



Minnesota Academy of Otolaryngology

2008

Legislative Wrap Up

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This summary of the activities of the 2008 Legislature is intended as an overview. This document cannot be relied upon as evidence of the provisions of the Minnesota laws.

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INTRODUCTION

At the start of the 2008 legislative session in February, two things were very clear. First, the Democratic legislature and the Republican governor were both intent on passing comprehensive health care reform. Second, the \$935 million budget deficit was going to make it very hard to pass comprehensive health care reform.

These conflicting issues created a challenge for policy makers and advocates alike throughout the entire session. In the end, when the final gavel came down on May 19, 2008, this legislative session was more notably successful for the Minnesota Academy of Otolaryngology for those items that did not pass, rather than for those that did pass.

The MAO carefully monitored health care reform discussions and weighed in with other physician groups to prevent passage of proposals that would have negatively impacted patient care. Although reform does not include medical liability reform, it makes significant progress to address access, cost and quality issues and maintains a market-based approach. We helped defeat efforts to add prior authorization for additional services for public program enrollees (including stopping legislative language to adopt non-coverage for portions of the Oregon priority list) and helped defeat efforts to establish a technology assessment as part of health care reform. Our continued vigilance monitoring supply-side issues and state health care program prior authorization requirements remains important. The voice of otolaryngology was also heard by the Minnesota Medical Association as it negotiated the terms of the medical home concept within the health care reform proposal. As passed, health care homes do not incentivize primary care physicians to become gatekeepers.

Non-controversial audiology and speech pathology provisions passed as well. The MAO did not oppose the proposal because it did not jeopardize patient safety.

The assistance from the MAO opposing the proposed raid on the Health Care Access Fund despite the budget deficit also proved successful. Early proposals by the governor to use nearly \$400 million from the Fund to help balance the budget were thwarted. Instead, portions of the Fund surplus were used for health care reform efforts including a \$48 million “loan” from the Fund for investments in public health. When (or if) the state accumulates savings from health care reforms, this loan is required to be paid back from those savings.

The following report provides a more detailed summary of the above issues and other issues important to otolaryngologists, head and neck surgeons, and your patients. I appreciate the opportunity to represent the MAO at the capitol and look forward to representing you during the 2009 legislative session.

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BILLS THAT PASSED

Section I **Appropriations**

Bonding Bill

Chapter 179

(H.F.380 – Hausman/S.F. 223 – Langseth)

Chapter 179 is the Omnibus Bonding bill, which funds a multitude of building projects throughout the state. This year, the act contains several items relating to the provision of health care.

The act includes a new biomedical science research funding program to further the investment in biomedical science research facilities in Minnesota, benefit the state's economy, advance the biomedical technology industry, benefit human health, and facilitate research collaboration between the University of Minnesota and other private and public institutions in this state. It establishes a process to authorize the commissioner of finance to issue up to \$219 million of state bonds for up to four capital programs identified by the newly created Minnesota Biomedical Sciences Research Facilities Authority. The state appropriation may cover up to 75 percent of project costs with the University paying the remaining 25 percent from non-tuition sources. \$54.8 million is appropriated over the course of the first six years, with \$15.5 million each year thereafter for up to 25 years. In each of those years, the university has been given the authority to apply for these funds to build needed research facilities without needing to go to the legislature each year for approval. The act requires the university to make laboratory and other services available on a fee-for-service basis to individuals and firms in the bioscience industry in Minnesota.

The act also approves \$820,000 in capital investments for a grant to Hennepin County Medical Center to redesign their outpatient clinic and health education facility; \$300,000 for a grant to Gillette Children's Specialty Healthcare for surgical suite renovations and pediatric ICU improvements; and \$2,700,000 for the Veterans Nursing Home in Fergus Falls to add a 21-bed dementia unit.

Effective Date: April 8, 2008

Federally Qualified Health Center Subsidies

Chapter 292

(S.F.3323 – Higgins/H.F. 3412 – Loeffler)

Chapter 292 modifies the allocation of subsidies for federally qualified health centers so that the amount of subsidies shall be in proportion to the amount of discounts granted to patients in the most recent calendar year, rather than based only on the year 2006, as currently calculated.

