2007 Legislative Report
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This summary of the activities of the 2007 Legislature is intended as an overview. This document cannot be relied upon as evidence of the provisions of the Minnesota laws.

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With a new DFL majority in the House of Representatives and a stronger majority in the Senate, leaders promoted an ambitious agenda which included health care reform, significant health care program expansion including covering all kids, enhanced K-12 funding and all-day kindergarten, transportation investments through an increase in the gas tax, and property tax relief. Despite a nearly $2 billion state surplus, legislative leaders were stifled throughout the session by Governor Pawlenty’s continuing opposition to raising additional revenue and the discovery that $2 billion doesn’t go far after accounting for inflationary program growth. The result is that many legislators and advocates were disappointed with the outcome of the session and left the Capitol yearning for “what could have been.”

The MMA had a very successful session. Most notably we passed the Freedom to Breathe Act prohibiting smoking indoors in bars and restaurants. Minnesota once led the nation by passing the first clean indoor air law. Today, more than 30 years later, Minnesota physicians helped complete that work by ensuring that no workers are left unprotected from the harmful health effects of secondhand smoke.

While real health care reform eluded legislators this year there continues to be momentum for reform in 2008. Following the introduction of legislation by Healthy Minnesota, A Partnership for Reform, which laid out a plan for universal coverage utilizing medical homes, promoting public health, and providing incentives for health information technology, legislators became tied up in all the conflicting opinions on reform. They did authorize a number of study groups and commissions to try to lay the groundwork for accomplishing reform next session.

Guarding the use of the Health Care Access Fund has been a top priority for the MMA for many years. For the first time since 2003, we are pleased to report that the revenue raised from the provider tax will not be used for General Fund obligations, rather it is being used to expand access to health care programs and restore cuts to the health care safety net programs.

Significant progress was also made on requiring health plan reimbursement for medical interpreters. Absent the threat of a gubernatorial veto, this mandate would have become law. We made significant progress working with health plans and are hopeful the agreement will hold up over the interim.

The following report provides a more detailed summary of issues considered at the Legislature which are important to physicians, their practices and patients.

MMA staff would like to thank each of you who took the time to come to the Capitol during Grand Rounds and Day at the Capitol, those who met with legislators near their homes through in-district meetings and those of you who contacted your legislators by phone and email. We are especially grateful to the members of the MMA Committee on Legislation, chaired by Benjamin Whitten, M.D. The success of the MMA is a direct reflection of active participation by our members.
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Section I

BILLS THAT PASSED

2007 LEGISLATURE
Chapter 41: Adverse Health Care Reporting

(H.F. 1990 – Ruud/S.F. 1790 – Hann)

Chapter 41 makes changes to the adverse health care events reporting system. Currently, hospitals and outpatient surgical centers are required to report certain health events to the Minnesota Department of Health. The list of reportable events are consistent with those adopted by the National Quality Forum (NQF).

The act modifies the reporting requirement to conform with recent changes to the NQF list of events. There are three changes. First, hospitals must now report a patient death or serious injury associated with any patient disappearance, not just those lasting for more than four hours. Second, the act requires the reporting of artificial insemination with the wrong donor sperm or the wrong egg. Third, it requires the reporting of a serious disability resulting from a fall, whereas previous law only required the reporting of deaths associated with falls.

Effective Date: October 7, 2007

Chapter 42: Sexual Assault Victim Emergency Room Care

(H.F. 1442 – Slawik/S.F. 1266 – Pappas)

Chapter 42 is the Compassionate Care for Sexual Assault Victims Act providing emergency care to sexual assault victims. It states that the standard of care is for all hospitals to provide each victim with medically and factually accurate information about emergency contraception, orally inform the victim of her option of receiving emergency contraception, and immediately provide emergency contraception if the victim requests it and it is not medically contraindicated. In addition, hospitals are required to provide all sexual assault victims, both male and female, with written and verbal information about receiving prophylactic antibiotics for the treatment of sexually transmitted diseases, provided they are not medically contraindicated.

The commissioner of health is authorized to investigate complaints to ensure that hospitals are in compliance with the act. Failing to comply may be grounds for the suspension or revocation of a hospital’s license.

Effective Date: August 1, 2007
**Fire-Safe Cigarettes**  
*Chapter 54*  
*(H.F. 829 – Paymar/S.F. 650 – Higgins)*

Included in the Omnibus Public Safety Budget Act is a requirement that all cigarettes sold in Minnesota be fire-safe cigarettes. According to Chapter 54 no cigarette may be sold in this state unless they have been certified by the state fire marshal to be fire-safe cigarettes. They must pass testing standards that show that the cigarette will not fully burn without constantly being puffed.

The act authorizes the state fire marshal to enforce this act. It creates civil penalties for tobacco wholesalers and retailers who sell cigarettes that are not certified as fire safe. Fines on wholesalers start at $10,000 for the first offense and fines on retailers start at $500. Fines are deposited in the reduced cigarette ignition propensity account that is used to pay for enforcement activities.

The fire-safe cigarette provisions were promoted by the state firefighters’ organizations to address the fire risks associated with smoking. Smoking is the number one cause of fire-related fatalities. This act will also reduce the harms of secondhand smoke in the home by extinguishing cigarettes that are left unattended in an ashtray. Minnesota becomes the 13th state to pass similar legislation.

**Effective Date:** December 8, 2008

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**Biomonitoring: Environment, Natural Resources, & Energy Budget Act**  
*Chapter 57*  
*(H.F. 2410 – Wagenius/S.F. 2096 – Anderson)*

Chapter 57 directs the commissioner of health, in cooperation with the commissioner of the Pollution Control Agency, to establish an environmental health tracking system to organize, analyze, and interpret statewide and localized geographic patterns of chronic diseases including, but not limited to, cancer, respiratory diseases, reproductive problems, birth defects, neurological diseases, and developmental disorders. The commissioner shall conduct biomonitoring of communities on a voluntary basis, including biomonitoring of pregnant women and minors when scientifically appropriate; communicate findings to the public; share analytical results with the advisory panel and submit a biennial report to the Legislature by January 15, beginning January 15, 2009, on the status of the biomonitoring program and any recommendations for improvement.
In addition, the act establishes an Environmental Health Tracking and Biomonitoring Advisory Panel with eight members who have a background in designing, implementing, and interpreting health tracking and biomonitoring studies or in related fields of science. The members shall include at least two scientists representing nongovernmental organizations with a focus on environmental health, environmental justice, children's health, or specific chronic diseases and statewide business organizations; at least one scientist who is a representative of the University of Minnesota; two citizen panel members appointed by the Legislature; and one representative each appointed by the commissioners of the Pollution Control Agency and the Department of Agriculture, and by the commissioner of health to represent the department's Health Promotion and Chronic Disease Division. The advisory panel shall make recommendations to the commissioner and the Legislature on priorities for health tracking, priorities for biomonitoring, the specific chronic diseases to study, the specific environmental hazard exposures to study, and the specific communities and geographic areas on which to focus.

Effective Date: July 1, 2007

**Hearing Aid Coverage**

Chapter 60 mandates that health plans cover the cost of hearing aids for children 18 years of age or younger. This is a change from current law that covers them only due to functional congenital malformation of the ears.

The health plans did not oppose this legislation and do not believe it will add significant cost to premiums. The act passed over the objections of the Minnesota Chamber of Commerce, which opposes any new mandated benefit.

Effective Date: August 1, 2007

**Colorectal Cancer Screening Coverage**

Chapter 66 amends Minnesota statutes to require that every health policy and medical plan provide Minnesota residents coverage for routine colorectal screening tests as a standard practice of medicine. This screening coverage is added to the section of law that requires coverage for routine cancer screenings. This act was not opposed by the health plans because it clarifies current interpretation of the law.

Effective Date: Immediately
Chapter 82 implements the Freedom to Breathe Act of 2007. It adopts a statewide smoking ban that prohibits smoking in all public places and worksites, including restaurants and bars, making Minnesota smoke free effective October 1, 2007.

This act allows Minnesota residents, workers and visitors to benefit from clean, smoke-free indoor environments offering protection from the health risks of exposure to secondhand smoke. Secondhand smoke contains more than 4,000 chemicals, including more than 50 carcinogens, and causes lung cancer and heart disease in adults, lower respiratory illnesses, asthma, middle ear disease and sudden infant death syndrome in infants and children.

The act defines “indoor area” as all space between a floor and a ceiling that is bound by walls, doorways, or windows, whether open or closed, covering more than 50 percent of the combined vertical surface area. This definition attempts to prohibit creative uses of “patio” spaces to create indoor smoking rooms.

The exceptions to smoke-free workplaces include tobacco shops that allow smoking of a sample, over-the-road trucks where two adults may be in the cab, farm equipment, family farms and smoking by an actor as part of a theatrical performance. In addition, smoking is permitted as part of peer reviewed scientific studies related to the effects of smoking, in nursing home rooms with proper ventilation, and by patients in a locked psychiatric unit if the unit has a policy allowing it and if the treating physician determines that smoking is needed to obtain a patient’s cooperation.

Chapter 82 clearly states that nothing in this law prohibits local governments from enacting or enforcing more stringent measures to protect individuals from secondhand smoke.

The MMA had been diligent in the lobbying efforts to pass this legislation. Minnesota was the first state to pass groundbreaking legislation back in 1975, which addressed early concerns about the risks of exposure to secondhand smoke.

Effective Date: October 1, 2007
Mercury-Containing Products

Chapter 109

H.F. 1316 – Hortman/S.F. 1085 – Marty)

Chapter 109 provides for further regulation of mercury-containing products adding to last year’s law additional products that contain mercury and prohibiting their sale within the state. The act prohibits the sale, distribution and the use of a number of mercury-containing products, including sphygmomanometers, gastrointestinal devices, thermostats, barometers, manometers, pyrometers, switches, relays, cosmetics, fragrances, and over-the-counter pharmaceuticals. This ban is effective August 1, 2007.

