Don't wait until the next budget – fix the problem now.

Sincerely,

Lane C. Robeson, OD  
President

CC: Senator Linda Berglin  
Representative Fran Bradley

Senators Berglin and Johnson, D.E. introduced-

S.F. No. 2625: Referred to the Committee on Health and Family Security.

A bill for an act

1. proposing an amendment to the Minnesota Constitution, article XIII, by adding a  
1.3 section; affirming that every resident of Minnesota has the right to affordable  
1.4 health care.

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

1.6 Section 1. CONSTITUTIONAL AMENDMENT PROPOSED.

1.7 An amendment to the Minnesota Constitution is proposed to the people. If the  
1.8 amendment is adopted, a section will be added to article XIII, to read:

1.9 Sec. 13. Every Minnesota resident has the right to health care. It is the responsibility of  
1.10 the governor and the legislature to implement all necessary legislation to ensure affordable  
1.11 health care.

1.12 Sec. 2. SUBMISSION TO VOTERS.

1.13 The proposed amendment shall be submitted to the people at the 2006 general  
1.14 election. The question submitted shall be:

1.15 "Shall the Minnesota Constitution be amended to state that every resident of  
1.16 Minnesota has the right to health care and that it is the responsibility of the governor and  
1.17 the legislature to implement all necessary legislation to ensure affordable health care?

1.18 Yes .....

1.19 No ....."

1.20 Sec. 3. ACTION BY THE LEGISLATURE AND GOVERNOR.

2.1 If the constitutional amendment proposed in section 1 is approved by the people at  
2.2 the 2006 general election, the legislature and governor must enact legislation to implement  
2.3 the constitutional amendment by July 1, 2008.

1.1 Senator ..... moves to amend S.F. No. 2625 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "Section 1. CONSTITUTIONAL AMENDMENT PROPOSED.

4 An amendment to the Minnesota Constitution is proposed to the people. If the  
1.5 amendment is adopted, a section will be added to article XIII, to read:

1.6 Sec. 13. Every resident of Minnesota has the right to affordable health care. What  
1.7 constitutes affordable health care must be defined by law as enacted by the legislature.

1.8 The judicial power of this state does not include the power to determine what constitutes  
1.9 affordable health care.

1.10 Sec. 2. SUBMISSION TO VOTERS.

1.11 The proposed amendment shall be submitted to the people at the 2006 general  
1.12 election. The question submitted shall be:

1.13 "Shall the Minnesota Constitution be amended to state that every resident of  
14 Minnesota has the right to affordable health care and that what constitutes affordable  
1.15 health care must be defined by law as enacted by the legislature?

1.16 Yes .....

1.17 No ....."

1.18 "

*Mary Jo George*

**Health care is a  
right...**

**...anything less is  
wrong**

- The Minnesota Hospital Association
- The Minnesota AFL-CIO
- The Minnesota Nurses Association
- Education Minnesota
- The Minnesota Association of Social Workers
- The Minnesota Mental Health Association
- Walker Methodist Church
  
- The Minnesotans For Affordable Health Care Work Group
  
- The American Federation of State County & Municipal Employees, Council 5
- The American Federation of TV & Radio Artists
- International Association of Machinists and Aerospace Workers
- Minnesota Association of Professional Employees
- Minnesota Building & Construction Trades Council
- Service Employees International Union
- United Steelworkers of America

- International Brotherhood of Teamsters
- United Food and Commercial Workers

## Code of Ethics for

# Nurses

**1** The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

**2** The nurse's primary commitment is to the patient, whether an individual, family, group, or community.

**3** The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.

**4** The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.



**ANA**  
AMERICAN NURSES  
ASSOCIATION

© 2001 American Nurses Association

**5** The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

**6** The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.

**7** The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

**8** The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to address health needs.

**9** The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

Center for Ethics and Human Rights  
600 Maryland Avenue, SW  
Suite 100 West  
Washington, D.C. 20024-2571  
800/274-4ANA (4262)  
<http://www.nursingworld.org>

TESTIMONY OF EILEEN WEBER, RN, JD  
TO THE MINNESOTA SENATE HEALTH AND FAMILY SECURITY COMMITTEE  
ON BEHALF OF THE MINNESOTA NURSES ASSOCIATION  
Thursday, March 2, 2006

Madame Chair, members of the committee, my name is Eileen Weber. I am here to testify that there is a right to health care in our society, recognized by the codes and laws that guide the healing professions. Like other inarguable rights, we need to also enshrine them in the documents that guide and direct our larger society. It's time for Minnesotans to know, and for policymakers to show that the right to get the health care they need when they need it is enshrined in our state Constitution.

