



2006

Legislative Report



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This summary of the activities of the 2006 Legislature is intended as an overview.
This document cannot be relied upon as evidence of the provisions of the Minnesota laws.

Introduction

The Minnesota Legislature adjourned *sine die* late Sunday night, May 21, 2006, one day early than their constitutional deadline. The session will be remembered by most Minnesotans for the authorization of an on-campus football stadium for the University of Minnesota and an outdoor ballpark in downtown Minneapolis for the Minnesota Twins. It was also the first session in five years when the state's budget was running a surplus. This, in combination with a favorable Supreme Court ruling on the Health Impact Fee (cigarette tax), allowed for some new spending, as opposed to the budget cuts we've faced in recent years.

This year was the second of the two-year biennial budget cycle. Any bill introduced in 2005 was still alive and could be brought up for action in addition to new bills introduced in 2006. The second year of a biennium, however, is considered a non-budget year when the legislature tries to limit its work to "emergency" issues only.

The Minnesota Medical Association had a successful session. We prevented a significant amount of harmful legislation from passing. We were disappointed, however, in the missed opportunities to pass legislation that would have improved the health of our citizens. We were successful in stopping efforts to divert money from the Health Care Access Fund for issues not related to access, in stopping legislation to expand the scope of practice of physical therapists by removing the requirement for a physician referral for physical therapy services, and in stopping legislation that would have created a presumption that all patients would receive artificial hydration and nutrition unless they had a living will.

We also supported a number of missed opportunities including the statewide smoking ban, referred to as the Freedom to Breathe Act, proposals that would have required health plans and insurers to reimburse providers for the cost of medical interpreters for non-English speaking patients, repealed prior authorization requirements for cesarean sections and non-coverage for circumcisions, and enacted medical liability tort reform. Although we were not successful in passing legislation on these issues this session, all received hearings and significant discussion.

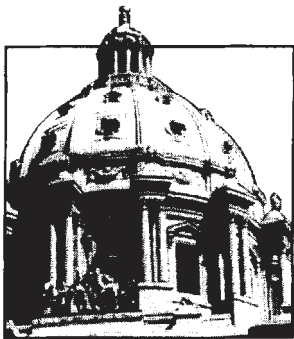
The following report provides a more detailed summary of the above issues and other issues important to physicians and their patients.

The MMA staff would like to thank each of you who took the time to contact your legislators this past 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

2006 LEGISLATIVE REPORT



Medicare Part D Dual Eligibles Funding Provided

Chapter 170

(H.F. 3015 – Bradley/S.F. 2653 – Rosen)

As a result of administrative problems by the federal government following the Medicare Prescription Drug Program rollout many qualified Medicare recipients were unable to get their drug costs covered by the new Part D program. In January, the Governor issued an Executive Order for the commissioner of human services to provide temporary pharmacy benefits as a payer of last resort to dual-eligible enrollees who are eligible for both Medicare and Medicaid. Chapter 170 provided the department with the necessary funding to fulfill the Executive Order.

Effective Date: Retroactive to January 1, 2006

Maple Grove Hospital

Chapter 172

(H.F. 1915 – Zellers/S.F. 1840 – Limmer)

Chapter 172 grants an exception to the hospital construction moratorium to allow a new hospital to be built in Maple Grove. After more than two years of debate over which hospital system should get the right to build the new facility, this act authorizes a new hospital to be built and operated by a new joint venture established by North Memorial and Fairview. This will be a 300-bed, full-service hospital facility to serve the fast-growing Northwest suburban region.

Effective Date: March 23, 2006

Foreign Medical Graduates

Chapter 188

(H.F. 2745 – Abeler/S.F. 2721 – Kelley)

Chapter 188 clarifies the Medical Practice Act related to potential Minnesota licensees who are not currently licensed in another state or Canada. If the applicant passed one of the recognized national licensing exams more than 10 years ago, the applicant must:

1. pass the special purpose examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or
2. have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

This act is a clarification of similar changes made a few years ago for foreign trained physicians applying for a Minnesota license.

Effective Date: August 1, 2006

Radiation Therapy Facilities

Chapter 190

(H.F 2810 – Powell/S.F. 2532 – Berglin)

For many years the legislature has struggled to determine what role the state should have in the regulation of new independent radiation therapy facilities. Proponents of regulation have argued that by allowing more independent facilities it will create duplication of services and put more financial strain on hospitals as well paying services are moved away from the hospital setting. Opponents of regulation have argued that independent facilities offer a more integrated model of treating cancer and competition will improve care options for patients.

The issue was before the legislature in 2006 once again. Chapter 190, as first introduced, would have made permanent the moratorium on independent facilities that was first put into law in 2003. It was amended, however, to simply extend the date the moratorium scheduled to sunset from August 1, 2008 to August 1, 2013. Until that date a radiation therapy facility may be constructed only by an entity owned, operated, or controlled by a hospital either alone or in cooperation with another entity.

The MMA opposed this legislation because it gives an unfair advantage to one type of owner without providing any control over the growth of supply.

Effective Date: August 1, 2006

Organ and Tissue Donation Education

Chapter 192

(H.F 3401 – Paymar/S.F. 2646 – Wiger)

Chapter 192 requires driver education programs to provide a minimum of 30 minutes of instruction relating to organ and tissue donations and the opportunity for all licensed drivers to designate that they are a donor on their driver’s license. This new requirement applies to all driver education programs offered in public schools, private schools, and commercial driver training schools. This requirement begins January 1, 2007.

This act is intended to ensure that all new drivers are aware of the importance of becoming an organ and tissue donor.

Effective Date: January 1, 2007

Interstate Contracts for Chemical and Mental Health

Chapter 193

(H.F. 3111 – Dean/S.F. 2881 – Rosen)

Chapter 193 amends the existing interstate compact that exists for the four states bordering Minnesota—North Dakota, South Dakota, Iowa, and Wisconsin—to allow appropriate mental health treatment to be provided to individuals, across state lines from their state of residence, in qualified facilities that are closer to the homes of individuals than are facilities available in the individual's home state. The act authorizes facilities that provide chemical health services to have interstate contracts to provide services to residents of a bordering state. It also provides that an individual who is detained, committed, or placed on an involuntary basis may be confined or treated in a bordering state pursuant to a contract for chemical dependency services.

Effective Date: August 1, 2006

Physician Licensure – Military Active Duty

Chapter 199

(H.F. 3771 – Bradley/S.F. 3457 – Lourey)

Chapter 199 allows the Board of Medical Practice to grant an extension to the time period required to pass the United States Medical Licensing Examination (USMLE), if an applicant is mobilized into active military service during the process of taking the USMLE, but before passage of all steps. Proof of active military service must be submitted to the board on the forms and according to the timelines of the board.

This act is effective retroactive back to December 1, 2005 to affect current applicants who were called to active duty.

Effective Date: Retroactive to December 1, 2005

Environmental Mercury Reduction

Chapter 201

(H.F. 3712 – Hackbarth/S.F. 3398 – Dibble)

Chapter 201 is intended to benefit public health by drastically reducing mercury emissions at the state's largest coal fired power plants by 90 percent thereby improving the quality of both Minnesota's air and water. Power generation is the single largest contributor of mercury to the Minnesota environment. This action is expected to reduce mercury emissions by nearly 1,200 pounds per year - cutting overall statewide emissions by one-third.

Effective Date: August 1, 2006

Organ Donation Leave of Absence**Chapter 220**

(H.F. 3217 – Hansen/S.F. 2840 – Scheid)

Chapter 220 requires public employers to grant paid leave to an employee for the purpose of donating an organ or partial organ to another person. This is designed to make it easier for public employees to volunteer as organ donors. The maximum leave required is 40 work hours for each donation and public employers are prohibited from retaliating against an employee for requesting or obtaining a leave of absence.

This act defines “employer” to include state, county, city, town, school district, or other governmental subdivision that employs 20 or more employees. It defines “employee” as a person who works at least 20 hours per week for a public employer.

