State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 3

01/10/2019 Authored by Liebling, Moran, Schultz, Loeffler, Morrison and others
The bill was read for the first time and referred to the Committee on Health and Human Services Policy
03/11/2019 Adoption of Report: Amended and re-referred to the Committee on Commerce

A bill for an act

relating to health care; establishing OneCare Buy-In; establishing outpatient prescription drug program; modifying provisions governing dental administration; modifying provisions governing health care; requiring studies and reports; amending Minnesota Statutes 2018, sections 62J.497, subdivision 1; 256B.0644; 256B.69, subdivisions 6d, 35; 256B.76, subdivisions 2, 4; 256L.03, by adding a subdivision; 256L.11, subdivision 7; proposing coding for new law in Minnesota Statutes, chapters 256B; 256L; proposing coding for new law as Minnesota Statutes, chapter 256T; repealing Minnesota Statutes 2018, section 256L.11, subdivision 6a.

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

Section 1. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

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

(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(c) "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.

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

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

(f) "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 and two-way transmissions related to eligibility, formulary, and medication history information.

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

(h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6~~.~~, excluding state and federal health care programs under chapters 256B, 256L, and 256T.

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

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

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

(l) "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.

(m) "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, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

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

(o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

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

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

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 2. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

Subdivision 1. **Contract for dental administration services.** (a) Effective January 1, 2022, the commissioner shall contract with a dental administrator to administer dental services for all recipients of medical assistance and MinnesotaCare.

(b) The dental administrator must provide administrative services including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and review for medical necessity of dental services;

(4) dental claims processing;

(5) coordination with other services;

(6) management of fraud and abuse;

(7) monitoring of access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation requirements; and

(10) management of third-party liability requirements.

(c) Payments to contracted dental providers must be at the rates established under section 256B.76.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 3. Minnesota Statutes 2018, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state

employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services. This section does not apply to dental service providers providing dental services outside the seven-county metropolitan area.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers providing dental services in the seven-county metropolitan area, at least ten percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the

commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625, subdivision 9a, shall not be considered to be participating in medical assistance or MinnesotaCare for the purpose of this section.

(e) A vendor of medical care, as defined in section 256B.02, subdivision 7, that dispenses outpatient prescription drugs in accordance with chapter 151 must participate as a provider or contractor in the MinnesotaCare program as a condition of participating as a provider in the medical assistance program.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 4. Minnesota Statutes 2018, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude ~~or modify~~ coverage for prescription drugs from the prepaid managed care contracts entered into under this section ~~in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates~~.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 5. Minnesota Statutes 2018, section 256B.69, subdivision 35, is amended to read:

Subd. 35. **Statewide procurement.** (a) For calendar year 2015, the commissioner may extend a demonstration provider's contract under this section for a sixth year after the most recent procurement. For calendar year 2015, section 16B.98, subdivision 5, paragraph (b), and section 16C.05, subdivision 2, paragraph (b), shall not apply to contracts under this section.

(b) For calendar year 2016 contracts under this section, the commissioner shall procure through a statewide procurement, which includes all 87 counties, demonstration providers, and participating entities as defined in section 256L.01, subdivision 7. The commissioner

shall publish a request for proposals by January 5, 2015. As part of the procurement process, the commissioner shall:

(1) seek each individual county's input;

(2) organize counties into regional groups, and consider single counties for the largest and most diverse counties; and

(3) seek regional and county input regarding the respondent's ability to fully and adequately deliver required health care services, offer an adequate provider network, provide care coordination with county services, and serve special populations, including enrollees with language and cultural needs.

(c) For calendar year 2021, the commissioner may extend a demonstration provider's contract under this section for a sixth year after the most recent procurement, for the provision of services in the seven-county metropolitan area to families and children under medical assistance and MinnesotaCare. For calendar year 2021, section 16B.98, subdivision 5, paragraph (b), and section 16C.06, subdivision 3b, shall not apply to contracts under this section. For calendar year 2022, the commissioner shall procure services in the seven-county metropolitan area for families and children under medical assistance and MinnesotaCare, from demonstration providers and participating entities as defined in section 256L.01, subdivision 7.