Effective Date: August 1, 2008

Supplemental Budget Bill

Chapter 363

(H.F.1812 – Carlson/S.F. 3813 – Cohen)

Chapter 363 is the Supplemental Budget Act which appropriates funds for state agencies necessary for operations in a non-budget year. Following the February 2008 budget forecast, the state budget was projected to be in a deficit by \$935 million. In order to balance the budget as required by the state constitution, very few programs receive funding increases; rather significant reductions are made across the board. Negotiations between the governor and Legislature to balance the state budget were intertwined with the discussions on property tax relief, K-12 education funding and health care reform. While the Governor had originally proposed cutting \$526 million in FY08-09, and \$258.4 million in FY10-11, the overall agreement to address the \$935 million shortfall includes \$355 million in spending cuts, \$109 million in tax revenues from changing a loophole for foreign operating corporations, accounting shifts raising \$30 million, and \$500 million from the state's \$653 million in budget reserve funds. The agreement also includes a 3.9 percent property tax cap for three years, and \$60 million in local government aid and \$25 million in direct property tax refunds. Several additional bonding projects were also part of the deal including the Central Corridor light rail project, improvements to the Minnesota Veterans' Home and the new Lake Vermilion State Park.

The health and human services budget received the largest cuts – \$229 million of reductions during the next year. Higher education took a \$21 million hit. Among the deep cuts were a handful of increases. They include a one-time increase of \$51 in per-pupil funding for public schools, a cost-of-living increase in nursing home reimbursement for direct-care workers, and a limit on the total monthly out-of-pocket co-pays for individuals with income at or below 100 percent of Federal Poverty Guidelines to no more than five percent of the recipient's total family income.

Health Care Access Fund (HCAF)

The act includes a one-time transfer of \$50 million from the Health Care Access Fund (HCAF) to the General Fund on June 30, 2009. This transfer is scheduled to be repaid to the HCAF using the projected savings accrued in the state health care programs as a result of cost saving measures in the Health Reform bill. Once the savings are projected to reach \$50 million, that amount will be transferred from the General Fund back to the HCAF. This "loan" from the HCAF is significantly better than earlier recommendations to transfer \$250 million from the

HCAF and use an ongoing \$48 million each year to offset other General Fund spending on health care programs.

Interpreter Services Quality Initiative

The act establishes a voluntary roster for medical interpreters and requires the commissioner of health to develop a plan for a registry and certification process for health care interpreter services. Although the act does not address the issue of reimbursement for interpreter services it does start the process of ensuring minimum quality standards for interpreter services.

Hospital Reductions

Chapter 363 makes significant cuts to hospital funding as a way to balance the budget. These cuts include delaying a scheduled hospital inpatient rebasing by 24 months beginning Jan. 1, 2009, saving the state \$9.7 million in FY09 and \$73.4 million in FY10-11. It reduces inpatient hospital rates, affecting fee-for-service care for Medical Assistance (MA) and General Assistance Medical Care (GAMC), by 3.46 percent in FY 09. In FY10, the cut drops to 1.9 percent. In FY2011, the rate cut will change again to 1.79 percent and will permanently remain at that level. These reductions are projected to save the state \$8.3 million in FY09 and \$16.7 million in FY10-11. The final bill does not include a further cut that would have eliminated disproportionate share payments for hospitals as was proposed in earlier versions of the bill.

Additionally, the act implements a permanent 3 percent rate reduction for hospital outpatient payments under MA and GAMC fee-for-service care provided on or after July 1, 2008. This cut does not apply to payments for mental health services.

Managed Care Reductions

The act achieves savings in the prepaid Medical Assistance programs by increasing managed care withholdings used by the Department of Human Services from 5 to 8 percent for services provided after January 1, 2009 and delaying the date the withheld payments will be repaid no later than July 31 of the following year. This saves the state a projected \$13.6 million FY08-09 and \$43.4 million FY10-11. It also reduces the allowable administrative costs for health plans that participate in MA, GAMC, and MinnesotaCare to 6.6 percent of total contract payments in response to findings by the legislative auditor that prepaid health plans' administrative spending for public programs averaged 7 percent. This limit saves the state a projected \$2.9 million in FY08-09 and \$16 million in FY10-11. The act does not include provisions from earlier versions of the Supplemental Budget Bill to limit health plan reserves then assess a tax on funds exceeding those limits. This would have raised an additional \$50 million.