Additionally, the act adds fluorescent and high-intensity discharge lamps to products that cannot be disposed of with solid waste or put down the drain. They must be recycled by a lamp recycling facility. Sellers of fluorescent lights must include a notice that they contain mercury.

Various Effective Dates

Uniform Anatomical Gift Act

Chapter 120

(H.F.1074 – Ruud/S.F. 883 – Scheid)

Chapter 120 updates the current Uniform Anatomical Gift Act. Anatomical gift is a donation of all or part of a human body for purposes of transplantation, therapy, research and education. The bill specifies who may make anatomical gifts, how to make a gift, and who may receive an anatomical gift. These changes are based on the recommendations of the national uniform laws commission.

The act states that an anatomical gift may be made to a hospital, medical school, organ procurement agency, a non-profit research or educational organization, an eye or tissue bank or to a designated transplant recipient. The purchase or sale of anatomical gifts is a felony offense.

Chapter 120 is cited as the “Darlene Luther Revised Uniform Anatomical Gift Act.” This is named after former Rep. Darlene Luther who was a strong advocate of organ donations after having received an organ donation herself.

Effective Date: August 1, 2007
Chapter 123 is the Omnibus Health Occupations Licensing Act. The act includes a number of changes to licensing requirements for physicians, x-ray technicians, audiologists, physical therapy assistants, professional counselors, and social workers. Most of these changes are minor and non-controversial.

**Physicians**

The act changes requirements for newly licensed physicians to pass the United States Medical Licensing Examination (USMLE) to provide more flexibility for non-traditional students. Current law requires an applicant to pass steps one, two, and three of the USMLE within seven years. Now, step three must be passed within five years of passing step two, or before finishing residency training. The act also provides that the Board of Medical Practice may grant an extension to the time period and to the number of attempts permitted to pass the USMLE if an applicant has been diagnosed with a medical illness during the process of taking the USMLE but before passage of all steps, or fails to pass a step within three attempts due to the applicant's medical illness. Proof of the medical illness must be submitted to the board on forms and according to the timelines of the board.

The act also clarifies the use of “dispense as written” with electronic prescriptions. It updates old language that referred to written prescriptions. The act allows a prescriber to state on an electronic prescription that the prescription is to be dispensed as transmitted. The act also states that nothing permits a prescriber to maintain "dispense as written" or "D.A.W." as a default on all prescriptions. Prescribers must add the "dispense as written" or "D.A.W." designation to electronic prescriptions individually, as appropriate.

**X-Ray Operators**

Beginning January 1, 2008, an individual in a facility with x-ray equipment for use on humans may not operate, nor may the facility allow the individual to operate, x-ray equipment unless the individual has passed a national examination for limited x-ray machine operators. A limited x-ray operator may only practice medical radiography on limited regions of human anatomy for which the operator has successfully passed an examination. The examination for limited x-ray machine operators must include:

1. radiation protection, equipment maintenance and operation, image production and evaluation, and patient care and management; and
2. at least one of the following regions of the human anatomy: chest, extremities, skull and sinus, spine, or ankle and foot. The examinations must include the anatomy of, and positioning for, the specific regions.
**Audiologists**

Beginning August 30, 2007, an audiology applicant must possess a doctoral degree with an emphasis in audiology, or its equivalent as determined by the commissioner, from an accredited educational institution. This is an increase from current requirements that they have either a master’s or doctoral degree and is intended to reflect the replacement of master’s-level programs by doctoral programs at hearing institutions within the state. Speech-pathologists can still be licensed with either a master’s or doctoral degree.

**Physical Therapy Assistants**

The act updates the licensing requirements for physical therapy assistants. It codifies many of the requirements that were in rules and puts them in the physical therapy practice act. It requires all physical therapy assistants to graduate from an accredited physical therapy assistant program and pass the National Physical Therapy Examination. It also codifies the grounds for discipline by the physical therapy board.

This act does not in any way change the scope of practice of physical therapists related to direct access. That was defeated in another bill.

**Licensed Professional Clinical Counselors**

Chapter 123 converts licensed professional counselors to licensed professional clinical counselors. This act specifies that to be licensed, an applicant must have completed a master’s or doctoral degree program in counseling, have earned 24 graduate-level semester credits in clinical coursework, and have demonstrated successful completion of 4,000 hours of supervised, post master’s degree professional practice in the delivery of clinical services in the diagnosis and treatment of child and adult mental illnesses and disorders.

**Advisory Councils Made Permanent**

Currently there are four groups of non-physician providers that are licensed under the Board of Medical Practice. Each of these groups has an advisory council that reviews their practitioners and recommends licensure and disciplinary action to the BMP. Under current law these councils sunset every three years and have to be renewed by the Legislature. In addition, the Health Professional Services Program that is used to address practitioners with chemical dependency problems also has an advisory council that will eventually sunset.

Chapter 123 removes all of these sunset provisions and makes each of these advisory councils permanent. The four licensed groups include physician assistants, acupuncture practitioners, respiratory care practitioners, and traditional midwives.

**Various Effective Dates**

| Safe Patient Handling: | Chapter 135 |
Included in the Jobs and Economic Development Budget bill is the Safe Patient Handling Act. This is an initiative from the Minnesota Nurses Association and the disability community to ensure that disabled patients receive necessary care and health care workers are protected from injury when moving patients.

The language found in Chapter 135 was originally in legislation introduced by Rep. Patti Fritz (S.F. 712) and Sen. Linda Higgins (S.F. 828). As introduced it required all hospitals, nursing homes and licensed surgical centers to adopt a written safe patient handling policy. The policy must be in place by July 1, 2008 and it must establish a plan by January 1, 2011 to minimize manual lifting of patients by direct patient care workers. The plan shall address the assessment of hazards regarding patient handling, the acquisition of an adequate supply of safe patient handling equipment, the ongoing training of staff on the use of the equipment, and periodic evaluations of the safe patient handling program.

The act also requires every licensed facility to establish a safe patient handling committee that includes direct staff to complete the hazard assessment, make recommendations on appropriate equipment, recommend training needs and conduct the program evaluation.

The act provides grants to facilities to acquire safe patient handling equipment. Grants to any one facility shall not exceed $40,000 and must be matched dollar-for-dollar by the facility.

The Safe Patient Handling Act does not apply to clinics, doctors’ offices, dental offices or other outpatient facilities. The act does, however, create a work group to discuss these settings. The Minnesota State Council on Disabilities is directed to form a work group composed of “representatives from the Minnesota Medical Association and other organizations representing clinics, disability advocates and direct care workers,” to assess current options for the use of safe patient handling equipment and identity barriers to the use of this equipment in clinic settings. The work group shall report to the Legislature by January 15, 2008.

Effective Date: July 1, 2007
Chapter 139 authorizes registered nurses to dispense oral contraceptives that have been prescribed by a physician, nurse practitioner, or physician assistant, pursuant to a dispensing protocol established by the facility’s medical director. The act specifically prohibits a registered nurse from dispensing oral contraceptives to a patient under 12 years of age.

The act also requires the commissioner of human services to work with family planning clinics to determine an adjusted Medical Assistance reimbursement rate to adequately cover the cost of their services. The commissioner shall report the adjusted rate to the Legislature by January 15, 2008.

Effective Date: October 1, 2007

Chapter 147 is the Health and Human Services Omnibus Budget Act. It appropriates funding for the two-year biennium for the Department of Human Services, Department of Health, and the health licensing boards, including the Board of Medical Practice. Spending nearly $10 billion, this act represents an 18.7 percent increase in funding over the last biennium ($1.46 billion). Of the increase, 56 percent is spent on a cost-of-living-adjustment for long-term care employees, 17 percent on a pay raise for state employees in the health and human services area, 9 percent on federal compliance, 10 percent on non-forecasted base items, and only 8 percent on new programs. This was the second omnibus HHS budget bill that was enacted this year, after an earlier bill was vetoed by the governor because he believed it spent too much.

Nearly all budget bills were vetoed the first time around because together they appropriated funds raised by various tax increases that were not acceptable to the governor. In order to fit within the more modest budget targets exclusive of large tax increases, a number of new programs and reforms were removed in this bill to address the governor’s concerns. Items removed to fit within the lower targets include the Covering All Kids program, Insurance Exchange, MinnesotaCare eligibility for small employers, increasing the inpatient hospital cap for MinnesotaCare, and funding for the Birth Defects Information System (BDIS). Nursing home staff also receive less of an increase.

The final act was a disappointment to many because it doesn’t include more money, but it includes significant investments in important programs including steps toward health care
reform. The 508-page bill does not restore all cuts to programs from budget deficit years; instead it tinkers around the edges and invests a little bit of money in lots of areas.

As promised, Governor Pawlenty line-item vetoed a number of provisions in the bill primarily dealing with welfare programs.

**Health Care Reform**

Early in session it became clear that real reform would not be achieved this year. In the last days of the legislative session, the House also failed to act on the Constitutional Amendment on the 2008 election ballot to guarantee every Minnesotan a right to affordable health care. Instead, Chapter 147 calls for multiple studies and groups to make recommendations for achieving universal coverage. There is significant overlap in the charge of many of the groups and some even appear to contradict one another. This is indicative of the different ways in which the Governor, the House and the Senate each proposed to cover all Minnesotans. Most proposals are due in time to be considered during the 2008 session.

**Health Care Transformation Task Force**

Although the bill put forward by Healthy Minnesota did not advance, this act creates the Health Care Transformation Task Force to advise on health care reform and develop recommendations. The group consists of two senators and two representatives, two state agency appointees, three leaders in health care, two labor representatives, one representative of group purchasers/employers, and five at-large appointees.

The task force is charged with presenting a statewide action plan with measurable goals and deadlines to ensure all Minnesotans have health coverage by January 2011. Additionally, the Task Force must make recommendations on how to reduce health care expenditures by 20 percent by January 2011 and limit the rate of growth in spending to no more than the Consumer Price Index plus 2 percent for all urban consumers. They must also come up with recommendations to improve health care safety, reduce health disparities, reduce preventable chronic illness, promote cost-effective investment in technology, facilities and drugs, develop options for small employers and self-employed, and reduce administrative costs within the entire health care system.