I am a registered nurse, a licensed attorney and a 25-year member of the Minnesota Nurses Association. With over 19,000 members, MNA is our state's largest and oldest authority on nursing care. I am honored to be here today to speak on behalf of these members, my colleagues.

My experience includes membership on MNA's Ethics Committee and its public policy body, the Government Affairs Commission. I started the Emergency Nurses Association Ethics Committee in the 1980s, researched ethical dilemmas in the emergency room, and helped to start the Nursing Ethics Committee for the east metro Fourth District Nurses. I worked with Dr. Steve Miles as Project Coordinator for a multi-disciplinary research project on end-of-life care at the University of Minnesota Center for Bioethics, and I represented MNA on the MN Health Care Commission for its duration in the 1990s.

I said earlier that a right to health care already exists, supported by law and ethics. As for the law, like many nurses and doctors, I have seen the right to health care in action because I worked in urban emergency rooms for 16 years. Federal law forbids emergency rooms from diagnosing a patient's ability to pay before diagnosing the patient. That law establishes a right to necessary health care in emergency rooms which we feel logically must be extended to every health care setting.

It's **illogical** to only guarantee necessary care in certain settings. It's **immoral** to only guarantee necessary care if someone can pay for it. It's **inconceivable** that we would guarantee a prisoner's right to necessary health care and not a law-abiding person's. And it's **irresponsible** public policy to only guarantee necessary care when and where it is the most expensive. Saying your right to

health care is only guaranteed in an emergency is like saying your child's right to go to school is only guaranteed after he flunks an exam.

As for ethics, one of the reasons the public trusts nurses above all other professionals is that people see that we live our Code of Ethics at the bedside and at the policy table. The most basic ethical principle that drives our practice is respect. "The nurse ... practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems."

Furthermore, our Code recognizes nurses' duty to promote, advocate for, and protect the health, safety and rights of patients. You are no doubt familiar with some of these patient rights, which are often connected in principle to each other: the right to privacy, the right to confidentiality, the right to self-determination, the right to informed consent, the right to refuse treatment, the right to refuse to participate in research and so on. Everyone in here accepts the validity of these rights. But these patient rights can only be exercised if they are connected to a right to health care in the first place. Therefore, guided by our Code, our members are preparing now to come out in force this year to promote, advocate for and protect the right to health care in this state.

You have sworn to uphold the basic Constitutional premise of a free people, that we are created equal with inherent, inalienable rights. If that means anything, it must mean that we have equal human rights and an equal claim to exercise those rights, despite efforts to dis-equalize us in the name of profit. The Minnesota Nurses Association is ready, willing, and eager to stand with you and work with you to **put in writing what we know in fact: every one in this state has a right to have the health care they need when they need it.**

Thank you.

**startribune.com**

**Woman walking from Windom to St. Paul to push for state health coverage**

**Conrad Defiebre, Star Tribune**

October 30, 2005

WINDOM, MINN. - When Sue Eichstadt gets angry, she goes for a walk. "It's a good relief for stress," she says.

These days what angers Eichstadt, 49, a Windom factory worker and mother of four, is America's health care system. She figures that doing something about it will take a really long walk.

So before dawn on Saturday, outfitted with a yellow reflective vest, red flashers, a tiny can of pepper spray, a Walkman and a pair of U.S.-made New Balance running shoes, Eichstadt set off on foot.

Her itinerary extends from downtown Windom to the State Capitol, 154 miles away.

If all goes well, she'll arrive at 10 a.m. Friday for a rally of labor unionists and legislative supporters of her ultimate goal -- a state constitutional amendment guaranteeing universal health care for all Minnesotans.

Along the way, Eichstadt will convene evening town meetings in venues from a Lutheran church in Belle Plaine to a bar in West St. Paul to collect petition signatures and hear out Minnesotans on the issue that polls consistently identify as a top public concern.

"My mom always told me that if you believe in something and you know it's right, you need to do something," Eichstadt said. "People tell me, 'Don't think your walk is actually going to do something.' My thought is, if it brings attention to the legislators, it's worth it."

What began with Eichstadt's dismay over her elderly parents' struggles to afford their medicine has grown into "The Great HealthCare Walk," a big-time public relations campaign financed by organized labor, complete with media kits, posters and T-shirts adorned with footprints across a map of Minnesota.

It is envisioned as a kickoff for a 2006 legislative session when DFLers hope to push for a universal health care amendment and a 2006 election when voters could get to consider it, along with the health-system proposals of office seekers.

