

**2005**

*Legislative Report*



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# Introduction

Legislative gridlock over the state's budget led to the first partial state government shutdown for Minnesota. A special session that lasted over seven weeks and a shutdown that lasted eight days finally came to an end when legislative leaders agreeing to overall spending amounts for the 2006-2007 biennial budget on July 9 and the Legislature passed the final budget bills on July 13. The three sticking points that led to the government shutdown were how much money to spend on K-12 education, how much money to spend on state health care programs, and how to raise the necessary revenues for these two spending areas.

A slim majority in both houses of the Legislature and strongly held beliefs on both sides of the aisle appeared to be the culprits in this drawn out legislative session. The House and the governor strongly believe that the state needs to control the growing cost of health care that is placing a stress on our state's budget. They proposed cutting more than 30,000 people from the state's MinnesotaCare program as a way to achieve savings. The Senate, along with the MMA and other health groups, argued that eligibility cuts to the health care safety net programs do not control overall health care costs, and, in fact, increase costs because patients often put off getting medical care until they are sicker and care is more expensive

The MMA's top priority this session was to ensure access to care by maintaining the health care safety net. We are very happy to report that the final budget bill did not eliminate 30,000 people from the MinnesotaCare program and it even repealed the \$5,000 cap on outpatient benefits for MinnesotaCare. This was a major victory given the position of the House and the governor.

Another MMA high priority was to increase the cigarette tax by \$1 per pack to reduce youth smoking. Studies have shown that significantly increasing the price of cigarettes is one of the most effective ways to reduce and prevent youth smoking. We are happy to report that the Legislature enacted a Health Impact Fee which will increase the price of a pack of cigarettes by 75 cents. Given the "no new taxes" position of the governor and many legislators, the MMA is extremely pleased that the price of cigarettes has been significantly increased.

Beyond the budget debate that dominated the 2005 session, the MMA worked on a number of other issues including the statewide smoking ban, referred to as the Freedom to Breathe Act, health care reform, and medical liability tort reform. Although we were not successful in passing legislation on these issues this session, all received hearings and significant discussion.

The following report provides a more detailed summary of the above issues and other issues important to physicians and their patients.

The MMA staff would like to thank each of you who took the time to contact your legislators during the 2005 session and our special thanks to members of the MMA Committee on Legislation, chaired by Benjamin Whitten, M.D. Your active participation is sincerely appreciated and key to MMA's success at the Capitol.

**Section I**

**BILLS THAT PASSED  
REGULAR SESSION**

**2005 LEGISLATIVE REPORT**



## Medicare Part D Conformance

Chapter 17

*(H.F. 925-Gaelka/S.F. 880-LeClair)*

Chapter 17 changes Minnesota laws to conform to the recent changes in federal law involving Medicare prescription drug coverage (Medicare Part D). With Medicare now beginning to provide drug coverage Minnesota laws related to supplemental coverage and Medigap policies needed amending to acknowledge these federal changes.

Much of this act involves the new federal requirements that (1) new Medigap policies must not be sold with prescription drug coverage after 2005; and (2) existing Medigap policies that cover prescriptions must drop the drug coverage if the insured chooses to enroll in Medicare Part D.

The act also enacts a version of the Limited Health Service Organization Model Act, recommended by the National Association of Insurance Commissioners (NAIC). This allows an insurer to sell a limited type of stand-alone coverage for Medicare, without being required to have a full license to sell health insurance in the state generally. The article enacts this NAIC model law with changes to limit it to apply only to stand-alone Medicare prescription drug plans (PDPs), to limit it to only the types of regulation permitted for those PDP plans by federal law, and to adjust the solvency requirements to account for inflation. Without this change, insurers wanting to offer PDPs here would have needed a full insurance license and would have had to submit to full state insurance regulation, or seek a federal waiver from state regulation and subject themselves to federal regulation.

**Various effective dates**

## University of Minnesota Academic Health Center – Bonding Bill

Chapter 20

*(H.F. 3 – Dorman/ Langseth)*

The University of Minnesota Academic Health Center requested and was appropriated bonding authority for \$11.6 million in this legislation. These dollars will be used to design, renovate, furnish, and equip classrooms, laboratories, and the veterinary medicine teaching center on the St. Paul campus.

**Effective Date: July 1, 2005**

## Lifejackets Required for Children

Chapter 31

**(H.F. 590 -- Samuelson / S.F. 1116 -- Chaudhary)**

Chapter 31 requires all children under the age of 10 to wear an appropriate personal flotation device when on a watercraft unless they are below deck in an enclosed cabin or are a passenger on a commercial watercraft whose operator is licensed by the state of Minnesota or the US Coast Guard to carry passengers for hire. An operator of a watercraft carrying a child under 10 who does not have a lifejacket will receive a warning for the first violation. Subsequent violations are a petty misdemeanor.

**Birth Record for Stillborns**

**Chapter 60**

*(H.F. 947-Klinzing/ S.F. 1029-Anderson)*

On or after August 1, 2005, in cases where a fetal death report is required, a parent may request that a record of birth resulting in stillbirth. If requested, the record must be filed with the state registrar within five days of the stillbirth. The person responsible for filing the fetal death report shall inform the parent or parents that they may request preparation of a record of birth resulting in stillbirth; that preparation of the record is optional; and how to obtain a certified copy of the record if one is requested and prepared.

A fetal death report must be filed within five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed, except for abortions. A fetal death report must be prepared in a format prescribed by the state registrar by: (1) a person or designee in charge of an institution if a fetus is delivered in the institution or en route to the institution; (2) a physician, certified nurse midwife, or other licensed medical personnel in attendance at or immediately after the delivery if a fetus is delivered outside an institution; or (3) a parent or other person in charge of the disposition of the remains if a fetal death occurred without medical attendance at or immediately after the delivery.

Effective Date: August 1, 2005

**Health Plan Regulations: Governor's Health Cabinet**

**Chapter 77**

*(S.F. 1998-LeClair/ H.F. 2023-Wilkin)*

Chapter 77 implements a number of reforms recommended by the Governor's Health Cabinet to reduce some of the administrative costs for health plans and insurers. It repeals an annual report on the number of insured lives the health plan has through qualified and unqualified plans, a report on how the health plan has paid the pass-through of the provider tax, and a report by self-insurers on the total cost of self-insurance for the previous calendar year.

Chapter 77 also modifies requirements related to provider billings. It clarifies the existing prompt pay definition of a clean claim to include "coordination of benefits information" as documentation needed before the 30-day payment requirement begins. It also clearly states that health plans cannot require providers to bill for any interest owed because of a delinquent claim.

This chapter adds a new requirement for "prompt billing" of claims by providers. It states that, unless otherwise provided by contract, a provider must submit a bill to a health plan within six months of the date of service, or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. The six-month submission requirement may be extended to 12 months if the health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. Any claims submitted after these time periods shall not be paid and the patient cannot be billed for these services.

Finally, Chapter 77 repeals a law that required every health plan to offer an “expanded provider network.” This expanded network had to include all “allied independent health providers,” including chiropractors, optometrists, physical therapists, advance practice nurses, pharmacists, audiologists, and others. Very few employers or individuals were purchasing this required product.

**Effective Date: August 1, 2005**

**Firearms: Conceal and Carry**

**Chapter 83**

*(S.F. 2259- Pariseau/H.F. 2428-Howes)*

Chapter 83 is the re-passage of what supporters call the Minnesota Citizen’s Personal Protection Act, otherwise known as the Conceal and Carry Act. It removes the ability of law enforcement agents to use their discretion when issuing permits to carry a concealed weapon. This law was passed in 2003 as an amendment to an unrelated bill. It was found to be unconstitutional by the courts because of the constitutional requirement that every bill must contain only one subject.

This act simply states that, “Laws 2003, chapter 28, articles 2 and 3, are reenacted effective retroactively and without interruption from April 28, 2003.” It also makes very few technical changes to clarify other portions of the law.