Sec. 6. Minnesota Statutes 2018, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

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

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

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

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

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding appropriated for this purpose. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, through December 31, 2016, payments to managed care

plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.

(l) Effective for services provided on or after January 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

(m) Effective for services provided on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.

(n) Effective for dental services provided on or after January 1, 2022, the commissioner shall increase payment rates by 54 percent. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers.

Sec. 7. Minnesota Statutes 2018, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2016, through December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter

62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

(c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

Sec. 8. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision to read:

Subd. 7. **Outpatient prescription drugs.** Outpatient prescription drugs are covered according to section 256L.30. This subdivision applies to all individuals enrolled in the MinnesotaCare program.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 9. Minnesota Statutes 2018, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 20 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 10. **[256L.30] OUTPATIENT PRESCRIPTION DRUGS.**

Subdivision 1. **Establishment of program.** The commissioner shall administer and oversee the outpatient prescription drug program for MinnesotaCare. The commissioner shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

Subd. 2. **Covered outpatient prescription drugs.** (a) In consultation with the Drug Formulary Committee under section 256B.0625, subdivision 13d, the commissioner shall

establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the requirements for an essential health benefit under Code of Federal Regulations, title 45, section 156.122. The commissioner may modify the formulary after consulting with the Drug Formulary Committee and providing public notice and the opportunity for public comment. The commissioner is exempt from the rulemaking requirements of chapter 14 to establish the drug formulary, and section 14.386 does not apply. The commissioner shall make the drug formulary available to the public on the agency website.

(b) The MinnesotaCare formulary must contain at least one drug in every United States Pharmacopeia category and class or the same number of prescription drugs in each category and class as the essential health benefit benchmark plan, whichever is greater.

(c) The commissioner may negotiate drug rebates or discounts directly with a drug manufacturer to place a drug on the formulary. The commissioner may also negotiate drug rebates, or discounts, with a drug manufacturer through a contract with a vendor. The commissioner, beginning January 15, 2022, and each January 15 thereafter, shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance of the rebates and discounts negotiated, their aggregate dollar value, and how the department applied these savings, including the extent to which these savings were passed on to enrollees.

(d) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Drug Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Drug Formulary Committee review a drug for prior authorization.

(e) Before the commissioner requires prior authorization for a drug:

(1) the commissioner must provide the Drug Formulary Committee with information on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs and information regarding whether the drug is subject to clinical abuse or misuse if such data is available; and

(2) the Drug Formulary Committee must hold a public forum and receive public comment for an additional 15 days from the date of the public forum.

(f) Notwithstanding paragraph (e), the commissioner may automatically require prior authorization for a period not to exceed 180 days for any drug that is approved by the United States Food and Drug Administration after July 1, 2019. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Drug Formulary Committee shall recommend to the commissioner general criteria to use

for determining prior authorization of the drugs, but the Drug Formulary Committee is not required to review each individual drug.

(g) The commissioner may also require prior authorization before nonformulary drugs are eligible for payment.

(h) Prior authorization requests must be processed in accordance with Code of Federal Regulations, title 45, section 156.122.

Subd. 3. **Pharmacy provider participation.** (a) A pharmacy enrolled to dispense prescription drugs to medical assistance enrollees under section 256B.0625 must participate as a provider in the MinnesotaCare outpatient prescription drug program.

(b) A pharmacy that is enrolled to dispense prescription drugs to MinnesotaCare enrollees is not permitted to refuse service to an enrollee unless:

(1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug in time to treat the enrollee's medical condition;

(2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the drug is dispensed;

(3) after performing drug utilization review, the pharmacist identifies the prescription drug as being a therapeutic duplication, having a drug-disease contraindication, having a drug-drug interaction, having been prescribed for the incorrect dosage or duration of treatment, having a drug-allergy interaction, or having issues related to clinical abuse or misuse by the enrollee;

(4) the prescription drug is not covered by MinnesotaCare; or

(5) dispensing the drug would violate a provision of chapter 151.

Subd. 4. **Covered outpatient prescription drug reimbursement rate.** (a) The basis for determining the amount of payment shall be the lowest of the National Average Drug Acquisition Cost, plus a fixed dispensing fee; the maximum allowable cost established under section 256B.0625, subdivision 13e, plus a fixed dispensing fee; or the usual and customary price. The fixed dispensing fee shall be $1.50 for covered outpatient prescription drugs.