**Voluntary statewide pool study group**

The act forms a group to study and make recommendations on the creation of a voluntary, statewide health plan purchasing pool to contract directly with providers to provide affordable health coverage to eligible Minnesota residents. The group’s membership includes members of the Legislature, attorney general’s office, three health care providers, two state employee unions, the state teacher’s union Education Minnesota, the Minnesota Business Partnership, and the Metropolitan Interdependent Business Organization. Health care providers are not included in the study group.

**Legislative Commission on Health Care Access**
The Legislative Commission on Health Care Access was first enacted in 1992 by the original HealthRight legislation that created MinnesotaCare. It has been dormant for the last six years. It is made up exclusively of legislators – five from the Senate and five from the House. With the renewed legislative interest in health care reform, the commission is being revived to make recommendations on how to achieve universal health coverage, including a timetable to reach that goal by 2011.

**Agricultural Cooperative Health Plan for Farmers**

The act creates a four-year, joint self-insurance pilot project administered by one or more agricultural cooperatives to improve access, expand health plan choice, and improve the affordability of coverage for farm families.

**Minnesota Health Insurance Exchange**

One of the keys to Governor Pawlenty's health care reform proposal was the creation of the Minnesota Health Insurance Exchange. It would have served as a clearing house of all insurance products and required all individual products to be sold through the Exchange. This combined with his proposal to allow individuals to purchase individual products with pre-tax dollars, was designed to make individual products more affordable.

Following significant opposition from health plans and other groups to the Governor’s proposal, the act calls for a study of the feasibility of developing the program. The report shall include recommendations for creating the exchange, potential eligibility requirements, participating health plan loss ratio requirements, and the potential ability to process premiums on a pretax basis through federal Section 125 plans.

**Health Care Access Survey**

The act appropriates funding for the Department of Health to conduct a health insurance survey of Minnesota households, in partnership with the University of Minnesota. This survey, conducted every few years, provides lawmakers and the public with information on how many Minnesotans are uninsured and why.

**Care Coordination and Medical Home**

One of the key components of the Healthy Minnesota recommendations that was embraced by the Legislature was the medical home model. This model envisions dramatic reforms to our payment systems that reward physicians for caring for patients with complex medical conditions. Many provisions included in Chapter 147 promote this model.

**Provider-directed Care Coordination**

Chapter 147 creates a program to reimburse a health care provider an average of $50 per-patient per-month for fee-for-service enrollees for coordination of care for patients with complex and chronic medical conditions. Clinics that qualify for the payment must have the capacity to develop care plans, have a dedicated care coordinator, evaluation mechanism, quality improvement processes and an adequate number of eligible patients. A primary care clinic was carefully defined in response to concerns raised by the MMA
that these clinics develop strong relationships with the patient. In order to qualify, a clinic must be a medical clinic that is the patient’s first point of contact for medical care that is available 24 hours a day and seven days a week, that provides or arranges for comprehensive health care needs, and that is integrated for referrals for specialty care. Retail-based clinics such as Minute Clinics and others would not be eligible for the payment under this definition.

**Care Coordination Pilot Projects**
The act creates four care coordination pilot projects for children and adults enrolled in fee-for-service Medical Assistance. The act specifies that at least two must focus on children with autism or other complex/multi-diagnosis physical conditions. It requires pilot projects to be evaluated on patient and provider satisfaction, process and outcome measures, costs and savings and economic income on providers within the context of medical home. These projects are separate from and not eligible for the care coordination payments.

**Pediatric Medical Home Project**
The act appropriates $1 million from the Health Care Access Fund to expand the Medical Home Learning Collaborative initiative for children with special health needs operated in partnership with the Minnesota Chapter, American Academy of Pediatrics. This is an existing pilot project funded through a $300,000 federal Maternal and Child Health grant which expires in the spring of 2008. The expansion is for fiscal years 2008 and 2009 and will be coordinated in collaboration with the Department of Human Services to maximize federal Medicaid matching funds. A report on cost savings must be presented to the Legislature on January 15, 2010.

**Reimbursement Reform**
Chapter 147 calls for the commissioners of the departments of employee relations, human services, commerce and health to work together to facilitate changes in the methods used for paying for health care in order to reward primary and preventive care, reward evidence-based care, discourage underutilization, overuse and misuse, promote the use of the most cost effective settings, treatments and providers and encourage consumers to use the health care system appropriately. The commissioners shall examine changes to reimbursement for health care services, drugs, devices, supplies and equipment.

**Emergency Room Diversion Pilot Project**
The act creates a new pilot project to try to address inappropriate use of the emergency room. This is a primary care access initiative in Hennepin and Ramsey Counties for a web-based program that can help schedule appointments with primary care clinics for patients presenting for non-emergency use of the emergency room.

**Care Coordination by Community Health Workers**
The act expands Medical Assistance to cover care coordination and patient education provided by a community health worker working under the supervision of a physician, registered nurse or advanced practice registered nurse. These workers, usually located in low-income communities, are intended to help link patients to health care providers.
**Health Care Access Fund Integrity**

For the first time in four years, no significant transfers are made from the Health Care Access Fund for purposes other than expanding health care access. Due to the vigilance of the MMA and individual health care providers, the integrity of the fund is maintained this year. Much of the surplus is spent, but it is spent on initiatives to increase health care access and move toward reform.

**Moving Toward Universal Coverage**

Legislative leaders estimate that 37,000 additional children will have access to state health care programs and 17,000 uninsured adults will be eligible for coverage under the expansions included in this act. Instead of only providing coverage for kids, the act expands access to state health care programs for single adults as well and restores many benefits to pre-2003 levels. A large number of the state’s uninsured, however, are already eligible for health coverage either in the private market or state health care programs. The governor’s initial budget proposal included funding to assist those eligible for private market coverage to obtain it via a proposed program called the Health Insurance Exchange and Section 125 Plans, which would have allowed an employee to deduct premiums paid for individual health insurance on a pre-tax basis. Although neither were passed this year, Chapter 147 makes moderate steps to encourage enrollment for individuals in private coverage but also makes significant investments in outreach to enroll those eligible for public programs.

**Safety Net Program Benefit Expansion**

Although all the cuts from the 2003 and 2005 budgeting sessions could not be restored, Chapter 147 includes a number of provisions to maintain the affordability of state health care program coverage for enrollees and ensure access to necessary benefits.

MinnesotaCare eligibility for adults with no children is expanded from 175 percent of the federal poverty level to 200 percent, and then expanded again to 215 percent on July 1, 2009 to ensure enrollees stay eligible in anticipation of an increase of the minimum wage. Parents and caretakers enrolled on MinnesotaCare are no longer subject to coinsurance and the sliding scale premium increases from 2005 are removed, resulting in lowering premiums for MinnesotaCare up to 8 percent based on income.

The act also lowers the maximum amount enrollees may spend on prescription drug co-pays from $12 to $7, and co-pays for all services are limited to one per day per provider. Pregnant women and children are no longer subject to $6 emergency room copays for non-emergency visits.

To decrease the number of enrollees who lose coverage due to re-enrollment, the eligibility period is extended to 12 months (from six) and many of the requirements on income verification are removed. The act also removes the add back of farm depreciation income, which is expected to extend access to more self-employed farmers.
Military families are no longer required to pay premiums for MinnesotaCare for the first 12 months home from active duty and the program will become more accessible for self-employed farmers.

**Dependents under Age 25**

After many years advocating for expanded access for dependent children, the efforts of the MMA was successful in changing the definition of dependent for the purpose of private health coverage. The new definition is no longer tied to a dependent’s status as a student. Previously in order to be considered a dependent, health plans sought proof of full-time enrollment. This is designed to reduce the number of 18-24 year olds who are uninsured because their entry-level job does not provide health benefits.

**Access Expansion for Children: Transitional Medical Assistance**

Effective October 2008, the act creates a new program called Transitional Medical Assistance. Children enrolled in Medical Assistance (MA) who become ineligible due to excess income of their parents will become automatically eligible for two more months of eligibility on MA then become eligible for extended coverage under MinnesotaCare until renewal (one year). The Department of Human Services estimated that transitioning off MA was the most significant area of loss of enrollment for children.

**Outreach and Enrollment Assistance for Public Programs**

Chapter 147 appropriates over $20 million to raise awareness of availability of health coverage through MA, GAMC and MinnesotaCare and to educate people on the importance of obtaining and maintaining health care coverage.

One of the most significant changes is the simplification and shortening of the state program application. The act eliminates the requirement that the Department of Human Services verify income and no longer requires an applicant to include contact information for their employer to determine whether the applicant is eligible for employer-sponsored coverage. Legislators also hope more homeless individuals will enroll by allowing a shelter address to be listed on the application. Previously temporary residences were not accepted.

In addition to streamlining the application for enrollment in state programs as a result of fewer verification requirements, applications will be available in more locations. Schools are required to provide one to each child receiving free and reduced lunch and have them available for other families. The act provides a $20 per application bonus for organizations that assist individuals with completing an application. The bonus can be passed along to the enrollee in the form of a gift certificate or other incentive.

Applications must be also available in physician offices. All hospitals and community clinics receiving state funds must provide assistance in completing the application. Physicians offices are not required to assist with the completion of applications, rather they must provide information on where an applicant can receive application assistance.
If a provider does assist with the completion of the application they may qualify for the application bonus as well.

Additionally, the act provides grants to create outreach collaboratives with providers, hospitals, pharmacies and others to distribute applications and a statewide toll-free number to provide information on public and private coverage.

**Federally Qualified Health Centers**
The act also appropriates $3 million from the Health Care Access fund to offset uncompensated care costs for Federally Qualified Health Centers. Federally Qualified Health Centers are “safety net” providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless.