**Effective Date: April 28, 2003**

**Hospice Bill of Rights Modifications**

**Chapter 122**

*(H.F. 675 – Samuelson / S.F. 687 – Higgins)*

Chapter 122 makes a number of modifications to the Hospice Bill of Rights. Under this chapter, the statement of rights in the Hospice Bill of Rights is no longer extended to the family of the individual receiving hospice care. The rights listed in the statement of rights were amended to eliminate the requirement that the individual receiving care be informed whether the hospice services were covered by their health insurance, including public programs, and that the individual might have to pay prior to receiving the services. Instead they now have the right to know in advance what services may be covered. The statement of rights now also requires providers to provide, at the individual’s request, a good faith estimate of the reimbursement the provider expects to receive from the health plan in which the individual is enrolled. This Chapter also requires all hospice providers to complete the National Hospice and Palliative Care Organization national data set survey and submit the survey to Hospice Minnesota as a condition of licensure

**Effective Date: August 1, 2005**

## **Positive Alternatives Act**

## **Chapter 124**

***(H.F. 952 – Finstad / S.F. 917 – Sams)***

Chapter 124, titled the Positive Alternatives Act, was the major legislative priority for the Minnesota Citizens Concerned for Life (MCCL). The purpose of this legislation is to provide grant money to non-profit organizations that offer alternative to abortion programs to help women carry their pregnancies to term and care for the child after birth. At a minimum, an alternative to abortion program must include nutritional services, housing assistance, adoption services, education and employment assistance, child care assistance, and parenting education and support services.

To be eligible to receive a grant, the organization applying must be a private nonprofit, demonstrate that the program is properly supervised, not charge for the services provided under the program, provide accurate information on the developmental characteristics of babies and the fetus, including offering the printed information required by the Woman's Right to Know law, ensure that the program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potential following the birth, ensure that none of the grant money is used to encourage or counsel a woman to have an abortion, and the alternatives to abortion. The program must have been in existence for at least one year as of July 1, 2005. The grants will be administered through the Minnesota Department of Health.

Any organization that provides abortions, directly refers for abortions, or is affiliated with an organization that provides or refers for abortions unless they are separately incorporated and independent from each other is not eligible to receive grant money under this Chapter. Organizations are able to do nondirective counseling.

**Effective Date: July 1, 2005**

## **Small Employer Flexible Benefits Plans**

## **Chapter 132**

***(H.F. 1809 – Wilkin / S.F. 1783 – Scheid)***

Chapter 132 allows health insurers to sell a flexible health benefits plan to small employers. The plans must comply with all current state regulations except those requiring coverage of specific benefits. They may exclude or modify coverage of benefits that would otherwise be required by law except for maternity benefits and benefits required by federal law. Each health benefit plan must be approved by the commissioner of commerce but approval cannot be denied based on a modification or exclusion of current state-mandated benefits. Prior to purchasing the flexible benefits plan the small employer must be given a written list of the excluded or modified benefits and an explanation of each benefit that has been excluded or modified. Each employee who will be covered by the plan must also be given a copy of the written list prior to the effective date of the plan.

**Effective Date: June 4, 2005**

***(H.F. 1 –Smith/ S.F. 609 – Ranum)***

Chapter 135 limits the number of methamphetamine precursor drug packages sold in a single sale, requires such drugs be displayed behind a checkout counter, and prohibits sale to a person under the age of 18. The act also increases the penalties for manufacturing methamphetamine. If an individual manufactures or stores methamphetamine-related products in a building where a child or a vulnerable adult is present, it is a felony punishable by a prison sentence of up to 5 years or a fine of up to \$10,000. Children with potential or actual methamphetamine exposure will be offered health screening, and may be taken into protective custody. Finally, the act allows judges to order individuals convicted of manufacturing a controlled substance to pay restitution for the site assessment and clean-up costs. The methamphetamine regulations were supported by the MMA.

**Various effective dates**

***(H.F. 1161 – Huntley/ S.F. 1206 – Kiscaden)***

Chapter 147 started as an omnibus health care provider licensing bill that implemented a number of housekeeping licensing changes for social workers, physical therapists, psychologists, dentists, audiologists, professional counselors, emergency medical technicians, and physician assistants. On the House floor, during the last day of session, it was amended to include provisions requiring payment disclosure by physicians and other health care providers and clarifying their ability to provide patients discounts.

The licensing provisions of the bill affect physicians who serve as supervisors for physician assistants (PAs) who have delegated prescribing authority. The act removes the requirement that the supervising physician review the PA's prescribing patterns at least weekly. Under the new law the prescribing must be reviewed "as outlined in the internal protocol." The act also removes the requirement that the supervising physician's name be printed on the PA's prescriptions. These changes mirror the requirements that exist for advanced practice nurses who have delegated prescribing authority.

The amendment that was adopted on the House floor changed the focus of Chapter 147 significantly. It requires each health care provider, except hospitals and outpatient surgical centers, to gather the following information, update it annually, and have it readily available to patients at no cost to the public on site:

- (1) the average allowable payment from private third-party payers for the 20 services or procedures most commonly performed;
- (2) the average payment rates for those services and procedures for medical assistance;
- (3) the average charge for those services and procedures for individuals who have no applicable private or public coverage; and
- (4) the average charge for those services and procedures, including all patients.

This is intended to assist consumers to be more informed on the costs of medical procedures as part of a consumer-centered health care system.

The second part of the floor amendment clarifies that health care providers can provide discounts to patients who do not have health insurance without having those discounts considered the providers' "usual and customary" charges. It states that a health care provider may provide care at a discounted payment amount for care provided to relatives, for hardship situations, and for cash payments.

**Effective Date: August 1, 2005**

**Emergency Health Powers**

**Chapter 150**

***(H.F. 1555 – Powell / S.F. 1483 – Lourey)***

Chapter 150 modifies the Emergency Health Powers Act, which was passed in 2002, to clarify the governor's powers in a public health emergency. Chapter 150 changes all references to a public health emergency to a "declared emergency" defined as a national security or peacetime emergency declared by the governor. This broadens the Emergency Health Powers Act to create an emergency planning and response to all emergencies or disasters. Under Chapter 150, providers are required to notify individuals of their right to refuse examination, testing, treatment, or vaccine and the consequences of their refusal prior to examination. Current law required that providers do this "when feasible." Chapter 150 also sets liability limitations in a declared emergency for a health care responder, which includes almost all health care providers, whose actions are consistent with an emergency plan.

**Effective Date: Sections 1-13, August 1, 2005 Section 14 June 4, 2005**

**State Health Care Purchasing Authority**

**Chapter 156**

***(H.F. 1481 - Seifert/S.F. 1285 - Kiscaden)***

Chapter 156 creates a new Minnesota Health Care Purchasing Authority to coordinate all the health care purchasing the state does for state employees, public programs, inmates, the Minnesota Comprehensive Health Association (MCHA), and the Workers' Compensation program. By December 5, 2005, the commissioner of employee relations, in consultation with the commissioners of health, human services, labor and industry, corrections, commerce, and administration and the Minnesota Comprehensive Health Association board of directors, may enter into interagency agreements regarding the formation of the Minnesota Health Care Purchasing Authority for the purpose of implementing a unified strategy and joint purchasing of health care services for the state of Minnesota. The strategy shall include implementing a process that examines the health care purchasing decisions and coverage in terms of cost and medical efficacy based on reliable research evidence to ensure access to appropriate and necessary health care.

The purchasing authority shall prepare and submit to the governor and legislature an annual plan for the unified purchasing of health care services. The plan must:

1. promote personal choice and responsibility;
2. encourage and promote better health of patients and residents of the state;
3. provide incentives to private health plans and delivery systems to improve efficiency and quality;
4. use community standards and measurement methods for determining the value of specific health care services based on quality and performance; and

5. separate the health care purchasing functions of state government from those activities relating to regulation and delivery of services, but require consistent use of uniform quality and performance standards and methods for purchasing, regulation, and delivery of health care services.

The purchasing authority shall convene a panel of health care policy experts and health care providers to establish a process to select evidence-based guidelines based on sound research evidence and implement an integrated approach using these guidelines for purchasing decisions and coverage design.