Reductions are also made to pharmacy reimbursement. Effective July 1, 2008, payments are cut from the current amount based on the average wholesale price minus 12 to the average wholesale price minus 14 percent. This saves \$2.5 million in FY08-09 and \$6.7 million in FH10-11.

Notable are those items once proposed to help balance the budget but not included in the act. In addition to maintaining much of the integrity of the Health Care Access Fund, the legislature did not approve a 3 percent cut to outpatient physician services, new prior authorization requirements for services and procedures based on Oregon's priority list, or a \$5 fee increase on all professional licenses.

Various Effective Dates

Section II

Health Care Delivery

Omnibus Health Care Services Bill

Chapter 326

(H.F.3222 – Huntley/S.F. 3168 – Berglin)

Chapter 326 makes changes to a variety of health care provisions including benefit expansions, fetal remains disposition notification, managed care contracts, county-based purchasing, eligibility for long-term care Medical Assistance, the Minnesota Sex Offender Program, and Minnesota Family Investment Program (MFIP).

Benefit Expansions

The act includes a number of benefit expansions for the state's public health programs. It expands eligibility for pregnant women on Medical Assistance from 200 to 275 percent of the federal poverty guidelines. This now corresponds with current eligibility for infants. For disabled persons, the act establishes home modifications as a covered benefit for home and community-based waiver services for persons with a disability, and defines eligible circumstances. It allows reimbursement for medication management services for in-home settings, excluding long term care and group homes, when the services are ordered by a provider-directed care coordination team. Finally, the act establishes benefit coverage for care coordination and patient education services relating to oral and dental care.

Language Assistance for Non-English Speaking Enrollees

The act expands the requirements for managed care contract holders (PMAP plans) to provide language assistance to non-English speaking enrollees by requiring them to ensure "meaningful access" to programs and services. Currently, plans are only required to provide a copy of the certificate of coverage in seven specific languages.

Determination of ADD/ADHD Diagnosis

For the purposes of indentifying a child with a disability who is eligible for and in need of special instruction and services through the Department of Human Services, the act establishes licensed physicians, advanced practice registered nurses, and licensed psychologists as eligible to make a diagnosis and determination of attention deficit disorder or attention deficit hyperactivity disorder. Formerly, the law did not specify who could make a determination of diagnosis for these conditions.

Fetal Remains Disposition

The act requires hospitals, clinics, and medical facilities to have a policy for informing a woman of available options for fetal disposition when the woman experiences a miscarriage or is expected to experience a miscarriage. The policy must be in place by January 15, 2009.

Quality Data Reporting

The act establishes new criteria related to centers of excellence. The Health Services Policy Committee within the Department of Human Services shall recommend criteria for designating centers of excellence for medical care where a specific set of combined services, volume of patients necessary to maintain a high level of competency, or specific level of technical capacity is associated with improved health outcomes. It also grants the commissioner of human services the authority to join and participate as a legal entity in a health information exchange.

County-Based Purchasing

The act addresses a number of issues related to county-based purchasing. Among the changes, the act requires the commissioner of human services to maintain existing arrangements and consider contracting on a single-health-plan basis with additional county-based purchasing plans.

Various Effective Dates

Prescription Modifications

Chapter 321

(S.F.2941 – Marty/H.F. 2639 – Gottwalt)

Internet Prescribing

Chapter 321 amends various laws related to prescribing in order to reduce abuses of prescriber privileges from illicit online pharmacies. To do so, the act makes a prescription or drug order invalid if there is not a documented patient evaluation. The evaluation must include an examination for prescribing controlled substances, muscle relaxants, opiates, and drugs to treat erectile dysfunction. The requirement for an examination is met if an in-person examination has been completed by the prescribing practitioner at the time the prescription or drug order is issued or as a result of a prior examination. Evaluations are also valid if performed by another prescribing practitioner within the same group or clinic, by a consulting practitioner, or via telemedicine.