**Formulary Changes and Notification**
In an effort to have providers pressure pharmaceutical manufacturers to enter into rebate agreements with the Department of Human Services, the act requires prescribers to be notified when a drug used by more than 2 percent of fee-for-service Medical Assistance enrollees is removed from the formulary due to the manufacturer’s failure to sign a rebate agreement.

**Quality Improvement and Incentives**
The act continues to fund Governor Pawlenty’s Q-Care initiative, a program intended to reward providers who provide optimal care for state health care program enrollees with diabetes and cardiac disease. A new program called Provider-Directed Care Coordination will manage health issues of both adult and pediatric patients with complex chronic illnesses through reimbursing for case management services.

**Administrative Uniformity**
Chapter 147 includes some of the biggest steps toward administrative simplicity in years including a new uniform billing and coding process. Combined with steps toward interoperability of health records, it will increase system efficiency and lower costs. The act requires all health care payers and providers doing business in Minnesota to use electronic methods for all claims and eligibility transactions. All group purchasers must accept from health care providers a standard uniform electronic claim form, beginning January 15, 2009. The forms, guidelines, rules, and timelines are articulated. Paper claims and eligibility transactions can no longer be exchanged in Minnesota after January 15, 2009.

**Health Information Technology**

**Interoperability Standards**
Chapter 147 requires all providers to have interoperable electronic health records in place within their hospital systems or clinical settings by January 1, 2015. The Department of Health and the Health Information Technology Infrastructure Advisory Committee must
develop a statewide plan, including uniform standards for sharing and synchronizing patient data across systems by January 1, 2009.

**E-Health Grants and Revolving Loan Fund**

In order to meet the goal of all hospitals and providers implementing interoperable records by 2015, the act appropriates $14 million to help small rural health care providers and community clinics prepare. Funding is appropriated from the Health Care Access Fund for these investments in health information technology designed to improve patient safety, interconnect clinicians and communities, and strengthen and improve public health in Minnesota. It establishes an electronic health records system revolving account and expands the interconnected electronic health records grant to include community clinics and implement regional or community-based exchanges.

The revolving, no-interest loan account may assist in financing the installation of an interoperable health record system for rural areas or clinics in towns with less than 50,000, nursing homes, and others. The term of the loan is two to six years with a maximum amount of $1.5 million.

**Health Records Act**

This is a complete rewrite of the Minnesota Health Records Act and the state’s patient consent requirements. It is intended to facilitate providers’ electronic exchange of health information, while maintaining current privacy protections. Under the Minnesota e-Health Initiative Advisory Committee’s direction, the Minnesota Privacy and Security Project (MPSP) conducted a systematic and comprehensive review of current laws and practices to identify and address the most significant privacy and security barriers to the electronic exchange of health information.

Although most of the language was just a restating of the old law, two controversial pieces of the act are the creation of the record locator service and “representation of consent” to obtain a patient’s record.

The record locator service is intended to facilitate the exchange of information between providers, serving as an index or card catalog for providers to be able to find the location of a patient’s electronic record. Privacy advocates were worried that providers using the service would learn information about a patient’s health history simply from seeing what other providers the patient had visited, without the patient’s consent, such as a dentist learning that a patient saw a psychiatrist. The record locator service only contains the identifying information necessary to assist providers in finding the location of all pertinent health information; it does not contain the patients’ clinical data.

Also in an effort to facilitate the electronic exchange of patients’ health information, the act provides a mechanism for patients to provide consent through the treating/requesting provider at the point of service. This means that the patient consent requirements would allow the disclosing provider to automatically and electronically exchange patients’ health information to the requesting/treating provider based on the requesting provider’s representation of having obtained the patient’s consent. Potential abuse of the representation of consent raised the fears of privacy advocates as well.
The MMA successfully fought off amendments from trial lawyers to enable them to have easier and less expensive access to plaintiff medical records. The only amendment that was adopted requires the commissioner of health to develop a standard release form that may be used by patients to access health records. This form must be accepted by providers as a legally enforceable request.

**Mental Health**

Chapter 147 includes over $35 million for improving quality and access to Minnesota’s publicly funded mental health system. Ironically, the Governor had difficulty last year convincing his Republican colleagues in the House to support his initiative to begin restructuring our state’s mental health system. This year, with Democrats in charge of both the House and Senate, he had more success. He originally proposed $45 million in new funding for his initiative. The commissioner of human services is authorized to expend these funds with the goal of improving the availability, quality and accountability of mental health care within the state.

**Integrated Care**

The act authorizes the commissioner of human services to fund up to three projects to demonstrate the integration of physical and mental health services within prepaid health plans. The projects will be based upon locally defined parameters, include at least one prepaid health plan and require counties to retain the responsibility and authority for social services. The projects can be implemented no earlier than January 1, 2009 and shall be limited to not more than 40 percent of the statewide population.

Another important provision of the mental health initiative includes a standard mental health benefit set for Medical Assistance, General Assistance Medical Care and MinnesotaCare. A consistent benefit set across these programs will greatly ease program administration.

A major ongoing issue of discussion not entirely addressed this year relates to county case management services and clarifying the responsibility of counties for the delivery of social services within an integrated physical/mental health system. The act directs the commissioner of human services to bring to the Minnesota Legislature and State Advisory Council on Mental Health recommendations for updating the role of counties, and to clarify the case management roles and decision making authority of counties and health plans. These recommendations must be submitted by January 15, 2008. In the interim, $32 million was appropriated from the state’s general revenues to counties to offset any reductions in federal funding of targeted case management services as a result of the federal Deficit Reduction Act of 2005. This is in addition to the $35 million previously mentioned.

**Children’s Mental Health**
The act grants nearly $6 million in 2008 and $6.8 million in 2009 to counties, mental health providers, Indian tribes or children’s collaboratives for providing services to children with emotional disturbances. The grants must be designed to help each child function and remain with the child’s family in the community consistent with the child’s treatment plan.

The act also establishes a two-year, 11 county regional children’s mental health initiative pilot project to plan and develop new programs and services related to children’s mental health in south central Minnesota. The counties included in the pilot project are Blue Earth, Brown, Faribault, Freeborn, Le Sueur, Martin, Nicollet, Rice, Sibley, Waseca and Watonwan.

Additionally, Chapter 147 appropriates $300,000 for a three-year pilot project to measure how children’s mental health needs affect participants in the Minnesota Family Investment Program and their ability to obtain and retain employment.

It also appropriates more than $5.3 million in fiscal years 2008 and 2009 for statewide funding for children’s mental health crisis services. An additional $1.75 million is appropriated for culturally specific treatment grants, services for children with special needs, such as victims of trauma, abuse and neglect, and evidence-based practices mental health treatment for children.

The act appropriates funding for the state’s suicide prevention program and to school districts for voluntary suicide prevention programs. Funding is also appropriated for licensed school counselors, nurses, social workers, psychologists and alcohol and chemical dependency counselors to provide early responses to behavioral and other student problems.

### Adult Mental Health

Chapter 147 appropriates $5.8 million for fiscal years 2008 and 2009 for mental health crisis services for adults. Similar to the additional investment for children, the act appropriates an additional $1.75 million for culturally specific mental health treatment grants, adults with special treatment needs, and evidence-based practices mental health treatment for adults. Also, Medical Assistance coverage is expanded to cover intensive mental health outpatient treatment for dialectical behavioral therapy for adults.

Medical Assistance is expanded to cover the services of mental health peer specialists. The commissioner of human services will develop a training and certification process for peer specialists who must be at least 21 years of age. A candidate must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services and demonstrate leadership and advocacy skills.

Finally, the act appropriates $3.25 million over 2008 and 2009 for grants to support increased availability of housing options for adults with serious mental illness.

### Mental Health Provider Fee Increase and Exemption from Payment Reductions
The payment rate increase that psychiatrists received two years ago will be extended to certain other mental health providers. Medication education provided by adult rehabilitative mental health services providers and mental health behavioral aide services provided by children’s therapeutic services and support providers will be increased by 23.7 percent effective January 1, 2008. Individual and family skills training after January 1, 2008 provided by children’s therapeutic services and support providers will be increased by 2.3 percent. Payments for mental health services will not be subject to existing ratable reductions or managed care plan rate cuts after December 31, 2007.

**Medical Education**

For many years the state has been able to leverage additional federal money for medical education costs with a funding formula that was based both on the number of students and residents being trained and on the amount of Medical Assistance patients that were served. The federal government has given indications that the portion of the formula based on students trained is at risk of losing matching funds. This has created problems with our entire Medical Education and Research Committee (MERC) process.

To maximize federal funds, Chapter 147 changes the MERC formula so it is based solely on each facility’s Medicaid volume, removing the 67/33 weighting factor or consideration for clinical training. This change significantly benefits facilities that treat a large percentage of Medical Assistance patients like Hennepin County Medical Center and Regions Hospital. In order to offset the Mayo Clinic’s loss and support the clinical training of physicians while a new MERC distribution formula is implemented, $15.5 million in one-time transition funding is appropriated to the Mayo Clinic for medical education costs. In addition, there is an appropriation of $1.475 million to the Fairview-University Medical Center, $2 million to the University of Minnesota Dental School, and $1.8 million to the University of Minnesota Academic Health Center. The act requires a study of the impact of the formula changes by January 15, 2009.

**Disease Prevention and Preparedness**

**Pandemic Influenza Preparedness**

Over $4 million is set aside to improve the state's preparedness for pandemic influenza through the purchase of antivirals and the stockpiling of medical and health care supplies. The MMA raised concerns about the Governor’s proposal to fund these efforts from the HCAF and insisted it was a statewide, public health obligation not a matter of health care access. As a result, legislative leaders appropriated the funds from the General Fund in the final act. This amount is significantly less than the $12 million that was requested.

**Cervical Cancer Prevention and HPV Vaccine Study**

Reacting to controversy on a proposal to mandate the human papilloma virus vaccine Giradasil for all school-age girls, the legislators sponsoring the bill instead agreed to require the commissioner of health to reconvene the cervical cancer task force to study and make recommendations on the vaccine. The task force shall study the risks and benefits, cost, and availability of the vaccine. The MMA expressed concern about the
Legislature returning to the practice of modifying the mandatory vaccines list and expressed preference for the process to be completed outside of the political environment of the Legislature. Many physicians were also concerned about mandating a vaccine so new to the market.