The purchasing authority, in consultation with a panel of health care policy experts, shall define a secure benefit set that includes coverage for preventive health services, as specified in preventive services guidelines for children and adults developed by the Institute for Clinical Systems Improvement, prescription drug coverage, and catastrophic coverage. The act, however, does not authorize the purchasing authority to change the benefits covered by any public health care programs. In developing a plan for the unified purchasing of health care services and a secure benefit set, the purchasing authority must take into account the needs of special populations, including, but not limited to, persons who are elderly or disabled and persons with chronic conditions.

The purchasing authority, in cooperation with organizations representing consumers, employers, physicians and other health professionals, hospitals, long-term care facilities, health plan companies, quality improvement organizations, research and education institutions, and other appropriate constituencies, shall identify and contract with a private, nonprofit organization to serve as a statewide source of comparative information on health care costs and quality.

**Effective Date: August 1, 2005**

**Section II**

**BILLS THAT PASSED  
SPECIAL SESSION**

**2005 LEGISLATIVE REPORT**



**Jobs, Economic Development,  
Environment and Agriculture Omnibus Bill**

**Special Session Chapter 1**

*(HF 78 – Ozment (Gunther) / S.F. 69 – Bakk (Sams))*

Special Session Chapter 1 provides the two-year appropriations for a number of state agencies, including the departments of Agriculture, Commerce, Economic Development, Labor and Industry, and Natural Resources. Included in this act were two items of importance to physicians.

**Minnesota Partnership for Biotechnology and Medical Genomics**

This chapter includes \$15 million in funding for the Minnesota Partnership for Biotechnology and Medical Genomics. This is a partnership of the Mayo Clinic, the University of Minnesota, and the state of Minnesota. Through this partnership, these institutions have committed to uniting on biotechnology and medical genomics research projects to help position Minnesota as a leader in biomedical research.

**Workers Compensation**

For many years, the chiropractors have been aggressively seeking to eliminate the scaling factor that is applied to workers' compensation payments that results in different payment levels for different types of providers. Removing this scaling factor would equalize the payments chiropractors and physical therapists receive with the payments that physicians receive. The chiropractors were successful in finding two very strong champions in the chairs of the committee in the House and in the Senate that have jurisdiction over workers' compensation issues. This made it very difficult to defeat the chiropractor's proposal.

The MMA reached a compromise with the chiropractors that will increase their payments to 72 percent of the physician payment for the same code instead of fully equalizing their payments as the original language proposed. Chiropractors are currently paid 54 percent of the physician payment. This will be phased in over two years. This compromise maintains a differential but brings chiropractors up to what they feel is a more reasonable rate. The compromise allows the commissioner of labor and industry to reduce future increases in the conversion factor for the next two years to pay for this adjustment. This will not result in a direct cut but could potentially impact future increases in the workers' compensation payment rate

**HSA Conformity—Omnibus Tax Bill****Special Session Chapter 3**

*(H.F. 138 - Abrams/S.F. 106 - Pogemiller)*

The Omnibus Tax Bill includes a provision to conform Minnesota tax law to the recently adopted federal deductibility for health savings accounts (HSAs). In fact the change is retroactive to allow those who purchased HSAs in 2004 to receive the deduction through an amended filing.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 allows the deduction of contributions to an HSA for individuals with high-deductible medical health plan coverage. The maximum deduction is \$2,250 for individuals with self-only coverage and \$4,500 for individuals with family coverage. The maximum deduction is \$500 higher for individuals age 55 or older, and is increased by an additional \$100 per year until tax year 2009, when it will be \$1,000 higher than the maximum deduction for individuals under age 55. "High-deductible" plan is defined as having an annual deductible of at least \$1,000 for self-only coverage and \$2,000 for family coverage, and having a maximum combined deductible and out-of-pocket expense requirement of at most \$5,000 for self-only coverage and \$10,000 for family coverage. Earnings on amounts contributed to HSAs are tax-exempt. Distributions from HSAs are tax-exempt if used for medical expenses.

**Effective Date: 2004 Tax Year**

***Health and Human Services Omnibus Budget Bill  
Chapter 4******Special Session***

***(H.F. 139 – Bradley / S.F. 107 – Berglin)***

Special Session Chapter 4 is the Health and Human Services Omnibus Budget Act. It appropriates over \$9.8 billion 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. This act represents a 14 percent increase in funding over the last biennium.

Funding for health and human services was a major sticking point in the overall budget negotiations. When the House and Senate began negotiations their budget proposals for health and human services were over \$400 million apart. The major difference between the two budgets was that the House proposed major reductions in eligibility for the health care safety net programs while the Senate proposed increasing spending by repealing many of the eligibility cuts that were passed in the 2003 session.

The final agreement maintained the health care safety net in and increased revenues for Minnesota health care programs by adopting the 75-cent-per-pack "Health Impact Fee" on tobacco products. The 448-page act included many other items of importance to MMA members and their patients.

**75 Cent Health Impact Fee**

While the Governor was very vocal about his opposition to raising any new taxes, he did propose a new Health Impact Fee (HIF) of 75 cents per pack on tobacco products. This HIF was included in Special Session Chapter 4. Because this is considered a fee and not a tax, the Governor was able to support it.

The price of a pack of cigarettes will go up 75 cents effective August 1, 2005. This fee, which is applied to all tobacco products, will go into the General Fund. Although the total amount raised by this fee is not fully dedicated to health care, the act requires the commissioner of human services to each year determine the costs attributable to smoking and allocate that amount of the HIF to health care safety net programs. The HIF raises \$404 million for the biennium.

Raising the price of cigarettes has been a priority for the MMA for many years because of the public health benefits. Raising the price of cigarettes is one of the most effective ways to prevent youth smoking. Kids are shown to be two to three times more responsive to price increases and are more likely to never start, quit, or cut back to avoid paying higher prices. Studies have shown that every 10 percent increase in the price of cigarettes will reduce youth smoking by about 7 percent and overall cigarette consumption by about 4 percent.

With the new HIF, the overall tax on cigarettes in Minnesota will be \$1.23 per pack. This is higher than Minnesota's border states, but far from the highest tax in the nation. Minnesota now has the 12<sup>th</sup> highest tax.

### **No Eligibility Cuts**

MMA leadership had identified maintaining the health care safety net as a top legislative priority for the 2005 legislative session. The MMA is pleased to report that the final budget act did not include any eligibility cuts to Minnesota's health care programs. In fact, the act repealed a number of eligibility cuts that were passed in 2003. The act repeals the \$5,000 limit on outpatient coverage for MinnesotaCare recipients without children, who earn between 75 percent and 175 percent of the federal poverty level. It also repeals the \$500 cap on dental coverage for the same population.

This was a major victory for the MMA given that the Governor and the House of Representatives budget cutting recommendations called for eliminating MinnesotaCare coverage for adults without children earning more than 75 percent of poverty. They argued that Minnesota was one of only a few states that provided any type of coverage for adults without children. They had also recommended reducing eligibility for parents from 275 percent of poverty to 175 percent of poverty. The MMA provided testimony and letters to legislative leaders and the Governor, participated in a media campaign with other health care organizations opposing the cuts, and lobbied legislators and the Governor.

The act does add some new copays for MinnesotaCare and repeals copays for GAMC. For MinnesotaCare a \$3 copay for preventive services and a \$6 copay for non-emergency visits to emergency rooms is added. These are similar to the co-pays that exist for MA and GAMC. These copays save \$2.4 million. For GAMC the \$3 copay for preventive services is repealed. The payment rate, however, is not increased by that amount.

### **Benefit Changes to Safety Net Programs**

To save money Special Session Chapter 4 does make a number of changes to the benefit sets of the state's health care safety net programs. The act requires the prescribers to receive prior authorization for any drug approved by the FDA after July 1, 2005 for the first six months. Patients will have to fail existing therapies before authorization will be granted for the new product.

For drugs to treat mental illness authorization to use a brand name drug must be granted for up to 60 days after the first new generic of that drug becomes available. This is designed to give the prescriber time to prepare a request for ongoing authorization of the brand name product.

The act requires prior authorization for a number of more expensive procedures. They include non-emergency cesareans, tympanostomy tubes, hysterectomy, and non-trauma related spinal fusion. The prior authorization requirement is effective for services provided after September 1, 2005. The act also requires prior authorization for outpatient CT scans, MRIs and nuclear cardiology. The effective date for these services is postponed as DHS explores new ways of managing the authorization process.