This legislation was introduced in response to the death of a young man because of an overdose of prescription medications obtained through an illegitimate internet pharmacy in 2006. His parents worked with the Food and Drug Administration and Minnesota Pharmacists Association to pass enhanced regulation of internet prescribing. Representatives for physicians participated in discussions to ensure that access to legitimate prescriptions would not be restricted.

Sexually Transmitted Disease

Separately, the act allows prescribing practitioners to dispense appropriate oral antibiotics for the management of sexually transmitted diseases for the sexual partners of patients diagnosed with chlamydia or gonorrhea, consistent with recommendations from the Centers for Disease Control (CDC). The act also allows registered nurses in a family planning agency to dispense all forms of contraceptives. Existing law limited their authority to orally-administered contraceptives.

NASPER

The act makes technical changes to the Schedule II and III Controlled Substances Prescription Electronic Reporting System Law passed in 2007. Among the changes, the act delays the deadline for establishment of the system by one year to 2010 as a result of delays in federal approval for the system. The act also clarifies that the intent of the program is not to limit or interfere with the legitimate treatment of intractable pain.

Chiropractic Treatment

Additionally, the act regulates free and discounted chiropractic treatment. Unless identified for the purpose of screening, an exam must be comparable to similar, non-discounted chiropractic treatments and must provide sufficient information to allow for a diagnosis and initiation of treatment.

Various Effective Dates

Radiation Therapy Construction Moratorium Extended

Chapter 213

(S.F.2667 – Berglin/H.F. 3265 – Thissen)

Chapter 213 extends the existing moratorium prohibiting the construction of new radiation therapy facilities located in the following counties: Hennepin, Ramsey, Dakota, Washington, Anoka, Carver, Scott, St. Louis, Sherburne, Benton, Stearns, Chisago, Isanti, and Wright. This moratorium prohibits the construction of new radiation therapy facilities for an additional two years, until August 1, 2011. The act does not apply to the relocation or reconstruction of an existing facility owned by a hospital if the relocation or reconstruction is within one mile of the existing facility. The original moratorium was scheduled to expire in 2009.

Although not ideal, the act is a compromise between parties who sought to remove the moratorium completely and others who sought to make it permanent.

Effective Date: August 1, 2008

Rural Ambulance Staffing Flexibility

Chapter 222

(S.F.2377 – Lourey/H.F. 2591 – Olin)

Chapter 222 allows for flexibility in staffing rural ambulances and provides for hardship waivers of staffing requirements. For an ambulance service whose primary service area is located outside the metropolitan counties and based in a community with a population of fewer than 1,000 persons, basic life support ambulances may respond to emergencies or perform inter-facility transfers staffed by one registered first responder driver and an emergency medical technician (EMT). Currently two EMTs are required for all ambulance service. The flexibility is provided for emergency response and a transfer following an initial emergency call until the initial ambulance is again available. The act specifies that

the EMT must accompany the patient. Similar hardship exceptions are provided for advanced life support ambulances. The EMS Board may authorize an advanced life support ambulance to be staffed by a first responder driver with a paramedic for all emergency calls and inter-facility transfers.

Effective Date: August 1, 2008

Section III

Health Care Reform

Health Care Reform

Chapter 358

(S.F.3780 – Berglin/H.F. 3924 – Huntley)

By far the issue of greatest importance and at times most controversial to physicians and their patients this year was health care reform. Legislative efforts to pass Chapter 358 began at the end of the 2007 legislative session with the creation of the Governor’s Health Care Transformation Task Force. This task force was directed to develop recommendations that would reduce health care costs by 20 percent by the year 2015. The 26-member task force met during the summer and fall of 2007 developing its recommendations.

At the same time the Legislative Commission on Health Care Access also had an aggressive schedule of work group meetings during 2007 to develop their recommendations for comprehensive reform. They were also focusing on controlling health care costs, but with the added goal of increasing access for the uninsured.