Effective Date: August 1, 2006

Identity Theft and Consumer Protection Bill**Chapter 233**

(H.F. 1943 – Kohls/ S.F. 2002 – Sparks)

Along with provisions regarding consumer protection of credit reports and identity theft, Chapter 233 amends the data warehouse privacy provisions enacted last session concerning disclosure requirements in cases where there has been a breach of a security system containing personal information.

As amended, medical clinics and other entities subject to the federal Health Insurance Portability and Accountability Act (HIPAA) are no longer exempt from state requirements that consumers be notified when there is a data security breach and personal information is reasonably believed to be acquired as a result. HIPAA does not include notification requirements. Therefore legislators believed it was reasonable, and the “right thing to do” to notify patients if their personal information may have been stolen.

Effective Date: August 1, 2006

Hospital Moratorium Exceptions and Process**Chapter 249**

(H.F. 3049 – Davids/S.F. 2576 – Sparks)

Chapter 249 grants two additional hospital moratorium exceptions and amends the hospital moratorium process in response to concerns that the Maple Grove Hospital selection process was too political. The purpose of the original bill to which the hospital moratorium process was amended added ambulances to the existing state lemon law.

In addition to the lemon law expansion, the chapter grants hospital moratorium exceptions for a new 25 bed hospital in Cass County and a hospital expansion in Fergus Falls, replacing a 13-bed skilled nursing facility.

The chapter also amends the existing process used to review whether a proposed medical facility expansion or construction is in the public interest. Prior to the commissioner of health making a recommendation on a new or expanded hospital the act requires the commissioner to hold a public hearing. If the commissioner determines there is a need for a new facility and there are multiple parties interested in building the new hospital, the commissioner must determine which applicant is best able to provide services according to newly established statutory review criteria. Timelines are specified for each of the steps totaling eleven months from the posting of the notice to the recommendation to the legislature. Applicants must reimburse the state for all incurred expenses. The alternative approval process is a pilot and sunsets January 1, 2009.

Finally, the chapter requires the department of health to complete a study by February 15, 2007 on recommendations for additional changes to the process for approving medical facility expansion and construction.

Effective Date: August 1, 2006

Data Practices

Chapter 253

(H.F. 3378 – Holberg/S.F. 3132 – Skoglund)

The Data Practices Act includes provisions on records management, tribal identification cards, and consumer telephone fraud. In addition, Chapter 253 contains two very important health care provisions.

Informed Consent for Sharing of Genetic Information

Chapter 253 requires written, informed consent to collect information about an identifiable individual derived from the presence, absence, alteration, or mutation of a gene, or the presence or absence of a specific DNA or RNA marker, which has been obtained from an analysis of either the individual's biological information or specimen or the biological information or specimen of a relative. Exceptions are provided when otherwise expressly provided in law. Automatic newborn screening is expressly provided by law and should not be affected by this change. It could, however, apply to the creation of a medical record if a family history is provided related to genetic information.

Chapter 253 expressly includes in its definition of genetic information, medical or biological information that is collected from an individual about a particular genetic condition that is or might be used to provide medical care to that individual or the individual's family members. Further, the act stipulates that genetic information about an individual may be used only for purposes to which the individual has given written informed consent; may be stored only for a period of time to which the individual has given written informed consent; and may only be disseminated with written, informed consent that must be reauthorized each year.

This provision was never heard in committee and was amended into the bill late in session as a delete-everything amendment without any testimony or discussion. Both bodies passed the bills unanimously, thereby avoiding a conference committee.

Additionally, the act instructs the commissioner of administration to create a work group to develop principles for the use of genetic information. The MMA is listed along with the ACLU, University of Minnesota, Mayo Clinic, March of Dimes, Citizen Council on Health Care, government agencies,

insurance companies and others to make recommendations to the legislature on the acceptable uses of genetic information.

Release of Medical Information to Family Members

Chapter 253 amends the statute governing access to medical records to authorize the release of records necessary for family and caretaker involvement in mental health care. A provider is authorized to disclose information about a patient to a family member or other person who requests the information if that person lives with, provides care for, or is directly involved in monitoring the patient's treatment; the involvement is verified by the provider, the attending physician, or someone other than the person requesting the information; the patient is informed in writing of the request, the name of the requestor, the reason, and the information being requested before the disclosure; the patient agrees to disclosure, does not object, or is unable to consent or object; the disclosure is necessary to assist in the provision of care or monitoring of the patient, and the request is in writing.

The information that may be disclosed is limited to diagnosis, admission to or discharge from treatment, name and dosage of medication, side effects, consequences of failure to take medication, and a summary of the discharge plan. If the provider reasonably determines that providing information would be detrimental to the health of the patient or is likely to cause the patient to inflict self harm or harm to another, the provider may not disclose the information.

This change was supported by the National Association for the Mentally Ill (NAMI), who represents families of those with mental illness.

Effective Date: August 1, 2006

<u>Omnibus Insurance Bill</u>	<u>Chapter 255</u>
<i>(H.F. 3760 – Wilkin, S.F. 3480 – Scheid)</i>	

Chapter 255 includes the majority of health care reform provisions, most designed to assist consumers in purchasing health care services.

Provider Disclosure of Payment

The act requires all health care providers other than hospitals and outpatient surgical centers to provide the average allowable payment from private third-party payers for the 50 services or procedures most commonly performed. This amends the current law that requires disclosure for the 20 most common services or procedures provided.

The act also requires that pharmacies provide the following information at no charge to patients upon request: the pharmacy's own usual and customary price for a prescription drug; a record, including all transactions with the pharmacy, of all co-payments and other cost-sharing paid to the pharmacy by the patient for up to two years; and the total amount of all co-payments and other cost-sharing paid to the pharmacy by the patient over the previous two years.

Health Plan Company Disclosure of Reimbursement

Chapter 255 also requires health plan companies to provide enrollees with a good faith estimate of the reimbursement the health plan company would expect to pay to a specified provider within the network for a health care service specified by the enrollee. On the enrollee's request, the health plan company must also provide to the enrollee a good faith estimate of the enrollee's out-of-pocket cost for the health care service. A provided estimate is not a legally binding estimate of the reimbursement or out-of-pocket cost.

Hospital Pricing Transparency

Chapter 255 requires hospitals and outpatient surgical centers also to provide a written estimate of the cost of a specific service or stay upon the request of a patient, doctor, or the patient's representative. "Estimate" means the actual price expected to be billed to the individual or to the individual's health plan company based on the specific diagnostic-related group code or specific procedure code or codes, reflecting any known discounts the individual would receive.

The person making the request must include the health coverage status of the patient, including the specific health coverage under which the patient is enrolled, if any, and at least one of the following:

1. the specific diagnostic-related group code;
2. the name of the procedure or procedures to be performed;
3. the type of treatment to be received; or
4. any other information that will allow the hospital or outpatient surgical center to determine the specific diagnostic-related group or procedure code or codes.

An estimate provided by the hospital or outpatient surgical center must contain the method used to calculate the estimate; the specific diagnostic-related group or procedure codes used to calculate the estimate, and a description of the diagnostic-related group or procedure codes that is understandable to a patient; and a statement indicating that the estimate, while accurate, may not reflect the actual billed charges and that the final bill may be higher or lower depending on the patient's specific circumstances.

The hospital's or surgery center's estimate may be provided in any method that meets the needs of the patient and the hospital or outpatient surgical center, including electronically. A paper copy must be provided, however, if specifically requested.

Evidence Based Standards

Chapter 255 prohibits insurers or utilization review organizations from denying coverage for a particular treatment or service solely on the basis that the service or treatment does not meet "evidence-based standards," when no independently developed evidence-based standards exist. The insurer or utilization review organization can still deny coverage for services that are investigational, experimental, or not medically necessary.