A number of services are no longer covered under Minnesota's health care safety net programs. They include circumcision, drugs for erectile dysfunction, sex reassignment surgery, services provided at the emergency room that are not for emergency, emergency stabilization, or urgent care.

Special Session Chapter 4 authorizes payment for pharmacists who provide medication therapy management services under MA and GAMC. This is a form of disease management for patients taking four or more prescriptions to treat or prevent two or more chronic medical conditions. The commissioner of human services shall establish an advisory committee of physicians, pharmacists, health plans, and consumers to implement this program. Payments are expected to begin in January 2006.

With the passage of Medicare drug coverage at the federal level there is no longer a need for the state Prescription Drug Program (PDP). The PDP provided discounted drugs to low income seniors who did not have drug coverage. This act repeals the PDP.

### **Payment Rates**

Special Session Chapter 4 did not include any cuts to physician reimbursements for any of our health care safety net programs. It did, however, include significant cuts to hospitals.

Hospitals will receive an overall 6 percent reduction in payments for MA services. This reduction does not apply to GAMC or MinnesotaCare payments, nor does it include hospital outpatient payments or payments for inpatient mental health services. This reduction provided \$58 million in savings to the state general fund.

There was an increase in hospital payments for rural hospitals. Payments for 16 specific diagnosis related groups (DRGs) to hospitals outside the seven-county metropolitan area are increased to 90 percent of the payment rate paid to hospitals in the metro area. This provides nearly \$5 million of new money to rural hospitals over the next two years.

Payments to pharmacists were also cut. The payment rate to pharmacists was reduced to the average wholesale price (AWP) minus 12 percent. The old rate was AWP minus 11.5 percent. This was a cut of over \$1.7 million over two years.

### **Health Care Access Fund Changes**

The Health Care Access Fund (HCAF) which funds the MinnesotaCare program and is funded mainly by the 2 percent provider tax will be going through some changes as a result of this chapter. A majority of the enrollees in the General Assistance Medical Care Program (GAMC), which serves the state's adults without children who earn less than 75 percent of poverty, are being transferred to the MinnesotaCare program. The GAMC program is currently funded by the general fund. Transferring enrollees to the

MinnesotaCare program saves the general fund almost \$70 million and costs the HCAF \$61 million. This eliminates much of the surplus dollars in the HCAF.

The HCAF will also become a forecasted program for fiscal years 2006-2009. If the HCAF doesn't have enough funds to meet the needs of the MinnesotaCare program, general fund dollars will be transferred to the HCAF to meet the programs needs.

### **Psychiatric Services**

There were a number of changes affecting psychiatric services. Public programs will pay for services provided telemedically. Effective January 1, 2006, MA, GAMC, and MinnesotaCare will cover mental health services provided via two-way interactive video, if medically appropriate. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Also effective January 1, 2006, MA, GAMC, and MinnesotaCare will cover psychiatric consultation to a primary care practitioner, including pediatricians. This is designed to address the shortage in mental health providers, especially outside the metro area.

Effective August 1, 2005, MA coverage for extended psychiatric inpatient services in community hospitals is expanded to include stays longer than 45 days. To receive the longer stay an individual review of medical necessity would be required.

Special Session Chapter 4 encourages, but does not require, clinical medical education programs that are training pediatricians to include training in case management and medication management for children suffering from mental illness as part of the curriculum in order to be eligible for state medical education dollars.

Finally, there is an expansion of the physician loan forgiveness program to help address the shortage of pediatric psychiatrists. The current loan forgiveness program is for physicians willing to serve in rural or underserved areas. This act provides loan forgiveness for medical residents specializing in pediatric psychiatry.

### **MinnesotaCare Premiums Increased**

Premiums that enrollees pay for MinnesotaCare coverage were raised by 8 percent. This will only affect recipients who earn over 150 percent of the federal poverty level. This raises \$2.5 million in additional funds for the Health Care Access Fund.

### **Health Professional Loan Forgiveness Program**

In order to maintain the existing health professional education loan forgiveness program, costs will be funded partially out of physician license fees. \$200,000 each year will be transferred from the surplus that exists at the Board of Medical Practice to help fund this program. Medical residents agreeing to practice in designated rural areas or underserved urban areas are eligible for the program. The idea to use license fee dollars came from the nurses and the pharmacists who both volunteered to use a portion of their license fees for this purpose.

### **Statewide Trauma System**

Special Session Chapter 4 creates a statewide trauma system for hospitals to ensure that severely injured people are transported to trauma hospitals that can appropriately treat their injuries. The trauma system establishes minimum criteria to address emergency medical service trauma triage and transportation guidelines, designation of hospitals as trauma hospitals, inter-hospital transfers, a trauma registry, and a trauma system governance structure in the form of a state trauma advisory council and regional trauma advisory councils. The law requires that the commissioner of health appoint a trauma surgeon, a general surgeon, a neurosurgeon, an emergency physician, a family practice physician whose practice includes emergency room care in a rural area, an emergency medicine pediatrician, an orthopedic surgeon, and other allied health care providers as members of the state trauma advisory council.

### **Electronic Health Record System**

The commissioner of health is required to work with the electronic health record planning group that was established in 2004 to develop a plan for all hospitals and physician groups to have in place an interoperable electronic health records system by January 1, 2015. When developing the plan, the commissioner must consider how to provide financial assistance to hospitals and providers, addressing specific needs of safety net hospitals and other providers who serve low-income populations, and how to provide assistance in developing alliances among providers. A preliminary report on the status of reaching this goal along with recommended statutory language for achieving the 2015 goal is due to the chairs of the House and Senate health care committees on January 15, 2007.

In addition, this act establishes a Health Information Technology and Infrastructure Advisory Committee to advise the commissioner of health. Its charge to assess the use of health information technology by the state, health care providers, facilities, and local public health agencies and to make recommendations for implementing a statewide interoperable health information infrastructure. The members of the advisory committee shall include department commissioners, local public health agencies, hospitals, health care providers, purchasers, and others. They shall make an annual report every January.

### **Performance Reporting**

Special Session Chapter 4 requires the commissioner of human services to establish a performance reporting system for health care providers who serve patients enrolled in Minnesota's health care programs. The requirements for performance reporting laid out in this Chapter are very consistent with what is currently happening in the private sector. This was done intentionally to be able to compare data with the data being collected in the private sector and to not make the process more complicated or duplicative for providers.

The measures used for the performance reporting system for medical groups are required to include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services and for inpatient hospitals, measures of care for acute myocardial infarction, heart failure, and pneumonia and measures of care and prevention of surgical infections. The measures for medical groups are required to be consistent with the current efforts of, although not expressly named in the Chapter, the Community Measurement Project of which the MMA is a participant. For inpatient hospitals, the commissioner will appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. The commissioner has the authority to require providers to submit information in the required format to the health care reporting organization or to cooperate with the information collection procedures of the health care reporting organization.

By October 1, 2007, the commissioner must report on a public Web site the results of each medical group and hospital's performance on the measures and must compare their results for patients enrolled in public programs with their results for patients enrolled in private health plans.

### **Hospital Price Disclosure**

Special Session Chapter 4 directs the Minnesota Hospital Association to develop a Web-based system for the public to use to compare hospital charge information. The system must be free of charge and must allow consumers to compare hospitals charges for the 50 most common inpatient services and the 25 most common outpatient services. The Web site will also compare hospital-specific data to hospital statewide data.

### **Additional Requirement for Informed Consent for Abortion**

Special Session Chapter 4 expands the necessary information that a physician is required to provide a woman seeking an abortion in order to obtain informed consent. For abortions after 20 weeks gestation the physician must tell the patient if an anesthetic or analgesic would eliminate or alleviate organic pain to the fetus and explain the risk associated with the particular anesthetic or analgesic. Prior to administering the anesthetic or analgesic the physician must disclose any additional cost of the procedure to the patient.

Legislation that was originally introduced with the support of the Minnesota Citizen's Concerned for Life (MCCL) contained a felony level criminal penalty for performing an abortion without providing the above information. The MMA was successful in amending the legislation to include it in the current requirements for informed consent which contains civil penalties but no criminal penalties.