It's all a bit dizzying for Eichstadt, a \$14.46-an-hour Machinists Union member who for the past 20 years has lacquered red tierods for snowblowers and lawnmowers at the Toro plant in Windom.

"I don't have a solution to the health care problem," she said during a town meeting Tuesday at the Windom Eagles Club. "If I had a solution, I wouldn't be walking to St.

Paul; I'd be running for office there. But, you know, we have an amendment for the right to hunt and fish. We should have one for affordable health care, too."

### **It's still only a distant dream**

Universal health care coverage, a fixture in various forms in much of the rest of the industrialized world, has remained little more than a distant dream of U.S. medical professionals and liberal activists. No state has instituted it. In Minnesota, it hasn't even gotten to the floor of the DFL-controlled Senate.

The uninsured are cared for when they get seriously sick, but usually in the costly and inefficient setting of a hospital emergency room. Their bills often get passed on in the form of higher health insurance premiums for those who have coverage, said state Sen. Linda Berglin, DFL-Minneapolis.

"We could be spending that money much better," said Berglin, chief sponsor of the latest proposal for universal care in Minnesota, which she says "wouldn't cost us more at all."

But universal care proponents have not overcome the opposition of those who warn that government control of the health system would degrade its quality, accessibility and choice for patients.

"Once you obligate the government to provide health care to everybody, the health care you'll get is the health care of a given budget," said Twila Brase, president of the Citizens' Council on Health Care, which advocates a free-market health system.

Most Republicans share that stance. Many favor individual health savings accounts, another alternative to the current U.S. system of private insurance and health maintenance organizations that is also a frequent target of GOP criticism.

### **Constitutional amendment**

Berglin, however, is hoping to find Republican sponsors to carry her bill in the GOP-controlled House, where DFL proposals have not advanced.

The bill would allow voters to consider this amendment to the state Constitution: "Every Minnesota resident has the right to health care. It is the responsibility of the governor and the Legislature to implement all necessary legislation to ensure affordable health care."

By most measures, Sue Eichstadt would seem an unlikely focal point in this high-stakes debate. She is in good health, gets relatively inexpensive Blue Cross/Blue Shield medical coverage for her family via her husband, Dayle, also a Toro machinist, and was not politically active until two years ago.

But she volunteered on a DFL legislative campaign in 2004 and took a three-day Camp Wellstone activists' training course with two coworkers last spring. "They told us that if you have an idea, don't give up," she said. "I just kept calling people."

Despite some bets at the Toro factory that she won't make it to St. Paul, Eichstadt is confident that her two months of 15-mile-a-day training will carry her through.

"I see it daily: people coming out of retirement because they can't afford their health care," she said. "They're sick and tired. Compared to that, what's a week of walking?"

Conrad deFiebre • 651-222-1673

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MINNESOTA CHAMBER  
*of Commerce*  
THE VOICE OF BUSINESS<sup>SM</sup>

March 2, 2006

Members of the Health and Family Security Committee:

First, I want to start by saying that the Chamber strongly supports access to quality, affordable health care. The Chamber represents over 2,500 employers who employ 500,000 people in Minnesota. With health care costs continuing to rise, health care is an issue that is on the front burner for every employer.

Employees are still the major source of health care insurance for Minnesotans – nearly 63% of Minnesotans receive their health care coverage through a plan offered by their employer. Minnesota employers want to continue to offer their employees a high quality, affordable benefit.

The Minnesota Chamber is concerned that this legislation is asking voters to support amending our constitution to make affordable health care a right without any details on how the state will accomplish this goal or how this will be financed. Are they voting for a single-payer system? An employer mandate? Is it a state solution or a market solution? How does the state ensure affordable health care for everyone? What is the definition of affordable? Will the state be funding this new system and if so, how?

The Chamber believes that this legislation raises many questions that voters need answers to prior to voting to amend the Constitution.

The Chamber will continue to be a partner in the discussion on health care but we believe building on our current employer-based system is where we should focus our policy efforts. We need to take steps to rein in health care costs but making health care a right does nothing to further this goal.

Sincerely,



Erin Sexton  
Director, Health Care and Transportation Policy

## Comparable findings from opinion polls on health care by The Minnesota Citizens Forum and Minnesota Unions

### Minnesota Citizens Forum on Health Care Costs

Conducted by MarketResponse International  
Nov. 19-30, 2003

Sample size: 800. Error attributable to sampling could be  
as much as 3.5% in either direction

### Coalition of Minnesota Unions

Conducted by Feldman Group,  
Jan. 11-14, 2004

Sample size: 600. Likely voters.  
Error attributable to sampling could be  
as much as 4% in either direction.