Discounted Charges

The act prohibits Minnesota insurers, health plan companies, reparation obligors, and workers' compensation insurers, from considering the following discounted payment situations when determining a health care provider's usual and customary payment, standard payment, or allowable payment used by the insurer:

1. care provided to relatives of the provider;
2. care for which a discount or free care is given in hardship situations; and
3. care for which a discount is given in exchange for cash payment.

Medical Malpractice Insurance Report

Chapter 255 requires the commissioner of commerce to provide to the legislature annually a written report on the status of the market for medical malpractice insurance in Minnesota. The report must summarize, interpret, explain, and analyze information on that subject available to the commissioner through annual statements filed by insurance companies, and information obtained from other sources.

The annual report must consider, to the extent possible, Minnesota-specific data on market shares; premiums received; amounts paid to settle claims that were not litigated, claims that were settled after litigation began, and claims that were litigated to court judgment; amounts spent on processing, investigation, litigation, and otherwise handling claims; other sales and administrative costs; and the loss ratios of the insurers.

Each insurance company providing medical malpractice insurance in Minnesota shall, no later than June 1 of each year, file with the commissioner, the Minnesota-specific data referenced above, other than market share, for the previous calendar year for that insurance company, shown separately for various categories of coverages including, if possible, hospitals, medical clinics, nursing homes, physicians who provide emergency medical care, obstetrician gynecologists, and ambulance services. Insurance companies with less than \$2,000,000 in direct premiums written in the state in the previous calendar year need not comply.

Various Effective Dates

Bonding/Capital Improvements

Chapter 258

(H.F. 2959 – Dorman/S.F. 2718 – Langseth)

Chapter 258 is the Capital Investment Act, otherwise known as the Bonding Act. It is the Legislature's primary focus the second year of the biennium. The legislature authorized a \$999.9 billion dollar bonding package for new building projects with \$949 million in general obligation bonds.

A significant part of the act is the \$40 million authorized to the University of Minnesota to build the first of five bioscience research laboratories over the next 10 years to ensure that Minnesota remains a leader in the biomedical field. In addition, Chapter 258 included \$10 million in bioscience development grants throughout the state with \$8 million going to Rochester and \$2 million to Greater Minnesota. Between the University of Minnesota and Minnesota State College and University System, a total of \$309 million was authorized for renovations and construction projects at higher education campuses in the state.

The act also provides \$60 million to complete the Northstar commuter rail line from Minneapolis to Big Lake and \$7.8 million for planning for the light-rail Central Corridor project between downtown Minneapolis and St. Paul. It also funds the expansion of the Faribault state prison, the Stillwater state prison and an expansion of the Shakopee women's prison. Cultural projects funded in the bill include the Ordway Center for Performing Arts, the Schubert Performing Arts Center and the MacPhail Center for Music. The bill also includes bonding for parks, trails and wildlife areas.

Effective Date: August 2, 2006

(H.F. 2656 – Smith/S.F. 2633 – Ranum)

Chapter 260 is the Omnibus Crime Prevention Act. Article 8 of the act rewrites and updates the state's coroner and medical examiners statutes. This is an initiative that has been promoted by the Minnesota Coroners and Medical Examiners Association for many years.

Most of the changes in this chapter update archaic language related to the qualifications for coroners and medical examiners, the list of reportable deaths, and the process conducting and recording autopsies. The act clarifies that a medical examiner must be a forensic pathologist who is certified or eligible for certification by the American Board of Pathology. A coroner must be a physician licensed in Minnesota who has had training in medicolegal death investigation. The medical examiner or coroner need not be a resident of the county to which they serve.

The act creates a new section related to the selection process for the Hennepin County medical examiner. The Hennepin County Board shall designate three physicians to act as the Medical Examiner Board. One member shall be a dean or professor of the Department of Pathology at the medical school, one shall be a member of the Minnesota Society of Pathologists, and one shall be a member of the Hennepin County

Medical Association. The Medical Examiner Board reviews all candidates for medical examiner and reports to the Hennepin County Board its ranked recommendations. The term for the Hennepin County medical examiner is four years.

Chapter 260 states very clearly that the coroner or medical examiner of the county in which the person dies has jurisdiction over the death, regardless of where the deceased lived or where the injury that resulted in death occurred. The act also clarifies that if the place of death is unknown, the place where the body is found is considered the place of death. Similarly, if the date of death is unknown, the date the body is found is considered the date of death.

This act updates the list of reportable deaths. All sudden or unexpected deaths or all deaths other than those caused by natural disease must be promptly reported to the coroner or medical examiner for evaluation. Reportable deaths include, but are not limited to unnatural deaths, including violent deaths from homicide, suicide, or accident; deaths due to fire or associated with burns; unexplained perinatal or postpartum maternal deaths; bodies to be cremated; deaths that occur during, in association with, or as the result of diagnostic, therapeutic, or anesthetic procedures; deaths due to culpable neglect; unattended stillbirths of 20 weeks or longer gestation; deaths within six months of a fracture of a major bone; deaths unattended or not seen by a physician within 120 days; deaths in an emergency department; death of a newborn when the mother has used illegal drugs; unexpected deaths of children; unexpected death occurring within 24 hours of arrival at a health care facility; deaths related to employment; deaths of nonregistered hospice patients; and deaths attributable to acts of terrorism.

Various Effective Dates

County Based Purchasing

Chapter 264

(S.F. 2833 – Hottinger/ H.F. 2807 – Abeler)

Chapter 264 attempts to correct a change made in 2005 related to county-based purchasing. This provision is included in an omnibus child care act.

In 2005 the Legislature provided counties the ability to be an exclusive contractor when establishing county-based purchasing arrangements for offering Medical Assistance coverage. This prohibited private health plans that were offering prepaid Medical Assistance products from offering services in these counties. Chapter 264 removes this exclusive arrangement in all areas except in the counties of Cass, Crow Wing, Morrison, Todd and Wadena, where a proposal has already been developed. The act instructs the commissioner to consider contracting on a single-health plan basis with county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, only for programs designed to serve persons with disabilities who voluntarily enroll, in order to promote better coordination or integration of health care services, social services and other community-based services.

Effective Date: August 1, 2006

Mental Health Treatment Liability Protection

Chapter 266

(H.F. 1106 – Greiling/S.F. 1040 – Betzold)

Chapter 266 provides a physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist in psychiatric and mental health nursing civil liable protection for conduct of a former prisoner or civilly committed person related to the use or nonuse of medicines prescribed before the prisoner's or committed person's release. This limitation on liability applies during the period from release from confinement until the former prisoner or committed person is scheduled to receive new medicines pursuant to a new prescription written after the release. In order for the liability protection to apply, the prescriber must have made the prescription in good faith, within the scope of lawful practice, and with reasonable care.

Effective Date: August 1, 2006

Woman's Right to Know/Health Care Cost Containment

Chapter 267

(H.F. 1010 – Abeler/S.F. 367 – Kiscaden)

Chapter 267 started out as a bill regulating the depth of swimming pools but late in session became a vehicle for a number of health care policy issues. It includes amendments to the Woman's Right to Know law, a directive to the Board of Medical Practice related to cost containment, a study of alternative and complementary providers, a study of infection control reporting, a study on hospital uncompensated care, and a study on mental health providers.

Woman's Right to Know

As it passed, Chapter 267 amends what is known as the "Woman's Right to Know" law. Current law requires that a woman considering an abortion be provided information on normal fetal development, financial resources to help raise a child, and the responsibilities of the father to provide support for a child. This act removes these disclosure requirements for a woman whose fetus has a fetal anomaly that is incompatible with life. A woman seeking an abortion because her fetus has an anomaly incompatible with life must be informed of available perinatal hospice services and offered this care as an alternative to abortion.

This language was agreed to by both pro-life and pro-choice advocates and passed without opposition.

Cost Containment

Chapter 267 included a number of additional policy provisions designed to control health care costs. It directs the commissioner of human services to encourage and assist providers to adopt and use electronic billing systems for all state programs. This will reduce administrative costs related to processing bills.