### **Education on Dangers of Shaking Infants**

Special Session Chapter 4 requires the commissioner of health to establish a protocol for all pediatric health care providers to educate parents and care givers about the dangers of shaking infants and young children. Pediatric health care providers will be asked to review the dangers with parents and primary caregivers of infants and young children up to the age of 3 at each well-baby visit.

Hospitals will also be required to make available for viewing a video on the dangers of shaking infants for parents of each newborn baby delivered in the hospital.

### **Postpartum Depression**

To ensure that new parents receive information on postpartum depression the commission of health shall work with hospitals, mental health professionals, mental health advocates, consumers, and families to develop useful materials. Physicians and other health care professionals who provide prenatal care to women must have information about postpartum depression available. Hospitals must provide new mothers upon departure from the hospital written information about postpartum depression, including symptoms, methods of coping with the illness, and treatment sources.

**Various Effective Dates**

**Cell Phone Use While Driving –  
Omnibus Transportation Budget**

**Special Session Chapter 6**

*(H.F. 140 – Holberg / S.F. 105 – Murphy)*

Special Session Chapter 6 prohibits provisional license holders (license holders under age 18) and permit holders from using a cell phone while driving. Legislation was introduced that would have prohibited the use of a cell phone while driving regardless of age unless the driver had a hands free device. The bill received hearings in the Senate but did not receive a hearing in the House.

**Effective Date: January 1, 2006**

**Section III**

**BILLS THAT FAILED PASSAGE**

**2005 LEGISLATIVE REPORT**



## **Alcohol Tax Increase to Fund Chemical Dependency Services**

*(H.F. 2232 – Ellison/ S.F. 1926 – Murphy)*

This legislation would have increased the alcohol tax and deposited the revenue it raised in an alcohol and chemical dependency account. Thirty percent of the funds in the alcohol and chemical dependency account would have been dedicated to county probation services grants to increase probation supervision of all offenders whose offenses involved alcohol or controlled substance abuse or dependency. Seventy percent of the funds would have been dedicated to the commissioners of human services and health to provide grants to counties for chemical dependency treatment services, treatment support services, detoxification services, and health assessments and supportive services to children and vulnerable adults who reside at the site where methamphetamine is manufactured or are subjected to health risks there. This legislation received a hearing in the Senate but failed to pass either body.

## ***Child Restraint Law***

*(H.F. 319 – Powell / S.F. 298 – McGinn)*

This bill would have required all motor vehicle drivers to restrain passengers under 9 years of age who weighed less than 80 pounds in a child passenger restraint system. Current Minnesota law only requires children under 4 to be restrained in a child safety seat. The National Highway Transportation Safety Administration recommends that all children ages 4–8 be properly restrained in a booster seat. According to an article in the June 2003 *Journal of the American Medical Association*, children ages 4–7 who use booster seats were 59 percent less likely to be injured in a crash than children who were restrained only by a safety belt. The proposal was included in the Senate Omnibus Transportation Policy Bill and passed but unfortunately the House did not act on the companion legislation.

## ***Cigarette Tax Increase***

### **Elimination of Minnesota Comprehensive Health Association Assessment and Premium Tax**

*(H.F. 1169 – Bradley / S.F. 1164 – Kiscaden)*

### **Elimination of Minnesota Comprehensive Health Association Assessment**

*(H.F. 1168 – Wilkin)*

### **Elimination of Provider Tax**

*(H.F. 1588 – Scalze / S.F. 1911 – Chaudhary)*

### **Elimination of Minnesota Comprehensive Health Association (MCHA) Assessment and Premium Tax**

This legislation would have increased the tax on cigarettes by 99 cents per pack and used the revenue raised to eliminate the assessment on health plans that is used to fund MCHA and to eliminate the 2 percent premium tax. MCHA makes health insurance available to people who are unable to purchase health insurance in the private market. This legislation was strongly supported by Blue Cross Blue Shield of Minnesota. This bill was defeated in the House Commerce Committee and passed two committees in the Senate but failed to be heard by the Senate Tax Committee.

### **Elimination of Minnesota Comprehensive Health Association Assessment**

This bill would have increased the tax on cigarettes by 42 cents per pack and used the additional revenue to eliminate the assessment that is applied to health plans to fund MCHA. It did not eliminate the premium tax. Following the defeat of the bill that eliminated the MCHA assessment and the premium tax, the author decided not to have this bill heard in the House Commerce Committee.

### **Elimination of the Provider Tax**

This legislation would have increased the cigarette tax by \$1.00 per pack and used the revenue to eliminate the provider tax. Sixty-two percent of the revenues raised by the total cigarette tax would have been dedicated to the Health Care Access Fund to help offset the elimination of the provider tax. This bill did not receive a hearing.

## ***Family Planning – Comprehensive Approach***

### **(H.F. 646 – Sieben / S.F. 581 – Marty)**

This legislation aimed to promote comprehensive sexual education. Under this bill, the commissioner of education would have been required to develop a plan that would ensure that all school districts provide comprehensive family life and sexuality education no later than the 2008-2009 school year.

The bill also would have changed the focus of Minnesota's education now and babies later (MN ENABLE) program from promoting abstinence until marriage to a program that would have taught comprehensive sexuality education that promoted abstinence and male sexual responsibility.

This legislation also would have amended the Woman's Right to Know Act to add a requirement that before or after an abortion is performed the health care facility performing the abortion must provide the woman with written information on all FDA-approved methods of contraception and natural family planning and offer information on community resources that provide contraceptive services and family planning counseling at no cost or at a reduced cost. This information would also have been included in the required written information and on a Family Planning Web site to be developed by the commissioner of health.

This legislation did not receive a hearing in either body.

## **Family Planning Grant "Gag Rule"**

***(H.F. 227 – Blaine/ S.F. 330 – Wergin)***

This legislation would have prohibited the distribution of family planning grants to an organization that:

- directly or indirectly subsidizes abortion services or administrative expenses,
- provides abortion services,
- has a policy that abortion is considered part of a continuum of family planning services and/or reproductive services.

Organizations would have been able to provide non-directive counseling, which means that a patient could be provided with a list of health care providers and social service providers that provide prenatal care, childbirth care, infant care, foster care, adoption services, alternatives to abortion or abortion services; but the organization would not be able to directly refer a patient to any organization that provides abortion services.

The bill also would have prohibited the distribution of family planning grant funds to organizations that engage in public advocacy that promotes the legality or accessibility of abortion services and organizations that display or distribute marketing materials about abortion services. Under this legislation, an organization also would have to be incorporated separately from any affiliated organization that provides abortion services in order to receive family planning grant funds.

The MMA opposed this legislation solely based on opposition to government or other third-party interference that compromises the free and open exchange of information about legal treatment options between a physician and patient. The bill received a hearing in the House but ultimately did not pass either body.

***Freedom to Breathe Act***

***(H.F. 405 – Meslow / S.F. 404 – Dibble)***

The Freedom to Breathe Act would have expanded Minnesota's Clean Indoor Air Act to all workplaces, including bars and restaurants. Noncompliance with the law would have been a petty misdemeanor. This legislation was strongly supported by health care groups, including the MMA, because of the public health benefits associated with reducing secondhand smoke. The legislation passed the Health and Family Security Committee and Commerce Committee in the Senate without any major amendments. The bill passed the House Health Policy and Finance Committee but was scaled back to exempt bars and private clubs and referred to the House Commerce Committee where it was defeated. The main arguments against the bill were related to individual liberties, personal responsibility, and the economic impact on small town taverns. The opposition did a very good job of raising fear in legislators' minds that this legislation would be devastating to their local businesses.

**Freedom to Breathe – Pre-emption of Local Regulations of Smoking in Public Places**

***(H.F. 564 – Holberg / S.F. 560 – Tomassoni)***

This bill would have required hospitality establishments that permit smoking to register annually with the commissioner of health and pay an annual registration fee. The dollars generated by the fee would have been appropriated to the commissioner of health for tobacco-use prevention efforts.

The MMA opposed this legislation not only because it was a weak version of a statewide policy on smoking in public places, but more importantly because it would have pre-empted all local ordinances. This means that all ordinances that have been passed at the city or county level would have been unenforceable. The tobacco companies support pre-emption efforts because they would no longer have to fight efforts on the local government level that were stronger than laws passed by the state. The MMA strongly opposed this bill. The bill did not receive a hearing in either body.