(b) The basis for determining the amount of payment for a pharmacy that acquires drugs through the federal 340B Drug Pricing Program shall be the lowest of:

(1) the National Average Drug Acquisition Cost minus 30 percent;

(2) the maximum allowable cost established under section 256B.0625, subdivision 13e, minus 30 percent, plus a fixed dispensing fee; or

(3) the usual and customary price. The fixed dispensing fee shall be $1.50 for covered outpatient prescription drugs.

(c) For purposes of this subdivision, the usual and customary price is the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes the prices the pharmacy charges to customers enrolled in a prescription savings club or prescription discount club administered by the pharmacy, pharmacy chain, or contractor to the provider.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 11. **[256T.01] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of this chapter, the terms in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Department.** "Department" means the Department of Human Services.

Subd. 4. **Essential health benefits.** "Essential health benefits" has the meaning given in section 62Q.81, subdivision 4.

Subd. 5. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 6. **MNsure website.** "MNsure website" has the meaning given in section 62V.02, subdivision 13.

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

Sec. 12. **[256T.02] ONECARE BUY-IN.**

Subdivision 1. **Establishment.** (a) The commissioner shall establish a program consistent with this section to offer products developed for the OneCare Buy-In through the MNsure website.

(b) The commissioner, in collaboration with the commissioner of commerce and the MNsure Board, shall:

(1) establish a cost allocation methodology to reimburse MNsure operations in lieu of the premium withhold for qualified health plans under section 62V.05;

(2) implement mechanisms to ensure the long-term financial sustainability of Minnesota's public health care programs and mitigate any adverse financial impacts to the state and MNsure. These mechanisms must minimize adverse selection, state financial risk and contribution, and negative impacts to premiums in the individual and group health insurance markets; and

(3) coordinate eligibility, coverage, and provider networks to ensure that persons, to the extent possible, transitioning between medical assistance, MinnesotaCare, and the OneCare Buy-In have continuity of care.

(c) The OneCare Buy-In shall be considered:

(1) a public health care program for purposes of chapter 62V; and

(2) the MinnesotaCare program for purposes of requirements for health maintenance organizations under section 62D.04, subdivision 5, and providers under section 256B.0644.

(d) The Department of Human Services is deemed to meet and receive certification and authority under section 62D.03 and be in compliance with sections 62D.01 to 62D.30. The commissioner has the authority to accept and expend all federal funds made available under this chapter upon federal approval.

Subd. 2. **Premium administration and payment.** (a) The commissioner shall establish annually a per-enrollee monthly premium rate. The commissioner shall publish the premium rate by August 1 of each year.

(b) OneCare Buy-In premium administration shall be consistent with requirements under the federal Affordable Care Act for qualified health plan premium administration. Premium rates shall be established in accordance with section 62A.65, subdivision 3.

Subd. 3. **Rates to providers.** The commissioner shall establish rates for provider payments that are targeted to the current rates established under chapter 256L, plus the aggregate difference between those rates and Medicare rates. The aggregate must not consider services that receive a Medicare encounter payment.

Subd. 4. **Reserve and other financial requirements.** (a) A OneCare Buy-In reserve account is established in the state treasury. Enrollee premiums collected under subdivision 2 shall be deposited into the reserve account. The reserve account shall be used to cover expenditures related to operation of the OneCare Buy-In, including the payment of claims and all other accrued liabilities. No other account within the state treasury shall be used to finance the reserve account except as otherwise specified in state law.

(b) Beginning January 1, 2023, enrollee premiums shall be set at a level sufficient to fund all ongoing claims costs and all ongoing costs necessary to manage the program and support ongoing maintenance of information technology systems and operational and administrative functions of the OneCare Buy-In program.

(c) The commissioner is prohibited from expending state dollars beyond what is specifically appropriated in law, or transferring funds from other accounts, in order to fund the reserve account, fund claims costs, or support ongoing administration and operation of the program and its information technology systems.