It also directs the health-related licensing boards, like the Board of Medical Practice, to annually inform and remind all licensees of the requirement in current law to disclose prices and payment levels for insurers to consumers when asked. In addition the act requires the Board of Medical Practices to encourage all licensed physicians to make available to patients information on free and discounted prescription drug programs offered by pharmaceutical manufacturers. Physicians are asked to provide this information to patients only when it is provided to the physician from the manufacturer at no cost.

Health Care Delivery Studies

Chapter 267 also authorizes a number of studies related to health care delivery. The first directs the commissioner of human services, through the DHS medical director and the health services policy committee, to consider the potential for improving quality and obtaining cost savings through greater use of alternative and complementary treatment methods and clinical practice, and ways to incorporate these methods into the state's health care safety net programs.

A second study directs the commissioner of health to consult with infection control specialists, health care facility representatives, and consumers to determine the need for action to implement health care associated infection control reporting in hospitals and nursing homes. If the outcome of the consultations warrant, the group of experts shall 1) select reporting measures relative to health care associated infections, 2) design and implement ongoing evaluation of a reporting system, and 3) ensure that the reporting measures remain flexible and adaptable to changing national standards.

A third study is related to hospital uncompensated care. The commissioner of health shall study and report to the legislature by January 15, 2007 the trends in hospital uncompensated care, both charity care and bad debt, the impact of any changes in hospitals' charity care policies and debt collection practices in the past three years on the amount of uncompensated care provided, and the value of hospital uncompensated care and community benefits in comparison to the value of tax exemption hospitals received as a result of nonprofit status. The final report shall include recommendations on the need for more uniform hospital charity care policies and the need for more uniform reporting of community benefits provided by nonprofit hospitals.

The final study directs the medical director for Medical Assistance, in conjunction with the mental health licensing boards, to evaluate the qualifications needed to receive Medical Assistance reimbursement for mental health services. This study is looking at the qualifications of licensed professional counselors. The report is to be completed by January 15, 2007.

Various Effective Dates

Supplemental Budget Bill

Chapter 282

(HF 4162 – Knoblach/No S.F. – Cohen)

Once again this year the omnibus budget bill was one of the last bills agreed to during the 2006 session. Since 2006 is the second year of the biennium, unlike last year, there was very little in the bill that was needed to keep the government running. The other difference from last year, and the last few years, was that in 2006 there was a projected surplus in the budget. So unlike years past when the disagreements were over where cuts should take place, this year the disagreements were over how much new spending there should be.

During most of the negotiations on the Supplemental Budget Bill there was uncertainty related to approximately \$350 million of the budget. The \$0.75/pack Health Impact Fee that the legislature passed in 2005 had been ruled unconstitutional by a Ramsey County court earlier in 2006. The decision had been appealed to the State Supreme Court and up until the last week of session they had not ruled on the case.

Finally, on Tuesday May 16, 2006 the Supreme Court overturned the lower court and ruled that the Health Impact Fee would stand. This opened the way for legislative negotiators to reach a deal.

The final agreement for the supplemental budget was to use half of the \$405 million surplus in the General Fund for tax relief and half for new spending. Chapter 282 appropriates \$202.5 million for the remainder of the current biennium (Fiscal Years 2006-2007) and nearly \$300.4 million for the next biennium (FYs 2008-2009). Of the total appropriation \$93.2 million in FYs 2006-2007 and \$126 million in FYs 2008-2009 is for health and human services spending.

In addition, the act appropriates new spending from the Health Care Access Fund. This fund has a surplus of over \$118 million and early in session all parties were suggesting spending the entire surplus on differing projects. In the end the agreement was to allocate HCAF spending for new projects of \$7.9 million in FYs 2006-2007 and \$12.7 million in FYs 2008-2009. With savings achieved from transferring funding for some General Assistance Medical Care recipients from the HCAF back to the General Fund the net new cost to the HCAF is \$6.2 million for FYs 2006-2007 and \$2.1 million for FYs 2008-2009.

Mental Health Initiative

One new set of programs funded by Chapter 282 is the beginning of what is called the Mental Health Initiative. Originally Governor Pawlenty proposed nearly \$50 million of new money for a number of programs to address the growing crisis related to care for the mentally ill. The final act funds \$6.5 million from the General Fund and \$3.4 million for the HCAF over the next four years for the mental health initiative.

To improve access to critical access mental health services, Medical Assistance reimbursements to psychiatrists, advanced practice nurses with a psychiatric specialty, community mental health centers, and

hospital outpatient psychiatric departments that have been designated as essential community providers will receive a 23.7 percent payment increase beginning July 1, 2007. This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of finding, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

To serve mentally ill homeless populations, the act appropriates \$168,000 in FY 2007 from the General Fund for two pilot projects for unsheltered individuals. The pilots in Hennepin and Ramsey counties will operate 10-bed facilities with on-site mental health services focusing on individuals who have been homeless for more than one year.

In addition, the act appropriates \$448,000 in FY 2007 and \$324,000 in FY 2008 from the HCAF to implement the mental health services outcomes and mental health tracking systems and \$250,000 in FY 2007 from the HCAF for children's mental health crisis infrastructure.

UM/Mayo Partnership for Biotechnology and Medical Genomics

The partnership created in 2005 between the University of Minnesota and the Mayo Foundation to promote collaborative biomedical research received a \$15 million General Fund appropriation in Chapter 282. This appropriation is the second year of a five year commitment the state has made to keep Minnesota a leader in the area of biomedical research and technology.

The partnership had originally asked for \$18 million and Governor Pawlenty had recommended that it be funded out of the HCAF. This is seen not only as an important investment in biomedical research but also as an economic development stimulus for the state's economy.

GAMC Transfer from HCAF to General Fund

Chapter 282 reverses a portion of a transfer that was made in 2005 when adults without children on GAMC, with incomes below 75 percent of poverty were transferred to the MinnesotaCare program. This act transfers back to GAMC recipients who are incarcerated, have end-stage renal disease, or receive services through the consolidated chemical dependency fund.

Last year's transfer caused barriers to access for these groups of recipients that were unacceptable to the legislature. Undoing last year's transfer saves the HCAF nearly \$12.5 million over the next four years and provides more comprehensive coverage for these populations.

Pandemic Influenza Preparedness

With the growing concern about avian flu, and the realization the state is not prepared for a pandemic of any kind, Chapter 282 appropriates \$5 million to the commissioner of health for preparation, planning, and response to an outbreak of influenza. This is a one-time appropriation from the General Fund.

Earlier in session Governor Pawlenty recommended \$10 million from the HCAF for pandemic influenza preparedness. This is something that most public health experts agree is desperately needed before a pandemic occurs.

Health Information Technology Grants

One expenditure from the HCAF that is not in line with the original intent of MinnesotaCare is the \$1.5

million one-time grants to small clinics and hospitals to assist in implementing interoperable electronic health records. The commissioner of health shall award grants to eligible community e-health collaborative projects to improve the implementation and use of interoperable electronic health records.

The grants are designed to assist community clinics, small rural hospitals, physician clinics in towns with population of less than 50,000, nursing homes, community health boards, and nonprofit entities formed to provide health information exchange coordination. An “eligible community e-health collaborative” must consist of at least three of these health care entities. Single grants cannot exceed \$900,000 per grant.

Dental Access

Chapter 282 expands access to dental services and increases payments to critical access dental providers to ensure that patients have access to dental services. The act removes a 50 percent co-payment for MinnesotaCare adults earning below 175 percent of the poverty level. This co-payment was for all dental services other than preventive services. This is for services provided on or after July 1, 2007 and has a total cost to the HCAF of \$7.9 million in FYs 2008 and 2009.