<p><b>Costs going up.</b> Nine of ten Minnesotans (89%) perceive their health care costs have been going up in recent years, and over half (58%) think they have been going up a lot.</p>	<p><b>Costs increasing.</b> 82% of Minnesota voters polled report that their out-of-pocket expenses for health care are increasing (48%, a lot; and 34%, a little).</p> <p>Most likely to have experienced rising out-of-pocket expenses:</p> <ul style="list-style-type: none"> <li>• Middle age voters (57% among age 35-44)</li> <li>• Voters with children (53%)</li> <li>• Voters whose employer covers only individual costs and not family expenses (56%).</li> </ul>
<p><b>Dissatisfied with cost they pay.</b> 58% are dissatisfied – 32% <i>very</i> dissatisfied – with total cost they pay for themselves and or their family for health care.</p> <p><b>Satisfaction is related to income.</b> Those in the highest income category are most likely to be satisfied with amount they pay. Among those whose household income is less than \$50K, one out of three is <i>very dissatisfied</i> with health care costs.</p>	<p><b>Concerns converge on cost.</b> MN voters' biggest concerns about their health care coverage are:</p> <ul style="list-style-type: none"> <li>30 % – their share of the premium.</li> <li>22% – increasing co-payments and deductibles.</li> </ul>
	<p><b>Concerned about losing coverage.</b> A majority of MN voters (52%) are concerned about losing their health care coverage completely, including 24% who are very concerned.</p> <p>This concern is concentrated among voters age 55-64 (72%), single voters (59%) and those on MinnesotaCare or Medicare (62%).</p>

<p><b>Health care should be available to all.</b> 91% of Minnesotans believe (66% strongly) that health care should be available to all citizens regardless of their income or employment status. Although people from higher income households (55%) and rural residents (60%) agreed, they were less likely to agree strongly.</p>	<p><b>Everyone should have access to affordable health care.</b> 92% of MN voters agree that everyone should have access to quality health care.</p> <p><b>Health care access is a basic right.</b> 85% percent of MN voters agree (62% completely) that “access to adequate health care should be a basic right.”</p>
<p><b>It’s government’s responsibility.</b> 76% believe (48% strongly) that it is the government’s responsibility to make sure that patients receive safe, high quality medical care.</p>	<p><b>Government has a responsibility.</b> 79% of MN voters (50% completely) believe government has a responsibility to ensure that all Minnesotans have quality health care.</p>
<p><b>A Public-Private approach is most popular.</b> 82% of Minnesotans favor a universal system where government insures that everyone has health insurance coverage, but the health care industry would remain in the private sector, as opposed to a system completely run by the government.</p>	<p><b>Both government and the market have a role.</b> Most MN voters see a role for the free market in the health care system – but also a role for the government in curbing the excesses of the market, such as the profiteering HMOs and insurance companies (84% agree, 59% completely).</p>



## Health-care plan's best bet

Coverage for all has a chance in Illinois

By Judith Graham  
Tribune staff reporter  
Published February 26, 2006

*This story contains corrected material, published Feb. 28, 2006.*

With millions of Americans losing health insurance and crying for relief from soaring medical costs, Illinois is considering a bold and once-unthinkable proposal--extending medical coverage to all state residents.

It's a daunting, politically controversial and potentially expensive prospect, with 1.8 million uninsured people in the state. But experts say health reform may stand a better chance of passing in Illinois than almost anywhere in the nation.

"The odds are long, but they're much better in Illinois than most other states," said Alan Weil, executive director of the National Academy for State Health Policy.

An unprecedented public debate is under way, with public hearings on health-care issues being held in each Illinois legislative district. Meanwhile, a new 29-member task force has been meeting regularly and plans to deliver a report on various reform proposals to the legislature as early as August.

A wide range of options is likely to be considered, including expanding Medicaid to cover more low-income adults, providing health insurance subsidies or tax incentives to small businesses, and letting the uninsured buy coverage through new insurance pools, several task force members said.

"The process in Illinois is unique, and we're all closely following what is happening there," said Mark Blum, executive director of America's Agenda, a coalition of 20 national and international labor unions.

Illinois last year became the first state to promise medical coverage to all children. But some experts suggest the time is ripe for even more aggressive action.

"Medical providers are taking it on the chin. Consumers are taking it on the chin. Employers are taking it on the chin. And there's a real feeling out there that this could be the last great chance we have to do something," said Wayne Lerner (the name as published has been corrected in this text), who heads the new health-care task force and is president of the Rehabilitation Institute of Chicago.