**Hospital Charges to the Uninsured**

***(H.F. 2213- Carlson /S.F. 1162-Berglin)***

Legislation promoted by the Attorney General would have prohibited a hospital from billing or charging an uninsured individual or the individual's representative more than 120 percent of the amount the hospital is paid for that service by a nongovernmental third-party payer plus any applicable cost-sharing payments payable by a patient during the previous calendar year. This would have applied to uninsured individuals with an annual family income below \$125,000.

In addition, it would have required the Commissioner of Health to compile the 25 most frequently performed hospital inpatient procedures, the 25 most frequently performed hospital outpatient procedures, and the 50 most frequently administered drugs in a hospital inpatient setting. Hospitals would have been required to report their average and median allowable charge for these services.

This bill passed the Senate Health and Family Security Committee but was withdrawn after the Attorney General and many Minnesota Hospitals entered into volunteer agreements to limit their charges to uninsured patients.

**Marijuana for Medical Uses**

***(H.F. 2151 – Huntley / S.F. 1973 – Kelley)***

This bill would have legalized marijuana for medical use. This legislation would have allowed patients diagnosed by a practitioner as having a debilitating medical condition, and whose physician stated that the health benefits of marijuana use would likely outweigh the health risks of marijuana use, to use marijuana for medical purposes without being subject to prosecution. The bill received a hearing in the Senate, but failed to advance.

## ***Medical Liability Reform***

***(H.F. 1464 – Dean / S.F. 2131 – Michel)***

This bill aimed to enact a number of reforms, including placing a \$250,000 cap on non-economic damages. A \$250,000 cap would also have been applied to punitive damages. In the case of punitive damages, the bill would have required that all damages be paid directly to the Minnesota Comprehensive Health Association.

The bill also aimed to address the issue of excessive attorney fees by only allowing attorneys to collect a percentage of total damages awarded.

One of the more controversial provisions in the bill as introduced would have provided an absolute defense for physicians who adhered to best practice guidelines approved by either a recognized specialty organization or an organization established to develop community-based clinical practice guidelines. Evidence that a guideline was or was not followed could only be used to determine if a provider was entitled to an absolute defense. Many raised concerns that this could lead to more lawsuits against physicians who did not follow a best practice guideline.

All of the bill language as introduced was deleted in the House Health Policy and Finance Committee and language was inserted to create a \$250,000 cap on non-economic damages to apply only to emergency medicine physicians and obstetricians because those providers are experiencing premium increases and having difficulty finding coverage. It was further amended in the House Civil Law Committee to eliminate the caps and instead create immunity from civil damages for physicians providing care in an emergency setting unless there is gross negligence. The legislation was not acted on by the full House and did not receive a hearing in the Senate. This legislation continues to be an uphill battle because Minnesota has the lowest premiums in the country and, with the exception of some emergency medicine and obstetric groups, has not experienced the medical liability crisis that other states have experienced.

## **Medical Liability Reform – Statute of Limitations**

***(H.F. 653 – DeLaForest/ S.F. 752 – Neuville)***

The MMA introduced this legislation in response to a Minnesota Supreme Court decision that significantly changed Minnesota's medical liability statute of limitations for genetics cases. In order to bring a medical liability claim there must be a negligent act and harm, and historically the negligent act and the harm have occurred at the same time. In this genetics case, however, the alleged negligent act of not performing a certain genetics test occurred in 1992 but the court determined that the actual harm didn't occur until another child was born and developed the same genetic disorder almost 10 years later. The court ruled that the case could proceed because the four year statute of limitation does not begin until after both the alleged negligent act and harm have taken place. Because of the court's decision, exposure to a possible lawsuit could potentially be limitless in genetic cases.

This decision raises a number of problems. The standard of care in medicine is constantly changing. How would a physician defend himself/herself against a case that is 30 years old? How good is a witness's memory 10 or 20 or even 30 years later? How long does a clinic need to keep a patient's

medical records after the physician retires or dies? How long does a physician need to maintain malpractice “tail” coverage?

To address these concerns, the bill made clear that genetics cases would be subject to the same 4-year statute of limitation that all other adult medical liability cases are subject to. The bill did not receive a hearing in either body.

### ***Mercury in Vaccines***

***(H.F. 1505 – Brod / S.F. 639 – Lourey)***

This legislation would have required that all vaccines administered in Minnesota be mercury-free unless mercury-free doses were not manufactured or not obtainable by the best efforts of the provider. The major concerns this legislation raised were that the legislation created a perception among parents that vaccines were harmful, which could lead parents to choose not to vaccinate their children, and that it would have reduced access to vaccines.

The MMA along with the Minnesota Chapter of the American Academy of Pediatrics and the Minnesota Academy of Family Physicians raised opposition to the legislation because scientific evidence currently does not support a link between Thimerosal and neurological disorders and most vaccinations offered are currently Thimerosal free or contain only trace amounts. This legislation would have raised fears in consumers for which there is no scientific basis.

This legislation would also have impacted access to vaccines. The Minnesota Department of Health estimated that 25,000 fewer doses will be administered through the Vaccines for Children Program (VCF) because of the need to use more costly thimerosal-free vaccines.

### ***Minor Consent Repeal***

***(H.F. 1921 – Wilkin)***

This bill would have significantly changed longstanding Minnesota law that gives minors the ability to seek medical health services to treat pregnancy, venereal disease, and chemical abuse without the consent of an adult. The law was enacted in the early 1970s to ensure that minors can seek the treatment they need without fear of punishment or reprisal. H.F. 1921 would have only permitted minors to give consent in cases of incest. In other cases the parent or legal guardian would have had to enter into an agreement with the provider to give the minor the authority to consent to future medical or mental health care services to treat pregnancy, venereal disease, and alcohol and drug abuse. The agreement could have specifically stated the services that the minor could consent to and the amount of time the agreement is valid. The bill passed the House Health Policy and Finance Committee but did not receive a vote on the House floor. No companion legislation was introduced this session in the Senate.

## ***No-Fault Auto***

### ***Reform***

***(H.F. 1399 – Kohls / S.F. 1094 – Scheid)***

### **Repeal**

***(H.F. 1358 – Wilkin / S.F. 1329 – Michel)***

Both of these bills were introduced as a way to control automobile insurance premiums. The insurance industry has argued that medical costs are becoming a much larger part of the auto insurance premium and that significant reform or repeal of the current No-Fault Automobile Insurance Act is necessary. The No-Fault Automobile Insurance Act covers up to \$20,000 of a person's medical expenses as a result of an auto accident. Health care providers are reimbursed their charges under the no-fault law.

The reform bill would have reimbursed health care providers based on the Minnesota Workers' Compensation fee schedule and treatment guidelines for a person injured in an auto accident.

The repeal bill would have fully repealed the No-Fault Automobile Insurance Act. Repeal of this law would have resulted in medical expenses being reimbursed by the injured person's personal health care insurance.

Neither bill received a hearing in the House because of lack of support for the proposals. The reform bill was heard in the Senate Commerce Committee and was defeated.

## **Obesity Drug Coverage**

***(H.F. 2474 - Thissen/S.F. 2275 - Foley)***

Currently there is a prohibition on the inclusion of drugs used for weight loss on the drug formulary for Medical Assistance. This bill would have expanded the drug formulary to include lipase drugs used to treat obesity necessary to control diabetes, hypothyroidism, Cushing's disease, cardiac disease, respiratory disease, and hypertension.

This legislation was introduced by the MMA in response to a resolution passed at the 2004 House of Delegates. The additional cost of adding coverage for these obesity drugs was the main reason that the bill failed to receive a hearing in either body.

## ***Physicians' Plan for a Healthy Minnesota – MMA Health Care Reform Bill***

***(H.F. 2175 --Abeler / S.F. 1933 – Kiscaden)***

This legislation was developed based on the MMA Health Care Reform Task Force Report, *Physicians' Plan for a Healthy Minnesota*. Rising health care costs continue to fuel an interest in health care reform at the Capitol. The *Physicians' Plan for a Healthy Minnesota* garnered enough attention that legislation was introduced to begin the discussion on many of the pieces in the plan.