The other initiative to address dental access problems increases payments to dentists under the Medical Assistance and MinnesotaCare programs. The act increases Medical Assistance reimbursements to dentists serving as critical access dental providers by 38 percent, and increases MinnesotaCare reimbursements by 50 percent. These increases are for services provided on or after January 1, 2007 and have a total cost to the HCAF of \$4.3 million in FYs 2007 and 2008.

Quality Improvement

Chapter 282 has two provisions that were adopted in the name of quality improvement. The first directs the commissioner of human services to develop and implement a pay-for-performance system to provide performance payments to medical groups that demonstrate optimum care in serving individuals with chronic diseases in Medical Assistance, General Assistance Medical Care, and MinnesotaCare. The act appropriates \$75,000 in both FY 2007 and FY 2008 for these performance payments.

The other quality related item is a \$100,000 appropriation for the Center for Health Care Purchasing Improvement within the Department of Employee Relations. The purpose of the Center is to support the state’s effort to be a more prudent and efficient purchaser of quality health care services. The goal of the Center is to promote greater transparency of health care costs and quality, and greater accountability for health care results and improvement,

The commissioner of employee relations is required to report annually to the legislature and the governor on the operations, activities, and impacts of the Center. The report will be made public on the agency’s Web site and must describe the state’s efforts to develop and use more common strategies for health care performance measurement and health care purchasing. The report must also assess the impacts of the Center’s efforts, especially in promoting greater transparency and accountability in health care.

University of Minnesota-Rochester

Chapter 282 appropriates \$5 million for Fy 2008 and \$6.33 million for FY 2009 to the Board of Regents of the University of Minnesota for the new university in Rochester. The focus of the new university is to be in the areas of biomedical technologies, engineering, computer technologies, health care administration, and allied health programs.

Various Effective Dates

Section II

BILLS THAT FAILED TO PASS

2006 LEGISLATIVE REPORT



Abortion Services and Physician Reporting

(H.F. 3258 – Brod / S.F. 2877 – Neuville)

This bill would have required physicians who perform abortions in out-patient settings to have hospital admitting privileges within 20 miles of where they performed the procedure. The bill would have imposed criminal misdemeanor penalties for violation of this requirement.

Additionally, the bill would have required new reporting requirements for abortions provided to minors for whom a judicial bypass had been granted in lieu of parental notification. The data reported by physicians would have been compiled and publicly reported by the commissioner of health.

The most controversial measure included in the bill would have prohibited the state from paying for abortions for women enrolled in state health care programs. The Department of Finance testified that Medical Assistance currently pays for approximately 4,000 abortions per year and under this bill the number paid for would be zero or close to zero. As a result, they projected a significant cost to the state on the assumption that there would be an immediate court challenge to the bill and estimated that this bill would result in the state paying for approximately 2,000 more births per year under Medical Assistance and health coverage for 2,000 more infants per year in the first year of life.

The MMA opposed the admitting privileges requirement on the basis that hospital admitting privileges are not required for any other outpatient surgical procedure. We also raised concerns that physicians were not the best source for the reporting requirements, and the legislation raised a dangerous precedent by making physicians responsible to report data on the judiciary. Although the bill passed in the House, it was not taken up by the Senate.

Alcohol Health Impact Fee

(H.F. 1014 – Clark/ S.F. 606 – Marty)

This bill would have placed a fee on alcohol, similar to the Health Impact Fee on tobacco products. The revenue generated would have been deposited in an alcohol health impact fund and used to reimburse the state for costs attributable to alcohol and controlled substance use. These costs include: enforcement and incarceration for driving while impaired, violent crime and domestic violence prevention, chemical dependency treatment, community policing grants and county and judicial expenditures related to chemical use assessments. These certified alcohol expenditures would have been reimbursed to the commissioners of public safety, corrections and human services. The legislation received a hearing in the House, but did not advance further in the Senate.

Child Restraint Law

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

This bill would have required all motor vehicle drivers to use booster seats for passengers under 9 years of age who weighed less than 80 pounds. 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 language did not advance in the House, but it passed as part of the Senate Omnibus Transportation Policy Bill (S.F. 3764, Murphy). Unfortunately the conference committee could not reach agreement prior to adjournment.

Clinical Trials Registration

(H.F. 2869– Lesch / S.F. 3342 – Hottinger)

This bill would have required manufacturers of prescription drugs to make public clinical trial information conducted or sponsored by the manufacturer on the publicly accessible Internet Web site of the federal National Institutes of Health or another publicly accessible Web site. The following information was to be included:

1. the names of all participating organizations and funding sources of the clinical trial, including all sponsors, cosponsors, and administrators of the clinical trial;
2. a summary of the purpose of the clinical trial, including the name of the drug being tested, overall design of the study, status or phase type of the trial, inclusion and exclusion criteria, treatment methods to be used, all hypotheses tested by the trial, the medical condition or conditions being studied, and outcomes that were evaluated;
3. the dates during which the trial took place; and
4. information concerning the results and outcomes of the clinical trial, including potential or actual adverse effects of the drug, and the numbers of participants who discontinued participation in the trial and the reasons for their discontinuance.

This legislation was in response to the recent Vioxx cases. The AMA supports similar legislation at the national level, but critics argued that this should not be passed state-by-state. The bill passed two committees in the Senate but was never heard in the House.

Constitutional Right to Affordable Health Care

(H.F. 3754 – Howes/ S.F. 2625 – Berglin)

This bill would have placed a constitutional amendment question on the election ballot in November asking voters: “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?” The bill passed to the full Senate floor but did not receive a vote. The House version was never heard in committee.

“Deprivatization” of Government Health Care Programs

(H.F. 3097 – Walker/S.F. 3417 – Foley)

This bill would have moved all of the state health care safety net programs (MinnesotaCare, General Assistance Medical Care, and Medical Assistance) into a fee-for-service program and prohibited health plans from delivering services. Currently most non-disabled and non-elderly recipients receive their services through prepaid coverage from private health plans that contract with the state. This bill did not advance in either the House or Senate.

Electronic Prescription Narcotic Registry

(H.F. 3264 – Abeler/ S.F. 2899 – Berglin)

This bill would have established an electronic reporting system administered by the Board of Pharmacy to assist prescribers and dispensers of narcotic drugs. Each dispenser would have had to report the name of the prescriber, the name of the dispenser, the name of the patient, and the name, strength, and quantity of the schedule II controlled substance dispensed. This database would then be available to all prescribers and dispensers to check a specific patient prior to prescribing or dispensing a schedule II controlled substance. As amended, the bill made it very clear that the purpose of the registry was to track patients’ patterns, not physician prescribing patterns, to reduce “doctor shopping” for illegal drug diversion.

Legislation passed last year at the federal level provides grants to states to establish electronic registries to assist in reducing illegal diversion and resale of narcotics. The legislation, known as the National All Schedules Prescription Electronic Reporting Act (NASPER), appropriated money for states to develop tracking systems.

The MMA supported the legislation because most physicians commented that this type of system would be very beneficial in helping identify patients who are doctor shopping for illegal narcotics. The Board of Medical Practice opposed the bill because of concerns that this type of system would have a chilling effect on physicians’ willingness to prescribe narcotics. The legislation was included in the Senate Health Omnibus Finance bill but because it was never heard in the House, it was excluded as part of the conference agreement.

Flu Shot Distribution

(H.F. 3458 – Heidgerken / S.F. 3169 – Tomassoni)

This bill would have required mass flu vaccination clinics to delay providing flu shots until after November 1 of each year to anyone not in a high-risk category if the commissioner of health declared there was a shortage of supply. The authors attempted to address concerns that large retailers in the metro area were providing mass vaccinations despite shortages of the vaccine in rural areas.

The bill passed the House floor and the Senate Health and Family Security Committee, but was not acted on by the full Senate prior to adjournment.

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. This legislation continues to be one of the MMA's top legislative priorities and is strongly supported by many other health care groups based on the public health benefits associated with reducing secondhand smoke. Unfortunately, the bill made no new progress this year. Although some progress was made in building support for the Freedom to Breathe Act in 2005, the Legislature failed to take any final action on the bill in 2006.