Other disease prevention efforts include $400,000 in additional funding that is appropriated for the Department of Health to respond to the increased incidence of tuberculosis in the state, specifically multi-drug resistant tuberculosis, and $2 million to update the state’s infectious disease reporting system and add occupational and residential histories in the cancer surveillance database.

**Public Health**

**Wellness and Obesity Prevention**
Chapter 147 includes a number of provisions to promote wellness in an attempt to reduce rates of obesity. Effective July 1, 2009 and upon federal approval, the state will develop a patient incentive health program. This program will provide rewards to patients enrolled in state health care programs that meet health goals to manage a chronic disease or condition established by the patient’s primary care provider.

In addition, the commissioner, in consultation with State Community Health Services Advisory Committee, shall develop a comprehensive health promotion program to effect change at a community level. The focus will be on childhood and adult obesity, tobacco and substance abuse, improved activity levels among seniors, and other lifestyle issues that affect health and health care costs. The act also includes permissive language for community health boards to work with schools and providers to coordinate wellness programs.

**Newborn Hearing**
Chapter 147 expands the existing newborn screening program to mandate the addition of a hearing screening. It provides for an advisory committee to develop protocols for the hearing screenings. Four physicians are included on the committee: two primary care (at least one pediatrician), a pediatric geneticist, and an otolaryngologist. All hospitals are required to establish an early hearing detection and intervention program to comply with the screening. No physician, midwife, nurse, other health professional or hospital can be held criminally or civilly liable for any acts conforming to this law. Immunity from civil and criminal liability is also provided for physicians and hospitals for failing to conduct a hearing screening. Newborn screening fees are increased to cover the added costs.

The act also includes funding for a grant to support the administrative costs associated with a statewide hearing aid and instrument loan bank to families with children (aged birth to 10) who are newly diagnosed with hearing loss. It also appropriates one-time funding to provide family support and assistance to families with children who are deaf or have a hearing loss.

**Other**
The Family Home Visiting Program is designed to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The act expands the program for Community Health Boards and Tribal Governments.

The act significantly increases funding for the prevention of, and intervention for, fetal alcohol spectrum disorders to $1.6 million annually, an increase of $1 million each year.

It also creates a registry of certified doulas for obstetric care. In order to be included on the fee-supported registry, a doula must meet minimal training standards.

**Environmental Health**

This act includes a number of environmental health programs. While there is no state funding for a statewide biomonitoring program, the commissioners of health and the Pollution Control Agency are required to apply for federal funding to expand the state’s environmental justice mapping to promote public health tracking. If funding is obtained, the department is required to investigate possible links between toxic exposures and environmental health and make recommendations to the Legislature.

The act also expands Medical Assistance coverage to pay for lead risk assessments by licensed lead risk assessors. This includes a one-time on-site investigation of a primary residence to determine the existence of lead in the primary residence of MA recipients under age 21 who have been identified as having elevated venous blood lead levels.

In addition, this act and the Omnibus Environment Budget Act both appropriate funding for a study of point-of-use water filters for eliminating perfluorochemicals (PFC) contaminants from drinking water. The Legislature held many hearings on PFCs related to concerns about the 3M’s use of the chemicals and reported leakage into the ground.

Finally, this act includes new statutory language requiring the commissioner of health to convene a meeting to recommend an education campaign to inform students about the effects of fragrance in their schools. The campaign is intended to address concerns that the health of children and adults may be affected by sensitivity to fragrances found not only in perfume and body spray but also in shampoo and lotions.

**Transparency and Reporting**

**Provider Price Disclosure**

Chapter 147 updates law passed in 2005 that requires providers to provide patients with a good faith estimate of the cost of health care services. It clarifies that providers must provide an estimate of the allowable payment the provider has agreed to accept from the patient’s health plan. This improves existing language that required disclosure of what the provider expected to receive from the health plan. This language is intended to provide more “price transparency” for consumers to be able to compare costs between
providers. Additionally, there is a new prohibition on charging patients or the patient’s employer to provide an estimate.

**Health Plan Disclosure of Performance Measures**
The act requires that health plans and risk management services use “bona fide” baselines on the practice experience of the provider group when doing performance evaluations and must disclose the baselines to the provider in writing prior to the evaluation period.

**Facility Reporting**
The act recodifies existing capital expenditure reporting requirements for hospitals and outpatient surgical centers. It is intended to streamline the reporting process and allow information about medical facilities’ capital investments to be tracked by the Department of Health in a more uniform manner. One notable change is that in addition to existing reporting requirements, surgical centers will now also report the total number of surgeries performed at the facility. This type of data could be used during debate over health care facility capacity and the need to build or restrict building of new facilities.

**Hospital Public Interest Review**
The act makes a small change to the criteria for the hospital moratorium exception process as well. As a result of labor disputes with the Fairview/North Memorial hospital approved for Maple Grove, the commissioner of health is required to consider applicants’ ability to maintain the current level of community benefit at an existing facility and the impact of a new facility on the hospital’s workforce.

**Radiation Therapy Facility Construction Moratorium**
Chapter 147 places a two-year moratorium on construction of new radiation therapy facilities located in the Twin Cities metropolitan area, St. Cloud or Duluth with a single exemption for a North Memorial Hospital project in Monticello. This is a continuation of the ongoing battle over independent radiation therapy facilities. The change strengthens the old moratorium that allowed facilities to be built if they were owned by, or in partnership with, a hospital. Many legislators believe we need to control the growth of these facilities as a way to control health care costs.

**Family Planning**

Chapter 147 restores many of the cuts to family planning services from 2003 and 2005. As part of the act, community clinics will receive a 25 percent increase for family planning services. Additionally, the act provides for registered nurses in a family planning agency to dispense oral contraceptives as prescribed by a licensed practitioner. This provision traveled in a stand-alone bill as well.

**Medical Interpreters**

Chapter 147 directs the commissioner of health to convene a work group to develop recommendations on ensuring access, quality and funding sources for medical interpreters. The findings of the group must be reported by the Legislature before
January 15, 2008. The work group shall include providers, insurers, interpreters and other stakeholders.

Insurance coverage for interpreter services was not included in the final act. Despite broad support within the Legislature and language agreed to by health plans, the Governor and the Chamber of Commerce maintained opposition to all benefit mandates. A fiscal note from the Department of Employee Relations also complicated our efforts.

**Prescription Drug Abuse Prevention**

**Schedule II and III Controlled Substances Prescription Electronic Reporting System**

In an attempt to curb the illegal use and diversion of prescription drugs, the Board of Pharmacy will develop and maintain an electronic database to track the filling of prescriptions for schedule II and III controlled substances. The purpose of this registry is to track patients who are "doctor shopping" for narcotics.

The act requires pharmacists to report the following information for the database to the Board of Pharmacy: the prescriber name and identifier number, the dispenser name and identifier number, the patient name and date of birth, the date the prescription was written and filled, and the name, strength and quantity of the controlled substance. The data is retained for a 12-month period.

A number of exemptions from the reporting requirements are articulated. These include a prescription to provide treatment for a period less than 48 hours, intravenous medication, and prescriptions for individuals in licensed nursing homes, group homes, assisted living, hospice and home care.

Physicians and dispensers will have access to the database to the extent the information relates specifically to a current patient to whom they are considering prescribing or dispensing any controlled substance, but they are not required to obtain information about a patient prior to prescribing or dispensing medication. Access to the database is restricted and cannot be used to identify individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of dosage for those controlled substances, and individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers. The act specifically prohibits a state or federal licensing board from accessing the database to initiate or substantiate a disciplinary action against a prescriber. In order to identify the prescriber of a controlled substance for unusual or excessive prescribing patterns, a search warrant or court order is required and data on dispensers and prescribers must be encrypted.

Prescribers and pharmacists are immune from any civil, criminal or administrative liability (including disciplinary action) for making the report in good faith. The electronic system shall be established by January 1, 2009.
Related provisions in the chapter require the Board of Medical Practice to convene a work group to discuss the appropriate prescribing of controlled substances and require persons paying cash for a schedule II or III controlled substance to present a photo ID. This does not apply if the drug is covered in whole or in part by a health plan or third-party payer.

**Internet Prescribing**
In an attempt to restrict the inappropriate access to prescription drugs over the internet, Chapter 147 limits pharmacists’ authority to fill certain internet-based prescriptions. It states that a prescription or drug order for a legend drug is not valid if it is based solely on an online questionnaire, unless a patient evaluation adequate to establish a diagnosis and identify underlying conditions and contraindication to treatment has been documented. There are certain websites available that allow a person to get a prescription online. Since these websites are often not based in the state of Minnesota, they cannot be shut down. Instead, this act penalizes the Minnesota pharmacist who fills the prescription.

Various Effective Dates

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**Section II**
BILLS THAT FAILED TO PASS

2007 LEGISLATURE

Affordable Health Care - Constitutional Amendment

(H.F. 683 – Huntley/S.F. 204 – Berglin)
This bill would have amended the Minnesota Constitution affirming that every resident in Minnesota has the right to affordable health care. The proposed amendment would have stated:

*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.*

If the bill had passed, the proposed amendment would have been submitted to Minnesota voters at the 2008 general election to read:

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

If adopted by the voters, the bill would have required the Legislature and the Governor to enact and implement legislation to implement the amendment by July 1, 2011 to ensure affordable health care for all. This bill will most likely be back in the 2008 session.

### Alcohol Tax

**(H. F. 1446 – Clark, K./ S.F. 1725 – Berglin)**

This bill would have created a health impact fee on alcoholic beverages similar to the health impact fee on tobacco products. The bill would have required the commissioners of public safety, corrections, and human services to provide certifiable state budget costs of alcohol and controlled substance abuse. The funds raised would have further enforced the DWI laws, community policing grants, domestic violence grants, costs of incarcerating offenders, funding state chemical dependency treatment programs and more.