### **Article 1 – Investment in Prevention and Wellness**

This article was meant to stimulate coordinated action by public and private entities through the development of a statewide action plan to improve the health status of Minnesotans and to promote primary prevention activities.

A “health improvement grant fund” would have been created to support (on a matching basis by grant recipients) public-private partnerships working to implement measurable activities to advance the statewide action plan.

### **Article 2 – Healthier Minnesotans**

This article would have advanced the health of Minnesotans by addressing one of the primary causes of morbidity and mortality – tobacco. The article included the statewide smoking ban, referred to as the Freedom to Breathe Act, and a \$1.00 tobacco tax increase.

### **Article 3 - Health Insurance Reform**

*Individual Mandate for Coverage* This article would have required all Minnesota residents to have and maintain health care coverage for an essential benefit set.

Every health plan would have been required to offer the essential benefit set;; additional coverage could have been provided, but would have had to be separately priced.

#### *Guaranteed Issue*

Guaranteed issue of the essential benefit set would have been required by this bill; supplemental coverage would not have had to be offered on a guaranteed issue basis.

*Community Rating* The premium rate for the essential benefit would have been community rated under this legislation, which means no premium variation would have been allowed for age, gender, geographic location, health history, health status, or whether coverage was group or individual. Actuarially valid variation would have been allowed for nonuse of tobacco, compliance with recommended health screenings and preventive care, or other health-promoting behaviors.

*Essential Benefit Set* An expert advisory committee would have been established under the auspices of the commissioners of commerce, health, and human services with full community input, to create a report, recommendations, and proposed legislation to establish an essential benefit set.

*Tax Subsidies/Deductibility* This bill would have allowed individuals to deduct from their federal taxable income the amount paid for the essential benefit set. For corporations, the bill required that the cost of any health insurance coverage provided to enrollees in excess of the essential benefit set be added to federal taxable income. The tax advantages would have applied only to the essential benefit set.

*Reinsurance* The commissioner of commerce was directed to create a plan for reactivating the state reinsurance pool and using it for high-cost cases in the individual and group markets.

#### *Provider Networks*

In order to remove obstacles to greater provider-level competition, the legislation directed the commissioner of commerce to prepare a report, recommendations, and proposed legislation to prohibit health plans from limiting or restricting an enrollee's ability to obtain coverage from a qualified provider of the enrollee's choosing. Issues that were also to be addressed were balance billing, co-payments, deductibles, and out-of-pocket maximum benefits.

*Individual Mandate Enforcement* The bill directed the commissioner of health to develop recommendations for enforcing the mandate for coverage. When developing recommendations the commissioner was required to consider whether to require evidence of coverage when applying for a driver's license, registering for school, or filing state income taxes.

#### **Article 4 – Improving Value in Health Care Purchasing**

This article recognized the need for access to cost and quality information in order to create more value-based health care purchasing decisions.

State agencies, in cooperation with other public and private entities and organizations, were asked to identify and contract with a private, nonprofit organization to serve as a statewide source of comparative information on health care quality.

The commissioner of health, in consultation with an advisory committee, was also called upon to develop a plan by January 1, 2006, for the development of useful, reliable, and valid information on cost to support the purchase of health care based on value.

#### **Article 5 – High-Quality Care**

Article 5 would have modified current law regarding “best practices” to reflect the recommendations of the Health Care Guidelines Work Group, which was formed by the Minnesota Department of Health as a result of legislation passed in 2004.

##### *Pay for Quality*

This article would have required the commissioners of human services and employee relations to develop a financial rewards program to compensate health care practices that implement effective quality improvement programs or systems, such as clinical information systems, patient education and support, and case and disease management.

##### *Electronic Medical Records*

This article would have established a loan program to help physician group practices obtain and install electronic medical record systems. The loans would have been limited to \$65,000 and required to be repaid in at least 15 years. Funds for the loans would have been generated from a bond issuance not to exceed \$5 million.

##### *Quality Improvement Investment Program*

The commissioner of health would have been required to develop recommendations to establish a quality improvement investment program, which would have provided technical assistance, grants, and low-interest loans to establish or update electronic information systems in care settings.

### **Smoking in State Operated Hospitals**

***(No H.F./ S.F. 108 – Betzold)***

During the 2003 legislative session, following a directive from the MMA House of Delegates, the MMA was successful in strengthening the Clean Indoor Air Act requirements dealing with smoking in hospitals and state-operated hospitals. The law was amended in 2003 to remove the exemption in the Clean Indoor Air Act that permitted smoking in chemical dependency and mental health units within hospitals and to prohibit the use of tobacco by patients, staff, guests, or visitors on the grounds or in the buildings of state-operated facilities.

There was an effort in 2004 and once again this session to repeal the law and allow smoking in a chemical dependence treatment program or mental health program in a separated well-ventilated area if prohibiting smoking would interfere with the treatment or recovery of a patient. The MMA opposed the repeal effort. The bill received a hearing and failed to pass out of the Senate Health and Family Security Committee.

***Stem Cell Research***

***(H.F. 1734 Kahn / S.F. 69 – Cohen)***

This bill would have created a state policy for stem cell research. The state policy would have:

- permitted research involving the use of embryonic stem cells, human embryonic germ cells, and human adult stem cells.
- required a health care provider treating a patient for infertility to provide the patient with information to help the patient make an informed decision regarding their options on how to dispose of remaining embryos following fertility treatment.
- prohibited the sale of embryonic or cadaveric fetal tissue for research purposes.

Creating a state policy would have clarified existing law, which many argue is not clear on the ability to perform stem cell research in Minnesota. The bill received hearings in the Senate but failed to receive a hearing in the House.

***Seat Belt As A Primary Offense***

***(H.F. 1087– Powell / S.F. 1070 – Murphy)***

This legislation would have changed the requirement to wear a seat belt from a secondary to a primary offence not only for the driver but also for passengers and would have allowed law enforcement officers to pull over and charge the driver with a petty misdemeanor if the driver and/or passengers did not have their seat belts fastened. The bill received hearings in both bodies and the language was included in the Senate Omnibus Transportation Policy Bill, which passed the full Senate, but the House did not take action on the companion legislation.

### **Sick Tax Itemization**

*(H.F. 1314-Davids/ S.F. 1246-Tomassoni)*

This bill would have allowed health care providers to itemize the sick tax on bills submitted to third-party purchasers. A third-party purchaser would have been required to comply with this section regardless of whether the third-party purchaser was a for-profit, not-for-profit, or nonprofit entity or whether the health care provider had chosen to itemize the tax on patient billings. If the third-party purchaser's contract limited provider payment to a specified amount, such as a usual and customary fee schedule, the third-party purchaser would have still had to pay the tax transferred or itemized by a health care provider based upon the contractual fee. A third-party purchaser would have also been responsible for reimbursing providers for the percentage tax levied on co-payments or deductibles paid by the insured.

The bill passed the House Tax Committee and was included in the House Omnibus Tax Bill, but in the end did not pass.

### **Sick Tax Reduction**

*(S.F. 399 – LeClair)*

This bill would have reduced the sick tax to 1.2 percent from January 1, 2006 until January 1, 2008, at which time the tax would return to 2 percent. This bill did not receive a hearing.

### **Tanning Bed Regulation**

*(S.F. 1114 – Metzen)*

This legislation would have provided for regulation of use of tanning facilities by minors. The bill would have prohibited a child under the age of 13 from using a tanning facility without a written order from a physician unless the child's parent or guardian remains at the facility while the child is using the facility. For teens ages 13, 14, or 15, the person's parent or guardian must accompany the teen to the facility and remain at the facility while the teen is using the facility. Teens ages 16-17 must have written consent from their parent or guardian stating that they understood the warnings given by the tanning facility, consent to the minor's use of a tanning device, and agree that the minor will use protective eyewear.