The primary arguments against the bill are related to individual liberties and the economic impact on small town restaurants and taverns. The opposition did a very good job of raising fear in legislators' minds that this legislation would be devastating to their local businesses and impact fall elections. This bill will be back in 2007.

Freedom to Breathe – Pre-emption of Local Ordinances

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

This is the anti-Freedom to Breathe bill, sponsored by opponents of smoke-free workplaces. This bill would have pre-empted all local smoke-free ordinances by the state law, which would have meant that all ordinances that have been enacted at the city or county level would have been unenforceable. Also, the bill would have required hospitality establishments that permit smoking to register annually with the commissioner of health and pay a registration fee each year. 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 because it would have prohibited local control of smoking in public places. The bill did not receive a hearing in either body.

Health Impact Fee Repealed, Cigarette Tax Increased

(H.F. 4147- Peterson, N. /S.F. 3778-Berglin)

Prior to the State Supreme Court ruling that upheld the Health Impact Fee, this legislation was introduced in an effort by the American Cancer Society, the MMA, Blue Cross Blue Shield and others to ensure that the cost of cigarettes remained high to discourage smoking. It would have renamed the Health Impact Fee a tax, ensuring that it was constitutional. The bill was not heard in either body since it was intentionally introduced after the committee deadlines.

Health Care Expenditure Reporting

(S.F. 1640 – Kiscaiden/H.F. 1862 – Abeler)

This bill would have amended the existing health care expenditure reporting law to require public hearings and commissioner of health approval for certain expenditures greater than \$5 million. Current law requires a report to be filed with the commissioner for any capital expenditure greater than \$1 million.

Under the bill the commissioner would have had to provide notice to all interested parties, within 15 days of receiving an expenditure report. The notice would have included either a copy of the report or an easily understandable description of the proposed expenditure in the report. Following the notice if another party requested a public meeting on the expenditure, the commissioner would have arranged for and coordinated a meeting. The party requesting the meeting would have had to pay for the meeting. The provider making the capital expenditure would have had to explain the impact on access, quality, and cost for the services provided.

Earlier versions of the bill included limitations of physician referral to facilities where there was ownership interest and required the commissioner to approve all major expenditures. The bill passed one committee in the Senate but the provisions were never heard in the House.

Integration of Public Health Care Programs

(H.F. 2934 – Bradley/S.F. 2638 – LeClair)

This bill would have required the commissioner of human services to develop a plan to integrate the delivery of services to enrollees of state-administered health care programs, including Medical Assistance, General Assistance Medical Care, MinnesotaCare and Minnesota Comprehensive Health Association. The goal of the plan was to save administrative costs. The plan would have had to articulate a common benefit set only differing from the benefit set provided to persons who are aged, blind, or disabled and establish eligibility criteria that in the aggregate did not increase state costs above that of existing programs. Enrollees would have been required to pay premiums based on a sliding scale and plan design would have included cost-sharing for non-preventive services also on a sliding scale. The bill passed the required committees in the House but did not receive a hearing in the Senate.

Marijuana for Medical Uses

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

This bill would have legalized marijuana for medical use. It 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 advanced through the Judiciary, Crime Prevention and Public Safety and Finance committees in the Senate, but was not taken up on the Senate floor. The House version did not receive a hearing.

Medical Interpreters

(H.F. 3689 – Abeler / S.F. 3373 – Higgins)

This bill would have required health plans to pay for the services of interpreters in medical care settings for non-English speaking enrollees. Although there was much talk about addressing the growing costs of providing medical interpreter services in clinics and hospitals, in the end, the health plans opposed any legislation creating a new coverage mandate. Their argument was that an insurance mandate to cover these services would not apply to large employers who self-insure, thereby not addressing the entire problem. There is a commitment to talk over the interim to find a solution that affects all payers.

Medical Liability Reform

Affidavit of Expert Review

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

\$300,000 Cap on Pain and Suffering

(Amendment offered by Rep. Powell to H.F. 1464)

“I’m Sorry” Medical Liability Reform

(H.F. 3918 – Abeler/S.F. 3613 – Hottinger)

Affidavit of Expert Review

This bill would have tightened the existing requirements for a plaintiff to file an affidavit of merit at the time of filing the lawsuit. It would have required the affidavit of expert review to be completed by a physician who was board certified and currently practicing in the specialty related to the applicable standard of care. The bill passed the required committees in the House and was taken up on the House floor. After lengthy debate and numerous amendments, the author moved to table the bill and a final vote was not taken. The Senate bill did not receive a hearing.

\$300,000 Cap on Pain and Suffering

One amendment offered to H.F. 1464 proposed implementing a \$300,000 cap on non economic damages for actions against practitioners providing emergency, obstetrical, and delivery services. Passage of any caps to non-economic damages continues to be an uphill battle since Minnesota remains relatively stable in the area of medical liability compared to many other states. In the area of emergency and obstetrical services, however, we are seeing the beginning of problems. Although the amendment failed 62-70, this was the closest vote since the mid-1980s on major medical liability reform.

“I’m Sorry” Medical Liability Reform

This bill would have implemented what is called an “I’m Sorry” law. It would have barred from admission in a medical liability case any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence, by the provider or the provider’s staff. This was intended to encourage physicians to have open communications with patients without fearing what they say would result in a lawsuit.

H.F. 3918 was included in a health care cost containment policy bill authored by Rep. Abeler and the provision passed one committee. When the Minnesota Trial Lawyers Association actively opposed it, the language was removed from the larger policy bill prior to passage. No action was taken on the provision in the Senate.

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 might create 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, especially flu shots.

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. In 2005, 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.

In response to the efforts of the MMA and other groups such as the Immunization Action Coalition, the House Health Policy and Finance Committee defeated the bill. It was not heard in the Senate.

Newborn Screening Opt-in

(H.F. 3387 – Holberg/S.F. 3344 – Scheid)

As introduced, this bill would have modified Minnesota's newborn screening program to require parents to give their consent before a newborn could be tested for many metabolic birth defects, changing the current "opt-out" option to an "opt-in" requirement. As amended in committee, both bills retained the opt-out but would have established additional requirements for the Department of Health to clarify procedures regarding destruction of blood samples and test results and required the Department of Health to post more comprehensive information on newborn screening on their website.

All states screen newborns for certain metabolic birth defects such as PKU, hypothyroidism and sickle cell anemia. These conditions are not physically obvious in a newborn, but can cause permanent physical disabilities, mental retardation and, in some cases, death. The MMA joined the Minnesota Chapter of the American Academy of Pediatrics, Minnesota Academy of Family Physicians, Mayo Clinic, the Minnesota Hospital Association and the March of Dimes in opposing the bill because of the fear that fewer babies would receive the important screenings. Advocates for the bill fear the inappropriate use of newborn blood spots for government DNA databases and disease prediction by insurance companies.

The bill passed all necessary House committees with the "opt-in" requirement removed from the bill, but was not acted on by the floor. The Senate version passed the Senate Commerce Committee with the "opt-in" requirement removed but failed to get a hearing the Senate Health and Family Security Committee.

No-Fault Auto

Reform Bill

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

Repeal Bill

(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.

The bills received a pre-session hearing in the House but no action was taken once session began.

Nutrition and Hydration Presumption

(H.F. 3255 – Wilkin/S.F. 2861 – Fishbach)

This bill would have created in law a presumption to provide artificial hydration and nutrition at the end of life to all patients, unless a person had declared his or her wishes in a living will or advance directive,. The legislation was sponsored by Minnesota Citizens Concerned for Life (MCCL) in response to the Terry Shiavo situation last year. They called it the “Minnesota Starvation and Dehydration of Persons with Disabilities Prevention Act.”