Furthermore, the bill would have doubled the special gross receipts tax rate on retail sales of alcoholic beverages from 2.5 percent to 5 percent.

The bill was heard in the House Tax Committee but was never heard in the Senate.

### Bad Faith Claims

**(H.F. 1215 – Atkins/S.F. 1152 – Clark, T.)**
This bill would have created a new cause of action for an insured party to sue his or her insurer for acting in “bad faith.” This would have applied to property and casualty insurers, as well as medical malpractice insurers. A lawsuit against the insurer would have been allowed if the insurer delayed or denied benefits without an objectively reasonable basis for its offer, delay, or denial. The insurer would have been liable to the injured party for costs, damages, and reasonable attorney fees. The fear was that this would have greatly increased the overall cost of insurance coverage because of the increased number of lawsuits.

The bill also would have created direct liability of the insurer, meaning that the insurer in addition to the defendant, could have been named in every lawsuit.

This bill was a major priority for the Minnesota Trial Lawyers Association. In the end, the bill was strongly opposed by the Governor and it did not pass.

### Biomedical Sciences Research Facilities

*(H.F. 132 – Mahoney/S.F. 265 – Cohen)*

This bill would have provided a framework to further the investment in biomedical science research facilities to advance biomedical technology, benefit human health, facilitate research and benefit the state’s economy. It would have established processes that would have authorized the commissioner of finance to issue $279 million of state bonds to capital programs identified by the Minnesota Biomedical Sciences Research Facilities Authority. The University of Minnesota would have been given the authority to apply for these funds to build needed research facilities.

This language was included in the Senate Bonding bill, but was not adopted by the conference committee.

### Birth Defects Information System

*(H.F. 906 – Thissen/S.F. 772 – Berglin)*
This bill would have authorized $1.5 million of state money to fund the Birth Defects Information System. This system was first created in 1996 and has been funded with a federal grant that is expiring this year. The system contains data on the cause, treatment, prevention and care of major birth defects.

Funds for the Birth Defects Information System were included in the first health and human services budget bill that was vetoed. Funding was not included in the final budget bill. Without funds, the system may be discontinued.

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**Booster Seats/Passenger Restraint for Children/Booster Seats**

*(H.F. 105 – Hortman/S.F. 122 – Carlson)*

This bill would have raised the age required for children to be in proper restraint systems in motor vehicles from under the age of four to under the age of eight, requiring the use of booster seats for many children. Violation of this requirement would have been a petty misdemeanor. Fines collected for violations would have been allocated to a new Minnesota child passenger restraint and education account.

This provision passed the full Senate as part of the Senate Omnibus Transportation Policy bill, but a conference report was not completed in time for the end of session. The bill passed the first House committee as well but did not advance further in the House. Senate leaders vow to bring the issue back in 2008.

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**Small Employer Access to MinnesotaCare**

*(H.F. 463 – Murphy, E./S.F. 66 – Lourey)*

This bill would have allowed small employers with 50 or fewer employees who currently do not provide health coverage for their employees to buy into the MinnesotaCare program to provide coverage to their employees and dependents. In order to participate the employer would have been required to agree to contribute toward the cost of the premium for the employee and the employee's dependents, certify that at least 75 percent of its eligible employees are enrolled in the program, offer coverage to all eligible employees, spouses, and have not provided employer-subsidized health coverage as an employee benefit during the previous 12 months. Premiums would have been subsidized for employers with low-wage employees.
This bill passed the House Health and Human Services Policy Committee and similar language was in the Senate version of the Health and Human Services Budget Bill, but the bill was not included in the final budget bill.

**Cell Phone Usage While Driving**

*(H.F. 41 – Jaros/ No S.F. Companion)*  
*(H.F. 311 – Hornstein/S.F. 247 – Dibble)*  
*(H.F. 1822 – Jaros/No S.F. Companion)*

**H.F. 41** would have prohibited the use of a mobile phone while operating a moving motor vehicle. The bill provided for an exemption if the call was in response to an emergency to contact an emergency response team, a hospital, a clinic, a fire department or a law enforcement agency.

This bill never received a hearing.

**H.F. 311** would have doubled a fine for a moving violation if the person was on a cell phone while committing the violation. This bill also provided an exemption if the call was in response to an emergency to contact an emergency response team, a hospital, a clinic, a fire department or a law enforcement agency.

This bill passed both the House Transportation Finance Division and the Senate Transportation Committee, but was not heard in other necessary committees in order to meet deadlines.

**H.F. 1822** would have required that mobile phones used in motor vehicles that are in motion be equipped with a hands-free device. This violation would have been a secondary offense requiring that a peace officer would not issue a citation for this offense unless the officer lawfully stopped or detained the driver of the motor vehicle for another moving violation. The bill provided the same exemptions for emergencies as the others.

**Cosmetic Procedures Tax**

*(H.F. 1027 – Kahn/No S.F. Companion)*
This bill would have expanded the 6.5 percent sales tax to apply to voluntary medical procedures used to improve one’s appearance, body image, or self-esteem. This cosmetic services tax, however, would not have applied to reconstructive surgery or reconstructive dentistry used to correct congenital defects, developmental defects, trauma, infection or disease, including procedures “to improve function or give a more normal appearance.”

The bill received a hearing in the House Tax Committee but was not included in the House Omnibus Tax bill. A Senate companion was never introduced.

The MMA lobbied against this bill, educating legislators about the existing provider tax on all medical services. In 2004, New Jersey implemented a tax on cosmetic surgery procedures, and though it has been widely recognized as a failure, and the chief author of the original bill has tried to repeal the measure, the legislation has been introduced in many states around the country.

**Diagnostic Imaging Authorization Moratorium**

*(H.F. 2003 – Huntley/S.F. 1752 – Pappas)*

This bill would have placed an immediate moratorium on health plans requiring prior authorization or notification for high-tech imaging. This bill was introduced by the MMA in response to recent notification programs implemented by health plans to address the growing costs of imaging. In addition, the bill would have established a diagnostic imaging services advisory committee composed of physicians, hospitals, health plans, clinic managers, and others. This committee would have gathered data on imaging utilization and developed recommendations on how to improve the delivery of evidence-based imaging services.

This bill was heard in the House Health Care Finance Division but was not heard in the Senate.

**Employer Health Care Coverage Reporting**

*(H.F. 177 – Lesch/No S.F. Companion)*
Frequently referred to as the “Wal-Mart bill,” this bill would have required employers with 10,000 employees or more to provide a minimum level of health care coverage to their employees or make payments to the Fair Share Health Care Fund. Large employers would have been required to report information to the state on their health care coverage expenditures and the report would be public. The fund would have been used to provide coverage to uninsured workers and their dependents through Medical Assistance and MinnesotaCare.

The bill did not receive a hearing in the House.

**Flu Shots Required for Children**

*(H.F. 168 – Thissen/ No S.F. Companion)*

This bill would have required annual influenza immunizations for children who attend school or are enrolled in child care facilities. The bill specified that no child over two months old would be allowed to enroll in or remain at any elementary or secondary school, or child care facility, until a statement from a physician or a public clinic confirmed that the child had received the required influenza immunizations compliant with medically acceptable standards.

The MMA expressed concerns about legislation mandating flu shots. Currently, vaccine requirements are implemented through rules established by the commissioner of health. These decisions should be made by experts through the health department and not by the Legislature.

The bill did not receive a hearing in either body.

**Health and Physical Education Requirements**

*(H.F. 420 – Ward/ S.F. 382 – Tomassoni)*

This bill would have added to the state’s high school requirements at least one-half year of physical education and at least one-half year of health education. Currently, these are optional for high schools. These requirements are important in our fight against childhood obesity. Similar language was included in the Healthy Minnesota health care reform recommendations but did not pass.
The bill would have also provided grants to school districts to implement local school wellness policies. The funds would have been used to address children’s diet-related health, physical activity and nutrition, and to involve parents, students, administrators and the public in implementing wellness policies.

Both the House and Senate bills passed through the required committees but the provision was not included in either of the final education budget bills.

**Health Care Access Fund Oversight Commission**

*(H.F. 644 – Huntley/S.F. 641 – Prettner Solon)*

Based the recommendation of the MMA House of Delegates, legislation was introduced to establish the Health Care Access Fund Oversight Commission. The commission would have consisted of three health care providers, two advocates for MinnesotaCare recipients, four legislators, one health plan and the commissioner of human services. The commission would have developed criteria for acceptable uses of the Health Care Access Fund (HCAF) with efforts to maintain the integrity of the fund as a funding source for expanding access to health care services for low-income Minnesotans. In the past, surpluses from the HCAF have been transferred to the General Fund and used to fund state deficits.

The bill would have required the commission to review all legislative proposals to establish new uses of the fund and make recommendations to determine whether the proposal met the specific criteria. The legislation would have required the commission to meet at least twice a year indefinitely with staff support from the department of human services.

Although the bill was well received in every committee in which it was heard, the bill was not included in the final Health and Human Services Bill.

**High Deductible Health Plans: Preventative Coverage**

*(H.F. 111 – Loeffler/S.F. 2229 – Olson)*
This bill would have promoted preventive health care by requiring high-deductible health plans used in combination with a health savings account to cover preventive care without a deductible, co-payment or other patient-sharing. It was based on studies showing that covering preventive services is cost effective.

The bill passed the House Commerce and Labor Committee as a stand-alone bill but was brought up for a vote on the House floor. The Senate bill did not receive a hearing.

### Support for High-Risk Children

**(H.F. 737 – Thao/S.F. 492 – Moua)**

This bill would have provided early intervention and collaborative services to children who are at high-risk for abuse, substance use, mental illness and violent offense. The services would have included multidimensional screening instruments, multidisciplinary collaborative services, integrated information systems, in-home and community casework, tracking of outcomes and cost-benefit evaluations.

Neither bill received a hearing but similar provisions were included in the mental health initiatives that passed in the Health and Human Services Bill.