The culmination of their work was the passage of Chapter 358. Some have called this act historic because it moves the state toward reforming our public health system, delivery system, and payment system to control costs, improve the health of the population and improve access to care. The act begins to change payment systems to reward physicians for care coordination for patients with chronic and complex conditions through the promotion of the health care home model. It rewards the provision of quality care through the development of pay for performance methodology that is valid, transparent, and standardized. It funds statewide health improvement grants to fight tobacco use and obesity. And it expands access to health care coverage for low-income Minnesotans.

The reforms in this act are estimated to have the potential for health care cost savings of roughly 12 percent by 2015. If achieved, this could represent savings of about \$6.9 billion compared to baseline projections. In addition, it is estimated that the act will expand coverage for more than 12,000 Minnesotans—8,700 under public programs and 4,000 through new incentives for private coverage.

Public Health

Chapter 358 provides \$47 million from the Health Care Access Fund (HCAF) in competitive grants to community health boards to reduce obesity and the use of tobacco for fiscal years 2010 and 2011. To receive these grants a community health board must show that its activities are based on scientific evidence, include community input, address behavior change, and occur in community, school, worksite, or health care settings. These grants must be used for new programs and cannot be used to supplant existing funding for public health improvement activities. The act requires a local match of 10 percent to receive a grant.

The act requires the commissioner of health to submit a biennial report to the legislature on the statewide health improvement programs funded by these grants. Since the act only funds these grants for two years, the commissioner's report must also recommend a sustainable funding source for the future for these grants other than the HCAF.

As introduced, the bill included more public health components that were determined to be too controversial to pass this year. Originally it would have formed a Health, Nutrition and Physical Education Advisory Council to develop statewide health, nutrition and physical education curriculum standards for high schools, increased the cigarette tax, and created a Body Mass Index (BMI) monitoring program for Minnesota children, in addition to the new statewide health improvement grants to combat obesity and tobacco smoking. The public health reforms were carried separately in the House in a bill sponsored by Rep. Diane Loeffler (DFL-Minneapolis) throughout the committee process then added to the health care reform bill just prior to House floor action.

Health Care Homes/ Chronic Care Management

The major delivery system reforms in Chapter 358 are related to the medical home concept that has been developed by the American Academy of Pediatrics, the American Academy of Family Physicians and the American College of Physicians. In the act this concept is called a health care home and the use of health care homes is promoted to coordinate care for people of all ages with complex or chronic conditions.

Qualifying health care homes will receive care coordination payment, in addition to reimbursement for services provided, from public and private health care purchasers. Payments will be based on the complexity of the patient being served, but they have been estimated to average \$50 per patient per month.

By July 1, 2009 the commissioners of human services and health shall develop and implement standards of certification for health care homes. The standards must emphasize, enhance, and encourage the use of primary care physicians, advanced practice nurses, and physician assistants. They must focus on delivering high-quality, efficient, and effective care and encourage patient-centered care, including active participation by the patient and family in decision making. Additionally, standards must require health care homes to provide patients with a consistent, ongoing contact with a personal clinician, or team of clinicians; ensure the development of comprehensive care plans; encourage the use of care coordinators; incorporate quality measurement; and encourage scientifically based health care. The act defines "personal clinician" as a physician, advanced practice nurse (APN), physician assistant (PA), or "other health care provider as determined by the commissioner of health."

The focus of the health care home initially must be on patients with chronic conditions in order

to administer the program within the available funding. National data shows that the greatest savings from the medical home model is in the area of secondary prevention for those with chronic conditions. If initial savings from the health care home do not accrue, then the commissioner of human services “may make recommendations to the legislature on reallocating costs within the health care system.”

The health care home model must be evaluated both three and five years after implementation to determine if it is meeting the expected goals. Once the health care home is fully implemented many believe we may not have enough primary care physicians available to serve patients’ needs. To address this expected health care workforce shortage Chapter 358 directs the commissioner of health, in consultation with the health licensing board and the professional associations, to study changes necessary in health professional licensure to ensure full utilization of advance practice nurses, physician assistants, and other licensed health care professionals. These professionals would be used in the health care home and in primary care delivery. This is related to the concept of ensuring that each professional is able to practice at the “top of his or her license.” The commissioner will make recommendations to the legislature by January 15, 2009.

Health Care Coverage/Affordability

To address the uninsured Chapter 358 expands coverage for low income citizens in our public programs and increases the use of tax credits and grants to increase enrollment in employer subsidized coverage.