### **Universal HealthCare**

*(H.F. 784 – Walker/ S.F. 723 – Marty)*

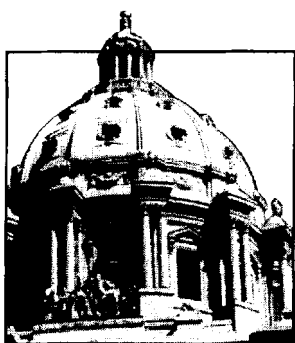
This bill would have established a work group to design a universal health care system for Minnesota. The universal health care system would have needed to ensure that all Minnesotans received comprehensive health care of the highest quality available, regardless of their income, and guaranteed that an adequate number of qualified health care professionals and facilities provided timely access to quality care.

The billed failed to pass.

**Section IV**

**GOVERNMENT INFORMATION**

**2005 LEGISLATIVE REPORT**



## MINNESOTA CAPITOL INFORMATION

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

<b>General Information</b>		<b>To order copies of bills</b>	
House Information:	651/296-2146 800/657-3550	Chief Clerk of the House:	651/296-2314
Senate Information:	651/296-0504 888/234-1112	Secretary of the Senate:	651/296-2344
<b>Committee Information</b>		<b>Information about bills</b>	
(24-hour hotline)		(With or without bill numbers)	
House:	651/296-9283	House Index:	651/296-6646
Senate:	651/296-8088	Senate Index:	651/296-2887
<b>Governor Tim Pawlenty's Office</b>		<b>Attorney General Mike Hatch's Office</b>	
Phone:	651/296-3391 800/657-3717	Phone:	651/296-6196 800/657-3787
Fax:	651/296-0674	Fax:	651/297-4193
<b>FAX Numbers</b>		<b>Legislative Information Via the Internet</b>	
House (DFL):	651/296-4165	Minnesota Legislature Home Page:	
House (R):	651/296-3949	<a href="http://www.leg.state.mn.us">www.leg.state.mn.us</a>	
Senate (DFL):	651/296-6511		
Senate (R):	651/296-9441		
<b>MINNESOTA STATE AGENCIES</b>			
<b>Department of Human Services</b>		<b>Department of Revenue</b>	
MinnesotaCare and Medicaid Questions		Provider Tax Questions	
Commissioner:	Greater Minnesota:	<i>Pam Dalstrom</i>	651/556-3880
Kevin Goodno	800/657-3672	<i>George Hoyum</i>	651/556-4713
Medicaid Director:	Metro Area:		
Christine Bronson	651/296-4332		
<b>Department of Health</b>		<b>Department of Commerce</b>	
Commissioner:		Commissioner:	
Diane Mandernach	651/215-5805	Glenn Wilson	651/296-4026
Health Plan Regulation:		Insurance Regulation:	
Irene Goldman	651/282-6327	John Gross	651/297-2319
		<b>Office of Rural Health</b>	
		Rural Health Issues	
		Director:	
		Mark Schoendaum	651/282-3859

### MINNESOTA LEGISLATORS' E-MAIL ADDRESSES

*For all members of the Minnesota House of Representatives:*

rep.firstname.lastname.@house.leg.state.mn.us  
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sen.firstname.lastname.@senate.leg.mn.us  
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Fax: 202/228-2186  
LA: Jonathan Heafitz  
Web E-mail form: [www.dayton.senate.gov](http://www.dayton.senate.gov)

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One Federal Drive  
St. Paul, MN 55111-4080  
Ph: 888/224-9043  
Fax: 612/727-5223

#### **Senator Norm Coleman (R)**

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Washington, DC 20510  
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Fax: 202/224-1152  
LA: Jayne Jones  
Web E-mail form: [www.coleman.senate.gov](http://www.coleman.senate.gov)  
web: [www.senate.gov/coleman/](http://www.senate.gov/coleman/)

Court International Bldg.  
2550 University Ave. W., Suite 100 North  
St. Paul, MN 55114-1025  
Ph: 651/645-0323  
800/642-6041  
Fax: 651-645-3110

## ***United States House of Representatives***

### **Minnesota Address**

#### *Washington Address*

#### **Congressman Gil Gutknecht (R-1<sup>st</sup>)**

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Fax: 202/225-3246  
LA: Ryan McLaughlin  
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web: [www.house.gov/gutknecht/](http://www.house.gov/gutknecht/)

1530 Greenview Dr. SW, Suite 108  
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**Congressman John Kline (R-2<sup>nd</sup>)**

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Fax: 952-738-9362

***United States House of Representatives  
cont.*****Congresswoman Betty McCollum (D-4<sup>th</sup>)**

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Fax: 202/225-1968  
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web: www.house.gov/mccollum/

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St. Paul, MN 55102  
Ph: 651/224-9191  
Fax: 651/224-3056

**Congressman Martin Sabo (D-5<sup>th</sup>)**

2336 Rayburn House Office Bldg.  
Washington, DC 20515-2304  
Ph: 202/225-4755  
Fax: 202/225-4886  
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Web E-mail form: www.sabo.house.gov

Commerce at the Crossings #286  
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**Congressman Mark R. Kennedy (R-6<sup>th</sup>)**

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Email: [mark.kennedy@mail.house.gov](mailto:mark.kennedy@mail.house.gov)  
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**Congressman Collin Peterson (D-7<sup>th</sup>)**

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Fax: 218/847-5109

**Congressman James Oberstar (D-8<sup>th</sup>)**

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Fax: 202/225-0699  
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Web E-mail form: [www.house.gov/oberstar/](http://www.house.gov/oberstar/)

231 Federal Bldg.  
Duluth, MN 55802  
Ph: 218/727-7474  
Fax: 218/727-8270

*Several congressional offices have more than one district office. For further information, contact the main office indicated above. The legislative assistants (LA) noted above are the primary staff members for health care issues.*

# Minnesota Medical Association Web Site

[www.mnmed.org](http://www.mnmed.org)

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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.*

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### **Federal Sites**

#### *Administrative Agencies*

Centers for Disease Control	<a href="http://www.cdc.gov/">www.cdc.gov/</a>
Federal Drug Administration	<a href="http://www.fda.gov/">www.fda.gov/</a>
Office of Inspector General	<a href="http://www.oig.doc.gov/oig/">www.oig.doc.gov/oig/</a>
U.S. Census Bureau	<a href="http://www.census.gov/">www.census.gov/</a>
U.S. General Accounting Office	<a href="http://www.gao.gov/">www.gao.gov/</a>

#### *Congress*

Library of Congress	<a href="http://www.loc.gov/">www.loc.gov/</a>
Thomas: Legislative Info. on Internet	<a href="http://thomas.loc.gov/">thomas.loc.gov/</a>
U.S. House of Representatives	<a href="http://www.house.gov/">www.house.gov/</a>
U.S. Senate	<a href="http://www.senate.gov/">www.senate.gov/</a>

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### **State Sites**

#### *Administrative Agencies*

Department of Health	<a href="http://www.health.state.mn.us/">www.health.state.mn.us/</a>
Department of Human Services	<a href="http://www.dhs.state.mn.us/">www.dhs.state.mn.us/</a>
Department of Labor & Industry	<a href="http://www.doli.state.mn.us/">www.doli.state.mn.us/</a>
Department of Revenue	<a href="http://www.state.mn.us/ebranch/mdor/">www.state.mn.us/ebranch/mdor/</a>
Office of Attorney General	<a href="http://www.ag.state.mn.us/">www.ag.state.mn.us/</a>
Office of Governor	<a href="http://www.governor.state.mn.us/">www.governor.state.mn.us/</a>
Office of Secretary of State	<a href="http://www.sos.state.mn.us/">www.sos.state.mn.us/</a>

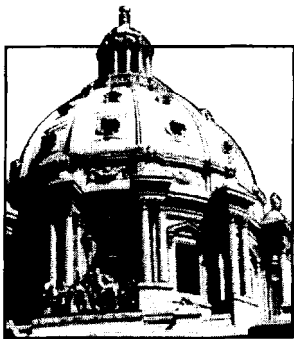
#### *State Legislature*

Minnesota State Legislature	<a href="http://www.leg.state.mn.us/">www.leg.state.mn.us/</a>
Office of Revisor of Statutes	<a href="http://www.revisor.leg.state.mn.us/">www.revisor.leg.state.mn.us/</a>

**Section V**

**MEMBER FEEDBACK**

**2005 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: \_\_\_\_\_

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