### Human Papilloma Virus Vaccine


This bill would have required that female children be vaccinated for the human papilloma virus (HPV). The bill would have required the schedule of immunizations for girls 12 years and over to include three doses of the vaccine beginning with the 2009-2010 school term.

Additionally, this bill would have required the commissioner of health to work collaboratively with the Minnesota Immunization Practices Advisory Committee in developing education materials that would have provided information on the risks associated with the human papilloma virus and cervical cancer and the potential risks that the vaccine may have posed.

The bill did not receive a hearing in either body after the authors acknowledged that it was too soon to pursue legislation following the vaccine’s release.
The final Health and Human Services Budget bill includes a study to examine the benefits, cost and availability of the vaccine prior to making it mandatory.

**Laboratory Technician Licensure**

*(H.F. 2109 – Murphy, E./S.F. 1830 – Kubly)*

This bill would have created the Board of Medical Laboratory Service to license all individuals who perform medical laboratory tests, including medical laboratory technicians, cytotechnologists, and histotechnicians.

This bill did not receive a hearing in either the House or the Senate.

**Licensing of Naturopathic Doctors**

*(H.F. 1724 – Walker/S.F. 1520 – Torres)*

This bill would have licensed naturopaths under the Board of Medical Practice and included in their scope of practice ordering, administering and prescribing food supplements, herbal remedies, and non-prescription drugs; performing physical exams; ordering diagnostic imaging, including x-rays and mammograms; performing naturopathic physical medicine; and prescribing all legend and schedule III, IV and V drugs. Licensed naturopaths would have also been permitted to perform minor office procedures, including removal of foreign bodies and surgical repair of superficial lesions, and they would have been allowed to perform naturopathic childbirth.

To be licensed, an applicant must have graduated from a four-year accredited school of naturopathy and successfully have passed the Naturopathic Physicians Licensing Examination. The bill did not, however, prohibit other non-licensed individuals from practicing naturopathy. They just would have been prohibited from presenting themselves as licensed naturopaths.

The MMA actively opposed this legislation, and through it received an informational hearing in the House Licensing Subcommittee, a vote was not taken. The bill did not receive a hearing in the Senate.

**Marijuana for Medical Use**

*(H.F. 655 – Huntley/S.F. 345 – Murphy, S.)*
This bill would have provided for the regulated use of small amounts of marijuana strictly for medical purposes for debilitating medical conditions. Twelve states currently allow for the legal use of marijuana for medical purposes.

Qualifying patients and caregivers would have been required to register as legal users and obtain identification cards issued by the commissioner of health. Debilitating medical conditions were defined to include conditions such as cancer, glaucoma, hepatitis C, HIV, and other chronic diseases and conditions that the commissioner could deem as a debilitating medical condition. The allowable amount of marijuana for patients would have been 2.5 ounces of usable marijuana and any amount of the other parts of the plant. The bill would have allowed primary caregivers to also have up to 2.5 ounces of usable marijuana.

The bill passed the full Senate, however the bill died awaiting final action by the full House. The MMA does not have a position on the medical use of marijuana.

Medical Imaging and Radiation Therapy Licensure

(H.F. 1070 – Hilty/S.F. 1267 – Olson, Mary)

This bill would have created new licensing requirements for medical imaging procedures and radiation therapy procedures through the Consumer Assurance of Radiologic Excellence Act.

The bill would have made it unlawful for individuals to provide any medical imaging procedures or radiation therapy to a patient for medical or chiropractic needs unless they have a medical radiation license. In addition, the bill would have required the commissioner of health to adopt minimum criteria for licensure based on those set by the Federal Consumer Assurance of Radiologic Excellence Act.

The bill was not heard in either the House or Senate.

Medical Interpreter Services

(H.F. 1077 – Ruud/S.F. 827 – Higgins)
This bill would have required health plans to cover medical interpreter services for the
deaf or hard of hearing and for people with limited English proficiency. It also would
have created a working group of providers, payers, interpreters, and other stakeholder
groups to develop recommendations for training requirements, minimum competency
levels, and broad-based funding for medical interpreters.

The MMA supported this legislation because it would have required all health plans to
reimburse providers or pay interpreters directly for language services and establish a state
registry of interpreters who meet the National Standards of Practice for Interpreters in
Health Care. Currently, the under-funded system endangers patients’ access to services.
Research has shown that language barriers can lead to impaired health status; reduced
access to medical care; and lower rates of preventive screenings. Language barriers
increase the chance that a patient will suffer drug complications and medical errors. A
lack of qualified interpreters can result in increased costs by lengthening medical visits,
increased use of diagnostic tests, and causing malpractice suits.

During the legislative session, an agreement was reached with the health plans on this
legislation. The business community and the Governor, however, continued to oppose
the bill because it would have created a new insurance mandate. The Health and Human
Services Budget Bill creates a working group to work over the interim on funding issues,
training issues and minimum competency standards.

**Medical Liability: “I’m Sorry” Law**

*(H.F. 2343 – Abeler/No S.F. Companion)*

This bill would have provided protection against medical liability actions for health care
providers by making health care provider statements, gestures or conduct expressing
sympathy, condolence, compassion, or apology for an unanticipated outcome of medical
care inadmissible evidence to any medical liability. Similar legislation that has passed in
other states has been referred to as the “I’m Sorry” law. It is intended to reduce medical
liability lawsuits by encouraging providers to communicate more sensitively with patients
in the event of an unanticipated outcome.

The MMA has supported this bill in past years, but it was not heard in either body.

**Minnesota Care Provider Tax**

*(H.F. 317 – DeLaForest/S.F. 341 – Ortman)*
This bill would have repealed the 2 percent tax on health care services provided by physicians, hospitals, dentists, and other health care providers. The bill did not recommend a replacement of these funds, however, so the MinnesotaCare program would have been funded out of existing general fund dollars.

This bill did not receive a hearing in either body.

**Minnesota Medical Information Council**

*(H.F. 1987 – Huntley/S.F. 1911 – Michel)*

This bill would have created a governmental council to “act as a consumer voice in medical care decision-making.” It was designed to oversee the gathering of statewide information regarding the availability of and access to medical facilities. The council would have reported to the Legislature on the number of medical facilities currently available and the capacity and use of those existing facilities.

The bill did not receive a hearing in either the House or the Senate.

**Minnesota Biomedical Sciences Research Facilities Authority**

*(H.F. 866 – Hausman/S.F. 2157 – Lanseth)*

This bill would have created a new bonding authority for the expansion of biomedical research facilities on the University of Minnesota campus. The bill stated as its purpose to “provide a framework for a biomedical science research funding program to further the investment in biomedical science research facilities in the state that will benefit the state's economy, advance the biomedical technology industry, benefit human health, and facilitate research collaboration between the University of Minnesota and other private and public institutions in the state.”

This bill would have resulted in $233.6 million of bonds for new construction of research facilities over the next 10 years. The bill was needed to ensure that Minnesota remains competitive in the area of biomedical research.

The language for the new authority was included in the Senate Bonding bill, but not in the House version.
<table>
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<tr>
<th><strong>Naturopathic Medicine in Schools</strong></th>
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<tr>
<td><em>(H.F. 748 – Hosch/S.F. 2002 – Fischbauch)</em></td>
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<tr>
<td>This bill would have allowed a parent to give school personnel permission to administer physician-prescribed naturopathic medications to a student during the school day. This change would have amended the section of law related to students bringing prescription medications to school.</td>
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<tr>
<td>The Senate version passed the Education Committee and was heard in the Senate Health Policy Committee but no action was taken. The House bill also passed the Education Committee but was never heard in any of the health committees.</td>
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<tr>
<th><strong>Physical Therapy Direct Access</strong></th>
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<td><em>(H.F. 1189 – Thissen/S.F. 1018 – Prettner Solon)</em></td>
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<td>This bill would have greatly expanded the scope of practice of physical therapists and allowed them to evaluate and treat patients indefinitely without a physician’s referral. It would have removed the current 30-day limitation on treatment from a physical therapist without a physician’s referral and allowed physical therapists to directly treat patient for an unlimited amount of time without any physician involvement. The bill would have also deleted the statutory requirement that physical therapists practice one year under a physician’s orders before treating patients without a referral. Additionally, the bill eliminated the requirement that a physical therapist communicate with the referring physician when the course of treatment is modified from an original prescription.</td>
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<tr>
<td>Physical therapists have advocated for this change for a number of years and have been unsuccessful due to the efforts of the MMA. This measure is a significant diversion from the principles of coordinated care being promoted in health care reform proposals.</td>
</tr>
<tr>
<td>This bill was heard in the House Licensing Subcommittee where it was amended to increase the length a patient could go to a physical therapist without a referral from 30 days to 90 days. This language was unacceptable to the physical therapy association so the bill was tabled and did not receive a vote.</td>
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<tr>
<th><strong>Provider Tax Contingent Reduction</strong></th>
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<td><em>(H.F. 275 – Brod/ S.F. 667 – Michel)</em></td>
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These bills would have provided for a contingent tax rate reduction for the 2 percent provider tax. On September 1st of each odd-numbered year beginning in 2007, the commissioner of finance would have been required to determine the projected balance of the Health Care Access Fund at the end of the current biennium. If the commissioner projected a surplus, then the provider tax would have been reduced by increments of one-tenth of 1 percent, or one-quarter of 1 percent, to a rate that would maintain adequate levels but eliminate any excess surplus.

This bill did not receive a hearing in either body.

**Seat Belt as a Primary Offense**

*(H.F. 106 – Thissen/S.F. 16 – Murphy, S.)*

This bill would have made seat belt violations a primary offense and required that seat belts be worn by all passengers in a vehicle. Current law only allows for the violation to be a secondary offense, which means that a ticket for failure to wear a seat belt can only be given if the driver is stopped for a separate violation.

This language passed as part of the Senate Omnibus Transportation Policy Bill, but was not included in the conference report. House members made a commitment to hear the measure in 2008.