The legislation stated that it shall be presumed that every person who is incapable of making health care decisions has directed his or her health care provider to provide him or her “with nutrition and hydration to a degree that is sufficient to sustain life.” The only exceptions to that presumption would have been that 1) the provider determined that nutrition or hydration would not contribute to sustaining the person’s life or provide comfort, 2) the person had declared their wishes in a living will or advance directive, or 3) there was “clear and convincing evidence” that the person gave express and informed consent to withdraw nutrition and hydration when they were capable of doing so.

The bill was amended to attempt to narrow its focus by adding language exempting cases where, “in reasonable medical judgment, the person will die imminently as a result of the person’s underlying disease or injury, and not as a result of dehydration or starvation, if nutrition or hydration is withheld or withdrawn, and the provision of neither will provide comfort to that person.” Opponents remained concerned that even with this language, the bill would have taken away the rights of family members to decide what was best for their kin and what the patient would have wanted.

The MMA strongly opposed the bill and testified in opposition. Our efforts were aided by the Minnesota Hospice Association, the Association of Palliative Care Physicians, and hundreds of physicians and families who opposed the legislation. In the House, the bill passed out of all necessary committees, but was tabled for the year when it was removed by an amendment from the House Omnibus Policy Bill by the author. The Senate companion bill did not receive a hearing.

Pharmacist Refusal to Dispense – Conscience Clause

(H.F. 3032 – Emmer / S.F. 2647 – Kiscaden)

In response to reports that pharmacists were refusing to fill prescriptions for contraceptives and emergency contraceptives, a number of bills were introduced across the political spectrum ranging from requiring pharmacists to fill every prescription as written to bills which explicitly allowed a pharmacist to refuse to fill any prescription for moral or religious reasons. This bill became the vehicle for the compromise brokered by the Minnesota Pharmacists Association. As session continued, the delicate agreement began to fall apart, and though the bill passed the health committees in both bodies, it didn’t receive a vote on the floor of either body.

The bill would have prohibited pharmacists from refusing to dispense a legend drug or device which had been legally prescribed unless they believed the drug or device would cause a harmful drug interaction or otherwise adversely affect the patient’s medical condition, or the pharmacist had a moral and religious

objection to the drug or device. In order to refuse to dispense a prescription on moral or religious reasons, a pharmacist must first notify their employer of the drugs to which they object. The employer must make reasonable accommodation to the pharmacist and establish protocols to ensure that patients have timely access to the prescribed drug or device.

Physical Therapist Scope of Practice Increased

(H.F. 854 – Finstad / S.F. 637 – Solon)

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 patients for an unlimited amount of time without any physician involvement. The bill would have also deleted the statutory requirement that physical therapists must practice one year under a physician's orders before treating patients without a referral. The House version of the bill went even further to eliminate the requirement that a physical therapist communicate with the referring physician when the course of treatment is modified from an original prescription.

Physical therapists presented this bill as a minor change to put Minnesota in line with all other states. In fact, this would have been a major change, expanding physical therapists' scope of practice beyond what they are trained to do, and beyond what state law allows them to do. Thirty-one other states prohibit physical therapists from treating patients without some form of physician involvement.

The MMA strongly opposed this legislation based on coordination of care principles and patient safety concerns. Unlimited access could result in a physical therapist treating a patient indefinitely without a doctor ever diagnosing what is wrong with the patient. Members of the MMA, the Minnesota Academy of Family Physicians and the Minnesota Orthopedic Society testified in opposition to the bill and over 100 physicians sent e-mails to their legislators urging them to vote against the bill. As a result, this legislation died awaiting final action on the House and Senate floors.

Health Care Reform: Republican Proposal

(H.F. 3658– Bradley/No S.F. Companion)

This bill included a number of provisions that together became the House Republican health care reform initiative. Pieces of the bill passed the full Legislature, but most were introduced for the benefit of discussion on health care reform and to contrast with DFL proposals.

Provider Pricing Fairness

In an attempt to eliminate discounted fee schedules and make the costs of health care services much more transparent to the consumer, the bill would have prohibited a health care provider from varying payment amounts accepted for services based on the type of payer, any contractual relation with a payer, or the type of patient, with the sole exception being government programs. The provision was an attempt to reengage market forces by allowing providers to set their own charges, and all payers would have had to pay that amount.

For-Profit HMOs

The bill would have eliminated the requirement that HMOs be nonprofit corporations incorporated in Minnesota, opening up the door for for-profit companies located in the state and elsewhere.

Small Health Plan Purchasing Pool

This provision would have permitted health plan companies that have less than 10 percent of the Minnesota market to form a purchasing pool to jointly negotiate contracts for health care purchases from providers in order to promote competition by allowing these smaller health plan companies to better compete with their larger competitors.

Health Insurance Tax

This section would have standardized the premium taxes on assessed on health coverage and broadened the definition of “health insurance” to include health plans offered by all health plan companies (for-profit and nonprofit) and stop-loss insurance coverage on self-insured health plans. Currently, for-profit insurance companies pay a 2 percent premiums tax, while nonprofit health plan companies (HMOs and Blue Cross) pay a 1 percent premiums tax. It would have deposited the revenues from the newly merged tax into the Health Care Access Fund.

Repeal of Capital Expenditure Reporting

This bill would have repealed the existing law that requires a provider making a major spending commitment in excess of \$1 million to report to the commissioner of health. This law was originally enacted in 1992.

Repeal of Balance Billing Prohibition

This would have repealed the mandatory Medicare assignment law enacted in 1992, which prohibits health care providers from balance billing Medicare patients for any amount in excess of the Medicare approved amount. Federal law permits balance-billing patients for up to 15 percent of the Medicare approved amount.

Seat Belt as a Primary Offense

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

This bill would have changed the penalty for failing to wear a seat belt from a secondary to a primary offence not only for the driver but also for passengers. This change would have allowed law enforcement officers to stop and charge the driver with a petty misdemeanor if the driver and/or passengers did not have their seat belts fastened. It has been shown that making this a primary offense increases compliance with the law by 11 percent. The bill passed the full Senate and was also included in the Senate Omnibus Transportation Policy Bill (S.F. 3764, Murphy). The House version did not receive a hearing. The provision was alive until the final day of session as part of late negotiations in the Transportation Conference Committee, but ultimately was not included.

Sick Tax Contingent Rate Reduction

(H.F. 2935 – Bradley / S.F. 2640 – LeClair)

This bill would have provided for a reduction in the sick tax if the commissioner of finance determines the Health Care Access Fund was projected to have a surplus. The commissioner would have made the determination each year and set the sick tax at the appropriate level, no higher than 2 percent. This would have eliminated the temptation to transfer large sums to the General Fund if the Health Care Access Fund was running a surplus, as has been done in the past.

Tanning Bed Regulation

(H.F. 3218 – Samuelson/ S.F. 2566 – Dibble)

This bill would have regulated the use of tanning facilities by minors by increased the age for which parental consent is required prior to using tanning beds from 16 to 18. The bill would have also required tanning facilities to have timers located remotely from the tanning bed and required training for operators and employees of tanning bed facilities. The bill did not receive a committee hearing in either body.

Undocumented Immigrants Prenatal Services Eliminated

(H.F. 2877– Emmer/No S.F. Companion)

This bill would have eliminated coverage for prenatal and postpartum care for illegal or undocumented immigrants. Under current law, Minnesota provides prenatal, labor and delivery and postpartum care to undocumented immigrants. The House Health Policy and Finance Committee heard the bill, but no companion was introduced in the Senate.