Subd. 5. **Covered benefits.** Each health plan established under this chapter must include the essential health benefits package required under section 1302(a) of the Affordable Care Act and as described in section 62Q.81; dental services described in section 256B.0625, subdivision 9, paragraphs (b) and (c); and vision services described in Minnesota Rules, part 9505.0277, and may include other services under section 256L.03, subdivision 1.

Subd. 6. **Third-party administrator.** (a) The commissioner may enter into a contract with a third-party administrator to perform the operational management of the OneCare Buy-In. Duties of the third-party administrator include but are not limited to the following:

(1) development and distribution of plan materials for potential enrollees;

(2) receipt and processing of electronic enrollment files sent from the state;

(3) creation and distribution of plan enrollee materials including identification cards, certificates of coverage, a plan formulary, a provider directory, and premium billing statements;

(4) processing premium payments and sending termination notices for nonpayment to enrollees and the state;

(5) payment and adjudication of claims;

(6) utilization management;

(7) coordination of benefits;

(8) grievance and appeals activities; and

(9) fraud, waste, and abuse prevention activities.

(b) Any solicitation of vendors to serve as the third-party administrator is subject to the requirements under section 16C.06.

Subd. 7. **Eligibility.** (a) To be eligible for the OneCare Buy-In, a person must:

(1) be a resident of Minnesota; and

(2) not be eligible for government-sponsored programs as defined in United States Code, title 26, section 5000A(f)(1)(A). 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 eligible for government-sponsored programs. An applicant or enrollee who is entitled to premium-free Medicare Part A shall not refuse to apply for or enroll in Medicare coverage to establish eligibility for the OneCare Buy-In.

(b) A person who is determined eligible for enrollment in a qualified health plan with or without advance payments of the premium tax credit and with or without cost-sharing reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), is eligible to purchase and enroll in the OneCare Buy-In instead of purchasing a qualified health plan as defined under section 62V.02.

Subd. 8. **Enrollment.** (a) A person may apply for the OneCare Buy-In during the annual open and special enrollment periods established for MNsure as defined in Code of Federal Regulations, title 45, sections 155.410 and 155.420, through the MNsure website.

(b) A person must annually reenroll for the OneCare Buy-In during open and special enrollment periods.

Subd. 9. **Premium tax credits, cost-sharing reductions, and subsidies.** A person who is eligible under this chapter, and whose income is less than or equal to 400 percent of the federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing reductions under Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), to purchase a health plan established under this chapter.

Subd. 10. **Covered benefits and payment rate modifications.** The commissioner, after providing public notice and an opportunity for public comment, may modify the covered benefits and payment rates to carry out this chapter.

Subd. 11. **Coverage for legislators.** Effective upon the availability of coverage through the OneCare Buy-in program, all members of the state legislature shall be eligible for health coverage through that program, and shall not be eligible for coverage offered under section 43A.24.

Subd. 12. **Request for federal authority.** The commissioner shall seek all necessary federal waivers to establish the OneCare Buy-In under this chapter.

EFFECTIVE DATE. (a) Subdivisions 1 to 11 are effective January 1, 2023.

(b) Subdivision 12 is effective the day following final enactment.

Sec. 13. **[256T.03] ONECARE BUY-IN PRODUCTS.**

Subdivision 1. **Platinum product.** The commissioner of human services shall establish a OneCare Buy-In coverage option that provides platinum level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option. This product must be made available in all rating areas in the state.

Subd. 2. **Silver and gold products.** (a) If any rating area lacks an affordable or comprehensive health care coverage option according to standards developed by the commissioner of health, the following year the commissioner of human services shall offer silver and gold products established under paragraph (b) in the rating area for a five-year period. Notwithstanding section 62U.04, subdivision 11, the commissioner of health may use data collected under section 62U.04, subdivisions 4 and 5, to monitor triggers in the individual market under this chapter. Effective January 1, 2020, the commissioner of health may require submission of additional data elements under section 62U.04, subdivisions 4 and 5, in a manner specified by the commissioner, to conduct the analysis necessary to monitor the individual market under this chapter.

(b) The commissioner shall establish the following OneCare Buy-In coverage options: one coverage option shall provide silver level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option, and one coverage option shall provide gold level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option.