**Stem Cell Research**

*(H.F. 34 – Kahn/S.F. 100 – Cohen)*

This bill would have created a state policy for stem cell research and explicitly allowed state funds to be used for stem cell research. The policy stated that research involving the derivation and use of human embryonic stem, germ and adult stem cells would be permitted, but it required a health care provider treating a patient for infertility to provide the patient with sufficient information to allow the patient to make an informed decision, based on the options presented, to discard, store or donate remaining embryos. The sale of embryonic or cadaveric fetal tissue for research purposes and cloning a human being were both explicitly prohibited. Advocates for stem cell research were concerned that the bill would have the opposite effect from the author’s intent. Since the state does not
currently have a policy on stem cell research, any statutory definition, particularly one
drafted to satisfy opponents of the measure, could restrict stem cell research in the state.

This bill passed the Senate floor, but did not receive final action in the House prior to
adjournment.

**Teachers’ Health Care Pool**

*(H.F. 464 – Sertich/S.F. 276 – Betzold)*

This bill would have created a pool for all employees of public school districts for the
purpose of purchasing health care coverage. It would have created the Minnesota School
Employee Insurance Board that would have overseen the functions of the purchasing
pool. Every school district in the state would have been required to purchase their health
care coverage through the purchasing pool.

This bill was the top priority of the teachers’ union, Education Minnesota. Interestingly,
the bill was not supported by the Minnesota School Board Association, or by some large
school districts. The districts that supported the bill were those that have had high health
care costs over the last few years. Districts with lower costs opposed the bill because
they have been able to get coverage that costs less than the projected cost of the pooled
coverage would have been.

The bill passed both the House and the Senate, but it was vetoed by Governor Pawlenty.

**Thimerosal-Free Vaccines**

*(H.F. 1917 – Madore/S.F. 1780 – Torres Ray)*

*(H.F. 2350 – Brod/ No S.F. Companion)*

This bill would have required that all vaccines administered in Minnesota be thimerosal-
free unless a thimerosal-free vaccine is not manufactured or the health care provider finds
that the thimerosal-free vaccine is not obtainable by utilizing reasonable efforts because
of a shortage of supplies or because the vaccine was not available for purchase. The
definition of thimerosal-free vaccine did not allow vaccines with only a trace amount of
thimerosal.

The MMA opposed this legislation. Flu shots are one of the few vaccines that still contain
thimerosal and limiting distribution or supply for Minnesota providers when supply is
unreliable each year could be detrimental to the health of populations of all ages.
This bill did not receive a hearing in either the House or Senate but advocates attempted, unsuccessfully, to amend the measure on to a number of budget and policy bills during floor session.

**Universal Health Care Coverage**

*(H.F. 1856 – Huntley/ S.F. 1689 – Prettner Solon)*

This bill was introduced as result of Healthy Minnesota: A Partnership for Reform and the Partnership’s recommendations. The bill was divided into four articles to reflect the four major areas of the Healthy Minnesota recommendations — medical home, universal coverage, protecting and promoting health, and health information.

The bill would have required that every Minnesotan have health coverage based on an essential benefit set. It would have also begun the process of reforming reimbursement systems to provide incentives for care management, team-based care, and practice redesign. It would have created wellness and health promotion grants to local committees and reinstated required physical education and health classes in high schools. In addition, it would have authorized the building of a statewide information exchange to promote the use of interoperable electronic health records.

While the bill did not pass, many of the provisions related to medical home, health information and wellness were included in the Omnibus Health and Human Services Budget Bill.
Section III

GOVERNMENT INFORMATION

2007 LEGISLATURE
Following is a list of the contact information and districts of legislators and members of Congress. “Cap” at the end of the number denotes Capitol. “SOB” denotes State Office Building. To determine who your state or national representative is, look for your district under your personal membership listing.

**Minnesota House of Representatives**

<table>
<thead>
<tr>
<th>Name</th>
<th>District</th>
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### U.S. Senate:

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<tr>
<td>Rachel Gustafson – Health Legislative Assistant</td>
<td>320 Hart Senate Office Building, Washington, DC 20510</td>
<td>(202) 224-5641, (202) 224-1152 (fax)</td>
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<tr>
<td><strong>Amy Klobuchar</strong></td>
<td>1 Federal Drive, Federal Building, Suite 298, Fort Snelling, MN 55111</td>
<td>(612) 727-5220, (612) 727-5223 (fax) Web E-mail form: <a href="mailto:senator.klobuchar@senate.gov">senator.klobuchar@senate.gov</a></td>
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<td>Ryan Crowley – Health Legislative Assistant</td>
<td>302 Hart Senate Office Building, Washington, DC 20510</td>
<td>(202) 224-3244, (202) 228-2186 (fax)</td>
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### U.S. House of Representatives:

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<td>227 E. Main St., Suite 220, Mankato, MN 56001</td>
<td>(507) 388-2149 Web E-mail form: <a href="http://www.walz.house.gov/ContactForm/zipauth.htm">http://www.walz.house.gov/ContactForm/zipauth.htm</a></td>
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<tr>
<td>Leah Rosales – Health Legislative Assistant</td>
<td>1529 Longworth House Office Building, Washington, DC 20515</td>
<td>(202) 225-2472, (202) 225-3433 (fax)</td>
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<td>Jean Hinz – Health Legislative Assistant</td>
<td>1429 Longworth House Office Building, Washington, DC 20515</td>
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<td><strong>Jim Ramstad</strong></td>
<td>1809 Plymouth Road S., Suite 300, Minnetonka, MN 55305</td>
<td>(952) 738-8200, (952) 738-9362 (fax) E-mail: <a href="mailto:mm03@mail.house.gov">mm03@mail.house.gov</a></td>
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<tr>
<td>Andrew McKechnie – Health Legislative Assistant</td>
<td>103 Cannon House Office Building, Washington, DC 20515</td>
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<tr>
<td><strong>Keith Ellison</strong></td>
<td>2100 Plymouth Ave., Minneapolis, MN 55411</td>
<td>(612) 522-1212, (612) 522-9915 (fax) Web E-mail form: <a href="http://www.ellison.house.gov/IMA/issue_subscribe.htm">http://www.ellison.house.gov/IMA/issue_subscribe.htm</a></td>
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<td><strong>James L. Oberstar</strong></td>
<td>38625 14th Ave., Suite 300B, North Branch, MN 55056</td>
<td>(651) 277-1234</td>
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(651)277-1235 (fax)
Contact form: http://www.house.gov/oberstar/zipauth.htm
MINNESOTA CAPITOL INFORMATION

The following numbers may be used to obtain information directly from the State Capitol.

**General Information**

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**To order copies of bills**

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<td>(With or without bill numbers) House Index</td>
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**Governor Tim Pawlenty’s Office**

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**Attorney General Lori Swanson’s Office**

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**MINNESOTA STATE AGENCIES**

**Department of Human Services**

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<td>651/201-5810</td>
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<tr>
<td>Cal Ludeman</td>
<td>651/431-2907</td>
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<td>Medicaid Director: Christine Bronson</td>
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<td>Michal Garber, Attorney</td>
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**Department of Health**

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**Department of Commerce**

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<td>Director: Mark Schoenbaum</td>
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**Legislative Web Sites**

Below is a list of some web sites related to the legislative and political process. These are only a sample of many useful sites. The MMA does not control any of the information found on these sites.

### Federal Sites

**Administrative Agencies**
- Centers for Disease Control: [www.cdc.gov/](http://www.cdc.gov/)
- Federal Drug Administration: [www.fda.gov/](http://www.fda.gov/)
- U.S. Census Bureau: [www.census.gov/](http://www.census.gov/)

**Congress**
- Legal Links: [www.compasscomputer.com/legal.htm](http://www.compasscomputer.com/legal.htm)
- Thomas: Legislative Inf. on Internet: [thomas.loc.gov/](http://thomas.loc.gov/)
- U.S. Senate: [www.senate.gov/](http://www.senate.gov/)

### State Sites

**Administrative Agencies**
- Department of Health: [www.health.state.mn.us/](http://www.health.state.mn.us/)
- Department of Human Services: [www.dhs.state.mn.us/](http://www.dhs.state.mn.us/)
- Department of Labor & Industry: [www.doli.state.mn.us/](http://www.doli.state.mn.us/)
- Department of Revenue: [www.state.mn.us/ebranch/mdor/](http://www.state.mn.us/ebranch/mdor/)
- Office of Attorney General: [www.ag.state.mn.us/](http://www.ag.state.mn.us/)
- Office of Governor: [www.governor.state.mn.us/](http://www.governor.state.mn.us/)
- Office of Secretary of State: [www.sos.state.mn.us/](http://www.sos.state.mn.us/)

**State Legislature**
- Minnesota State Legislature: [www.leg.state.mn.us/](http://www.leg.state.mn.us/)
- Office of Revisor of Statutes: [www.revisor.leg.state.mn.us/](http://www.revisor.leg.state.mn.us/)
SECTION IV

MEMBER FEEDBACK

2007 LEGISLATIVE REPORT
MEMBER FEEDBACK

YOUR INPUT IS IMPORTANT!

Two-way communication with MMA members helps build the grassroots support needed to achieve MMA legislative initiatives. The MMA will continue to inform members about MMA policy and events at the legislature. To more effectively serve you, we need to know your opinions and suggestions.

Please let us know how we can improve the MMA Legislative Report in the future, how we can better communicate legislative activities, and any opinions you may have on future legislative initiatives.

Please use the space provided below for your comments and mail or FAX them to us at the MMA.

MINNESOTA MEDICAL ASSOCIATION
State & Federal Legislation
1300 Godward Street NE, Suite 2500
Minneapolis, MN 55413
Phone: 612/378-1875 or 1/800/342-5662
FAX: 612/378-3875

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LEGISLATIVE FEEDBACK

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NAME: _______________________________________________________________________________
ADDRESS: ___________________________________________________________________________
PHONE: ______________________________________________________________________________
E-MAIL: ______________________________________________________________________________