Universal Health Care and Constitutional Amendment for Right to Health Care

(H.F. 3106 – Walker/ S.F. 2468 – Marty)

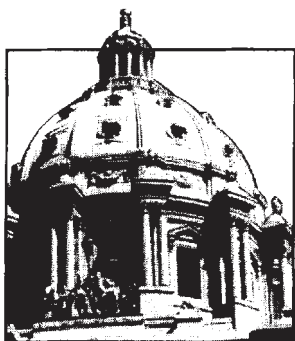
In addition to the constitutional amendment provision in S.F. 2625/H.F. 3754, this bill would have established a work group to design a universal health care system for Minnesota. The universal health care system would have needed to ensure that all Minnesotans received comprehensive health care of the 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 bill passed the Senate Health and Family Security Committee, but was not voted upon by the full body likely due to concerns that other constitutional amendments would be offered as amendments. In the House the bill received a hearing in the Health Policy and Finance Committee but was withdrawn by its author prior to a vote.

Section III

GOVERNMENT INFORMATION

2006 LEGISLATIVE REPORT



MINNESOTA CAPITOL INFORMATION

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

General Information		To order copies of bills	
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
Committee Information		Information about bills	
(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
Governor Tim Pawlenty's Office		Attorney General Mike Hatch's Office	
Phone:	651/296-3391 800/657-3717	Phone:	651/296-6196 800/657-3787
Fax:	651/296-0674	Fax:	651/297-4193
FAX Numbers		Legislative Information Via the Internet	
House (DFL):	651/296-4165	Minnesota Legislature Home Page:	
House (R):	651/296-3949	www.leg.state.mn.us	
Senate (DFL):	651/296-6511		
Senate (R):	651/296-9441		
MINNESOTA STATE AGENCIES			
Department of Human Services		Department of Revenue	
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	651/431-2914		
Department of Health		Department of Commerce	
Commissioner:		Commissioner:	
Diane Mandernach	651/201-5805	Glenn Wilson	651/296-4026
Health Plan Regulation:		Insurance Regulation:	
Irene Goldman	651/201-5166	John Gross	651/297-2319
		Office of Rural Health	
		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
(Example: rep.ron.abrams.@house.leg.state.mn.us)

For all members of the Minnesota Senate:

sen.firstname.lastname.@senate.leg.mn.us
(Example: sen.sheila.kiscaden.@senate.leg.state.mn.us.)

United States Senate

Washington Address

Senator Mark Dayton (D)

346 Russell Senate Office Bldg.

Washington, DC 20510

Ph: 202/224-3244

Fax: 202/228-2186

LA: Jonathan Heafitz

Web E-mail form: www.dayton.senate.gov

Senator Norm Coleman (R)

320 Hart Senate Office Bldg.

Washington, DC 20510

Ph: 202/224-5641

Fax: 202/224-1152

LA: Rachel Gustafson

Web E-mail form: www.coleman.senate.gov

web: www.senate.gov/coleman/

Minnesota Address

Federal Building, Suite 298

One Federal Drive

St. Paul, MN 55111-4080

Ph: 888/224-9043

Fax: 612/727-5223

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

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.

United States House of Representatives

Washington Address

Congressman Gil Gutknecht (R-1st)

425 Cannon House Office Bldg.

Washington, DC 20515-2306

Ph: 202/225-2472

Fax: 202/225-3246

LA: Eric Keber

Email: Gil@house.mail.gov

web: www.house.gov/gutknecht/

Congressman John Kline (R-2nd)

1429 Longworth House Office Bldg.

Washington, D.C. 20515-2302

Ph: 202/225/2271

Fax: 202/225-2595

LA: Jean Hinz

Email: Jean.Hinz@mail.house.gov

web: www.house.gov/kline/

Congressman Jim Ramstad (R-3rd)

103 Cannon House Office Bldg.

Washington, DC 20515-2306

Ph: 202/225-2871

Fax: 202/225-6351

LA: Karin Hope

Email: mn03@mail.house.gov

web: www.house.gov/ramstad/

Congresswoman Betty McCollum (D-4th)

1029 Longworth House Office Building

Washington, DC 20515

Ph: 202/225-6631

Fax: 202/225-1968

LA: Emily Lawrence

Email: betty.mccollum@mail.house.gov

web: www.house.gov/mccollum/

Minnesota Address

1530 Greenview Dr. SW, Suite 108

Rochester, MN 55902

Ph: 507/252-9841

800/862-8632 (in MN)

Fax: 507/252-9915

101 West Burnsville Pkwy., #201

Burnsville, MN 55337

Ph: 952/808-1213

Fax: 952/808-1261

1809 Plymouth Road South

Minnetonka, MN 55305

Ph: 952-738-8200

Fax: 952-738-9362

165 Western Avenue North, Suite 17

St. Paul, MN 55102

Ph: 651/224-9191

Fax: 651/224-3056

United States House of Representatives (cont.)

Congressman Martin Sabo (D-5th)

2336 Rayburn House Office Bldg.
Washington, DC 20515-2304

Ph: 202/225-4755

Fax: 202/225-4886

LA: Allison Skowronski

Web E-mail form: www.sabo.house.gov

Commerce at the Crossings #286
250 2nd Ave. S.

Minneapolis, MN 55401

Ph: 612/664-8000

Fax: 612-664-8004

Congressman Mark R. Kennedy (R-6th)

1415 Longworth House Office Bldg.
Washington, DC 20515

Ph: 202/225-2331

Fax: 202/225-6475

LA: Ericka Nelson

Email: mark.kennedy@mail.house.gov

web: www.house.gov/markkennedy/

1111 Highway 25 North, Suite 204
Buffalo, MN 55313

Ph: 763/684-1600

Fax: 763/684-1730

Congressman Collin Peterson (D-7th)

2159 Rayburn House Office Bldg.
Washington, DC 20515-2304

Ph: 202/225-2165

Fax: 202/225-1593

LA: Robin Goracke

Web E-mail form:

www.collinpeterston.house.gov/email.htm

714 Lake Avenue, Suite 107
Detroit Lakes, MN 56501

Ph: 218/847-5056

Fax: 218/847-5109

Congressman James Oberstar (D-8th)

2365 Rayburn House Office Bldg.
Washington, DC 20515-2308

Ph: 202/225-6211

Fax: 202/225-0699

LA: Chip Gardiner

Web E-mail form: www.house.gov/oberstar/

231 Federal Bldg.
Duluth, MN 55802

Ph: 218/727-7474

Fax: 218/727-8270

Minnesota Medical Association Web Site

www.mnmed.org

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/
Federal Drug Administration	www.fda.gov/
Office of Inspector General	www.oig.doc.gov/oig/
U.S. Census Bureau	www.census.gov/
U.S. General Accounting Office	www.gao.gov/

Congress

Library of Congress	www.loc.gov/
Thomas: Legislative Info. on Internet	thomas.loc.gov/
U.S. House of Representatives	www.house.gov/
U.S. Senate	www.senate.gov/

State Sites

Administrative Agencies

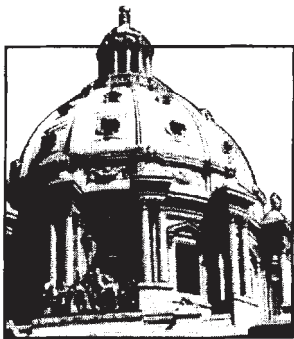
Department of Health	www.health.state.mn.us/
Department of Human Services	www.dhs.state.mn.us/
Department of Labor & Industry	www.doli.state.mn.us/
Department of Revenue	www.state.mn.us/ebranch/mdor/
Office of Attorney General	www.ag.state.mn.us/
Office of Governor	www.governor.state.mn.us/
Office of Secretary of State	www.sos.state.mn.us/

State Legislature

Minnesota State Legislature	www.leg.state.mn.us/
Office of Revisor of Statutes	www.revisor.leg.state.mn.us/
Minnesota Medical Association	www.mmaonline.net/

Section IV

MEMBER FEEDBACK
2006 LEGISLATIVE REPORT



Member Feedback

YOUR INPUT IS IMPORTANT!

Two-way communication with MMA members helps build the grassroots support needed to achieve MMA legislative goals. 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



LEGISLATIVE FEEDBACK

NAME: _____
ADDRESS: _____
PHONE: _____
E-MAIL: _____