"The sense of physicians at this point is if we don't find a solution for these problems, a solution will be imposed on us," echoed Dr. Craig Backs, another task force member and president of the Illinois State Medical Society. "That's not something we want to see

happen."

Illinois' political climate is especially favorable for health reform, with a governor who has made health care a signature issue and a legislature controlled by Democrats, who tend to make medical issues a priority. Still, here as across the country, there are deep ideological and partisan divides over how to fix a dysfunctional medical system and enormous concerns about potential costs.

"I think the business community would very much like to see government undertake initiatives to help the market work better. But unfortunately when something happens in this state, it almost always is an expansion of government-provided health care and we have great difficulty supporting that," said Todd Maisch, a vice president at the Illinois Chamber of Commerce.

The current debate was jump-started by the Health Care Justice Act, a little-known piece of legislation passed in 2004. For the first time, the act affirmed that "it is a policy goal of the state of Illinois to insure that all residents have access to quality health care at costs that are affordable."

The act went further by setting up a process for debating health reform throughout Illinois and a timetable for coming up with a "health-care access plan" for the state legislature to consider.

The key dates are approaching. More than half the legislative districts in the state have already held public hearings. The task force was due to present a report on reform proposals to the legislature next month, but that deadline has been pushed back to the end of summer because of funding delays. Meanwhile, the act strongly encourages lawmakers to vote on a proposed plan by the end of this year and start implementing reforms by July 2007.

"This is a process we have never formally engaged in before in Illinois, and a groundbreaking opportunity," said Dr. Lawrence Haspel, senior vice president of the Metropolitan Chicago Healthcare Council.

What's really new is the fact that consumer and business organizations, medical providers, health insurers, lawmakers and others are working together for the first time to consider reform options. In the past, the groups have held widely divergent views and made little effort to collaborate.

Consensus is by no means guaranteed. Virtually every other state that has attempted significant health reform has seen its efforts founder under the weight of competing special interests. And though some experts argue health care is a local concern that needs local solutions, others maintain problems are national in scope and beyond any individual state's ability to manage.

"Can you imagine every state having its own unique health-care system? That would be a

disaster," said Kim Maisch, Illinois state director for the National Federation of Independent Business.

Also, public officials keenly remember the fallout from President Bill Clinton's attempt to reform health care a dozen years ago--leaving a sense that the issue is so divisive that any attempt to address it is bound to end disastrously. The question now is, are enough people upset enough over soaring medical costs and eroding insurance coverage to make it worthwhile, politically, to take on these issues?

Kenneth Robbins, a task force member and head of the Illinois Hospital Association, thinks the answer is maybe. "For a dozen years, health reform has been one of the third rails of American politics," he said. "Now, the issue is regaining respectability and people are willing to come up to the rail. Whether they're willing to touch it yet, I just don't know."

In any case, no one expects a one-size-fits-all answer to emerge in Illinois, including advocacy groups that in the past devoted their efforts to pushing a Canadian-style, government-run health-care system.

"That just doesn't have enough appeal here," said Jim Duffett, executive director of the Campaign for Better Health Care. Instead, he predicts, a "hodgepodge of public and private solutions" will be put forward, and "controlling costs" will be part of any discussion to expand access.

Rep. Elizabeth Coulson (R-Glenview), who supported the passage of the Health Care Justice Act, said Illinois has already done "pretty much the obvious things" in expanding coverage to low-income children and their families through KidCare, FamilyCare and now Gov. Rod Blagojevich's new plan, All Kids. That program will extend medical coverage to about 250,000 uninsured children, beginning July 1.

Going forward, Coulson envisions a series of incremental reforms targeting specific populations, such as poor, single adults without children (who currently don't qualify for Medicaid) and young adults (who often lose their medical coverage when they leave college and start working in entry-level jobs). Another target group might be people ages 55 to 64 who can't get insurance because of a pre-existing medical condition and are too young to qualify for Medicare.

"Everybody is going to have to get something and everybody is going to have to give something for this to work," said Lerner, the chair of the state's health-care task force. Any expansion of coverage must be paired with measures to make health insurance more affordable and to encourage more preventive services that help keep people well, he said.