Subd. 3. **Qualified health plan rules.** (a) The coverage options developed under this section are subject to the process under section 62K.06. The coverage options developed under this section are deemed to meet requirements of chapters 62A, 62K, and 62V that apply to qualified health plans.

(b) Notwithstanding any other law to the contrary, benefits under this section are secondary to a plan of insurance or benefit program under which an eligible person may have coverage. The commissioner shall use cost-avoidance techniques to coordinate any other health coverage for eligible persons and identify eligible persons who may have coverage or benefits under other plans of insurance.

(c) The Department of Human Services is not an insurance company for purposes of this chapter.

Subd. 4. **Actuarial value.** Determination of the actuarial value of coverage options under this section must be calculated in accordance with Code of Federal Regulations, title 45, section 156.135.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 14. **[256T.04] OUTPATIENT PRESCRIPTION DRUGS.**

Subdivision 1. **Establishment of program.** The commissioner shall administer and oversee the outpatient prescription drug program for the OneCare Buy-In program. The commissioner shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

Subd. 2. **Covered outpatient prescription drugs.** Outpatient prescription drugs are covered in accordance with chapter 256L.

Subd. 3. **Pharmacy provider participation.** Pharmacy provider participation shall be governed by section 256L.30, subdivision 3.

Subd. 4. **Reimbursement rate.** The commissioner shall establish outpatient prescription drug reimbursement rates according to chapter 256L.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 15. **DIRECTION TO COMMISSIONER; STATE-BASED RISK ADJUSTMENT ANALYSIS.**

The commissioner of commerce, in consultation with the commissioner of health, shall conduct a study on the design and implementation of a state-based risk adjustment program. The commissioner shall report on the findings of the study and any recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over the individual health insurance market by February 15, 2021.

Sec. 16. **STUDY OF MINNESOTACARE EXPANSION.**

The commissioner of human services shall study the costs and requirements for a MinnesotaCare expansion that would:

(1) provide individual and small group health coverage with covered benefits and a provider network equivalent to MinnesotaCare, and enrollee out-of-pocket costs that are no higher than under MinnesotaCare;

(2) contract directly with all health care providers willing to participate and accept reimbursement and other contract terms;

(3) use a single third-party administrator, or be administered directly by the commissioner of human services;

(4) reimburse health care providers at rates no lower than those used under Medicare, except that the commissioner of human services may negotiate global budgets with health care providers to control costs and improve the quality of care;

(5) maximize federal financial participation, including capturing funding currently available for premium tax credits to reduce premium costs for enrollees;

(6) charge premiums on a sliding scale using an affordability standard, and state-funded tax credits for persons whose costs exceed the standard; and

(7) be available in every Minnesota county.

The commissioner of human services shall contract with an actuarial consulting firm to provide technical assistance in conducting the MinnesotaCare expansion study. The commissioner of human services shall present a report, implementation plan, and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and health insurance by December 15, 2019.

Sec. 17. **STUDY OF COST OF PROVIDING DENTAL SERVICES.**

The commissioner of human services shall contract with a vendor to conduct a survey of the cost to Minnesota dental providers of delivering dental services to medical assistance and MinnesotaCare enrollees under both fee-for-service and managed care. The commissioner of human services shall ensure that the vendor has prior experience in conducting surveys of the cost of providing health care services. Each dental provider enrolled with the department must respond to the cost of service survey. The commissioner of human services may sanction a dental provider under Minnesota Statutes, section 256B.064, for failure to respond. The commissioner of human services shall require the vendor to measure statewide and regional costs for both fee-for-service and managed care, by major dental service category and for the most common dental services. The commissioner of human services shall post a copy of the final survey report on the department's website. The initial survey

must be completed no later than January 1, 2021, and the survey must be repeated every three years. The commissioner of human services shall provide a summary of the results of each cost of dental services survey and provide recommendations for any changes to dental payment rates to the chairs and ranking members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 18. **REPEALER.**

Minnesota Statutes 2018, section 256L.11, subdivision 6a, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2022.

256L.11 PROVIDER PAYMENT.

Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2018, the commissioner shall increase payment rates to dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12 shall reflect the payment increase described in this subdivision. The prepaid health plans under contract with the commissioner shall provide payments to dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.