**ROLL CALL VOTE**

**HEALTH & FAMILY SECURITY COMMITTEE**

S.F. SF 2625

A-2 Amendment

Date 3-2-06

NAME	YES	NO	PASS	ABSENT
LOUREY		✓		
BERGLIN		✓		
FISCHBACH	✓			
FOLEY		✓		
HIGGINS		✓		
KELLEY		✓		
KISCADEN		✓		
LECLAIR	✓			
MOUA				
NIENOW	✓			
WERGIN	✓			

4 Yeas      6 Nays      -- Motion

Carried  
Requested by Sen. LeClair

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and Fiscal Analysis**

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**Senate**

**State of Minnesota**

**S.F. No. 2468 - Universal Health Care –  
Constitutional Amendment**

**Author:** Senator John Marty

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

**Date:** February 27, 2006

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**S.F. No. 2468** directs the Commissioner of Health to prepare a proposal for the Legislature that would establish a universal health care system for Minnesota that would take effect in January 2010. **S.F. No. 2468** also proposes a constitutional amendment to be submitted to the voters at the 2006 general election.

**Section 1** states legislative findings.

**Section 2 (144.7055)** establishes a proposal for a universal health care system.

**Subdivision 1** requires the Commissioner of Health to establish a working group to design a universal health care system to take effect in January 2010. States that the working group shall include medical providers, patients, and representatives of employers and employees.

**Subdivision 2** states that the proposal must:

- (1) ensure that all Minnesotans receive high quality health care regardless of income;
- (2) allow patients the ability to choose their own providers;
- (3) focus on preventive care and early intervention;
- (4) provide comprehensive benefits;
- (5) continue promoting medical education, training, research, and technology;

- (6) ensure an adequate number of qualified health care professionals and facilities to guarantee timely access to quality care;
- (7) not restrict or deny care or reduce the quality of care to hold down costs;
- (8) provide adequate and timely payments to providers; and
- (9) be funded through premiums and other payments based on the citizen's ability to pay.

**Section 3** proposes a constitutional amendment for the 2006 general election that, if adopted, would state that: "Every Minnesota resident has the right to comprehensive health care and that it is the responsibility of the governor and the legislature to implement all necessary legislation to ensure affordable health care."

**Section 4** states the question to be submitted to the voters: "Shall the Minnesota Constitution be amended to state that, effective January 1, 2010, every resident of Minnesota has the right to comprehensive health care and that it is the responsibility of the governor and the legislature to implement all necessary legislation to ensure affordable, comprehensive health care?"

**Section 5** provides an effective date of the day following final enactment.

KC:ph

**Senators Marty and Lourey introduced—**

**S.F. No. 2468:** Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; providing for a universal health care system that provides affordable access to high quality medical care for all Minnesotans; requiring a focus on preventive care and early intervention; providing comprehensive benefits; reducing costs through prevention, efficiency, and elimination of bureaucracy; directing the commissioner of health to prepare a plan to be implemented by 2010; proposing an amendment to the Minnesota Constitution, article XIII, by adding a section, affirming that every resident of Minnesota has the right to affordable, comprehensive health care; proposing coding for new law in Minnesota Statutes, chapter 144.

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

Section 1. LEGISLATIVE FINDINGS.

(a) All people deserve quality health care, yet an increasing number of Minnesota families are unable to pay for coverage.

(b) Many seniors find that Medicare, which promised health care in their retirement, does not provide needed coverage without costly Medicare supplemental policies and, even then, they cannot get coverage for needed prescriptions.

(c) Many workers do not earn enough to pay for health care; as a result, they do not receive preventive care and put off necessary treatment for themselves and their families until the medical condition becomes acute, requiring more costly treatment.

(d) Many people are forced, against their wishes, to switch from their personal doctors, clinics, and hospitals, not based on medical need, but because they switched jobs or their employer switched health plans. This replaces doctors who have their trust with new providers who do not know their medical history. Loss of continuity of care can put health at risk and wastes the time and resources of both doctors and patients.

2.1 (e) The lack of universal care has particularly serious consequences for the  
2.2 uninsured, but it also creates extra hardship and risks for many people with health care  
2.3 coverage and more expenses for the public.

2.4 (f) The lack of affordable care creates a huge burden on the Minnesota economy  
2.5 through lost worker productivity, higher special education costs, the spread of preventable  
2.6 infectious diseases, and skyrocketing long-term care expenses that could have been  
2.7 prevented with affordable in-home care alternatives. Furthermore, taxpayer-funded  
2.8 expenses for education, housing, health care, and crime prevention, including law  
2.9 enforcement, prosecution, and corrections, are higher due to untreated chemical  
2.10 dependency and mental illness.

2.11 (g) Insured patients and taxpayers end up paying costs to cover the underinsured  
2.12 through cost-shifting when hospitals provide expensive emergency care for illnesses and  
2.13 diseases that could have been prevented with routine preventive care.

2.14 (h) Bureaucratic paperwork for medical providers, insurers, patients, and government  
2.15 agencies, which is used to determine eligibility and financial responsibility, currently  
2.16 consumes more than one-fourth of all health care dollars in Minnesota. Additionally,  
2.17 cost-shifting between third-party payers results in expensive gatekeepers aimed at  
2.18 reducing financial responsibility and results in higher billing costs. A universal health care  
2.19 system would reduce these expenses that do nothing to promote health.

2.20 (i) Providing a universal health care system would improve the quality of life for  
2.21 all Minnesotans and would reduce overall costs to the public through prevention and  
2.22 efficiency.

2.23 (j) A well-designed universal health care system would continue to promote  
2.24 Minnesota's leadership in medical education, training, research, and technology and  
2.25 would free medical providers to focus on providing quality care without needing to worry  
2.26 whether the treatment or referrals they provide will be approved by the insurer and without  
2.27 wasting unnecessary resources on billing.

2.28 (k) A well-designed universal health care system would free small employers from  
2.29 wasting resources shopping for an affordable plan for their workers and would free  
2.30 employees to seek employment that best uses their talents instead of seeking jobs based on  
2.31 the employer's health benefits.

2.32 (l) A well-designed universal health care system would mean that patients would  
2.33 be able to get needed treatment promptly, instead of going through numerous additional  
2.34 doctor visits that are designed to deny care instead of provide it.

2.35 (m) It is in the public interest to establish a universal health care system for medical  
2.36 and economic reasons. Because the federal government has not provided universal health

3.1 care, Minnesotans will not obtain such coverage unless the state develops a system on its  
 3.2 own.

(n) In order to develop a system that serves Minnesotans best, the system must:

3.4 (1) ensure that all Minnesotans receive high quality health care, regardless of  
 3.5 their income;

3.6 (2) allow patients the ability to choose their own providers;

3.7 (3) provide an adequate number of qualified health care professionals and facilities  
 3.8 to guarantee timely access to quality care;

3.9 (4) continue promoting Minnesota's leadership in medical education, training,  
 3.10 research, and technology;

3.11 (5) focus on preventive care and early intervention;

3.12 (6) provide comprehensive benefits, including complete mental health services,  
 3.13 chemical dependency treatment, prescription drugs, medical equipment, dental care,  
 3.14 long-term care, and home care services;

3.15 (7) be funded through premiums and other payments based on the citizen's ability to  
 3.16 pay, so as not to deny full access to all Minnesotans; and

3.17 (8) hold down costs, not by restricting or denying coverage or reducing the quality  
 3.18 of care, but through prevention, efficiency, and elimination of bureaucracy.

3.19 **Sec. 2. [144.7055] UNIVERSAL HEALTH CARE SYSTEM.**

3.20 **Subdivision 1. Commissioner's working group.** (a) The commissioner of health  
 3.21 shall establish a working group to design a universal health care system for Minnesota.  
 3.22 The commissioner shall prepare proposed legislation for submission to the legislature by  
 3.23 January 31, 2008, to establish a universal health care system for Minnesota to take effect  
 3.24 in January 2010. The proposed legislation must meet all of the requirements specified in  
 3.25 subdivision 2.

3.26 (b) The working group shall include medical providers, patients, and representatives  
 3.27 of employers and employees in preparing the proposed universal health care system.

3.28 (c) The working group is governed by section 15.059, subdivision 6, and expires  
 3.29 January 31, 2008.

3.30 **Subd. 2. Requirements for universal health care system.** The commissioner's  
 3.31 proposal to the legislature under subdivision 1 shall be designed in a manner that:

3.32 (1) ensures all Minnesotans receive high quality health care, regardless of their  
 3.33 income;

3.34 (2) allows patients the ability to choose their own providers;

4.1 (3) focuses on preventive care and early intervention to improve the health of all  
4.2 Minnesotans and reduce later costs from untreated illnesses and diseases;

4.3 (4) provides comprehensive benefits, including all coverage currently required by  
4.4 law, complete mental health services, chemical dependency treatment, prescription drugs,  
4.5 medical equipment, dental care, long-term care, and home care services;

4.6 (5) continues promoting Minnesota's leadership in medical education, training,  
4.7 research, and technology;

4.8 (6) ensures an adequate number of qualified health care professionals and facilities  
4.9 to guarantee timely access to quality care;

4.10 (7) does not restrict or deny care or reduce the quality of care to hold down costs, but  
4.11 instead reduces costs through prevention, efficiency, and elimination of bureaucracy;

4.12 (8) provides adequate and timely payments to providers; and

4.13 (9) is funded through premiums and other payments based on the citizen's ability to  
4.14 pay, so as not to deny quality health care to all Minnesotans.

4.15 **Sec. 3. CONSTITUTIONAL AMENDMENT PROPOSED.**

4.16 An amendment to the Minnesota Constitution, article XIII, by adding a section, is  
4.17 proposed to the people. If the amendment is adopted, the section will read as follows:

4.18 Sec. 13. Every Minnesota resident has the right to comprehensive health care. It is the  
4.19 responsibility of the governor and the legislature to implement all necessary legislation  
4.20 to ensure affordable health care.

4.21 **Sec. 4. SUBMISSION TO VOTERS.**

4.22 The proposed amendment must be submitted to the people at the 2006 general  
4.23 election. If approved, it is effective January 1, 2010. The question submitted shall be:

4.24 "Shall the Minnesota Constitution be amended to state that, effective January 1,  
4.25 2010, every resident of Minnesota has the right to comprehensive health care and that it is  
4.26 the responsibility of the governor and the legislature to implement all necessary legislation  
4.27 to ensure affordable, comprehensive health care?

4.28 Yes .....

4.29 No ....."

4.30 **Sec. 5. EFFECTIVE DATE.**

4.31 Section 2 is effective the day following final enactment.

Testimony on SF 2468 to the Senate Health & Family Security Committee

March 2, 2006

GREATER MINNESOTA HEALTH CARE COALITION

1-888-694-5055

(1) My name is Bob Salisbury, I live in St. Cloud, and I am speaking for the Greater Minnesota Health Care Coalition, which represents over six thousand members in various parts of the state. We are a grassroots citizen organization, and we have worked on health care legislation for over 30 years.

We are strongly in support of SF 2468, which would set a process in motion that will result in a comprehensive, affordable, universal health care program for all Minnesotans.

It has to be crystal-clear to everyone, at this late date, that our current health care system is dysfunctional, out of control, and extremely hazardous to our physical and economic health. Recent estimates are that if nothing is done, health care will consume 20% of our nation's gross domestic product within ten years. Business and families are being driven to bankruptcy.

Nothing less than a total overhaul, a complete re-design, will help us.

One thing has been holding us back: The fact that the system works extremely well in a certain way. It provides enormous profits to the insurance and drug industries, their shareholders, and their multi-million dollar salary CEOs. And, we all know that Congress is making the health care system worse, not better.

The question for the Minnesota legislature is: Are you finally going to muster the political will to do what our citizens, families, and businesses desperately need AND WANT, or are you going to continue to concede defeat to the huge, powerful insurance and drug corporations? Please tell us.

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(2) My name is Marlene Hart, I live in Duluth, and I am also speaking for the Greater Minnesota Health Care Coalition. The nine criteria listed in SF 2468 are very important and very well thought out. They address the true interest of the public, and indeed our state's economy. I simply want to emphasize three of them, which merit special attention.

Criteria number three emphasizes preventive care, which takes a huge worry off of cash-strapped families, and will save great amounts of money in the long run.

Criteria number four has the list of comprehensive services, which includes drugs, long term care, and home care. It is important to include long term care and home care, since these systems are broken as well. The only way to remedy them is in a combined way with the other aspects of health care.

Criteria number nine requires a payment system according to a person's ability to pay. We agree that health care financing should be done this way, and without any burden on businesses. The legislature has already set a precedent - sliding scale premiums for Minnesota Care.

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(3) My name is Lila Skramstad, I live in Mora, and I am another speaker for the Greater Minnesota Health Care Coalition. I want to address the proposal for a constitutional amendment to make health care a right. This concept has become increasingly popular, with Senator Berglin's bill for this idea leading the way. We certainly support that idea. We also think that SF 2468, with its combination of the amendment PLUS the specific process and criteria to develop the new health care system, is what is really needed.

We worry that a constitutional amendment, by itself, would allow too much leeway for politics to warp and delay implementing the true intent of the amendment. SF 2468 gives a clear timeline, process, and binding criteria, that would go a long way to ensure that the final result meets the true need. It will make Minnesota a leader among states once again.

We don't need high deductible policies and health savings accounts, which simply shift crushing costs onto families. We need genuine reform, which is SF 2468. Thank you.

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*Speaking for the* **GREATER MINNESOTA HEALTH CARE COALITION:**

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