The public expansions provide MinnesotaCare coverage for an estimated 8,700 additional people by the year 2011 by expanding MinnesotaCare eligibility for adults without children from 215 percent to 250 percent of federal poverty and raise the income limit for parents with children from \$50,000 to \$57,500 annually. One expansion is aimed at providing seamless coverage for children between the Medical Assistance (MA) and MinnesotaCare programs. A child whose family income rises above the MA limits may remain eligible for MA for two additional months and is then deemed automatically eligible for MinnesotaCare until the family’s annual renewal date. It also allows a one-month grace period for enrollees who fail to submit renewal forms to remain eligible for MinnesotaCare. Finally, the act requires further study by the commissioner of human services to improve coordination between state health care programs and other assistance programs to streamline access to applications for state public health care programs.

In response to data showing that a high number of the uninsured in Minnesota are currently eligible for state programs, Chapter 358 increases outreach funds for state health care programs to assist Minnesotans who currently qualify, but are not enrolled in our public programs, .It also enhances an incentive program for organizations that assist those enrolling in public programs by increasing the disbursement to \$25-per person enrolled, up from \$20. The act also directs the commissioner of human services to use data from the free and reduced school lunch program to help identify children eligible for Medical Assistance.

To address the issue of affordability of low income Minnesotans, the act requires the commissioner of health to develop a health care affordability program for families with incomes of 300 percent FPG, both individuals and employees who have access to employer-subsidized coverage. The commissioner must evaluate direct payments to individuals, tax credits, and tax deductions as mechanisms to achieve affordability. Affordability is defined as the cost of premiums, deductibles, and other out-of-pocket costs equaling less than 8 percent of a gross monthly income of a family.

Chapter 358 reduces the MinnesotaCare sliding-scale premiums to increase the affordability of public health care programs. The premiums are capped to ensure that no one below 300 percent of the federal poverty level pays more than 8 percent of their gross family income on health care premiums.

In order to promote more private coverage, Chapter 358 requires employers who have 11 or more full-time equivalent employees and who do not currently offer group health insurance, to establish and maintain a Section 125 Plan. These federally established plans allow employees to purchase health insurance with pre-tax dollars. The act allows employers the opportunity to opt out of this requirement in certain situations.

The act also uses grants and tax credits to encourage other employers to offer health coverage. Grants are used to cover certain employers' cost for establishing Section 125 Plans. Tax credits are provided to qualifying employers to subsidize the cost of the coverage for currently uninsured employees to purchase coverage through the employer's Section 125 Plan.

Chapter 358 creates a work group to make recommendations on the design of an "essential benefit set." The benefit set shall provide coverage for a broad range of services and technologies, be based on scientific evidence of clinical and cost effectiveness, and require lower enrollee cost-sharing for cost-effective services. The work group shall include health care providers, health plans, state agencies, and employers, all of whom have expertise in evidence-based care, benefit design, actuarial analysis, or the cost impact of specified benefits. The work group shall submit an initial essential benefit set to the commissioner of health by October 15, 2009 and the commissioner shall report to the legislature by January 15, 2010.

Payment Reform

The most controversy over health care reform was related to payment reform. Specifically, concerns were generated over the proposed concept of requiring clinics to submit a "bid for the total cost of care" to the state, and having that bid used to set payment rates. Following concerns that the bidding idea seemed to be a return to total capitation and shifting of insurance risk to providers, the Minnesota Medical Association opposed the proposal and in the end the scheme was not included in the final act.

Payment reform that is included in Chapter 358 is directed at changing the incentives in our payment systems by moving away from rewarding providers for doing more procedures or offering more services, and instead toward a system that rewards providers for providing better quality care and providing services that keep patients healthier.

In addition to care coordination payments included in the health care home efforts, the act encourages quality improvement and transparency by establishing a single, statewide system of quality-based incentive payments to be used by public and private health care purchasers. By January 1, 2009 the commissioner of health shall develop a system of quality incentive payments, and by January 1, 2010 the state shall implement this incentive payment system for the state employee health plan.

The act also creates a set of tools to allow consumers and health care purchasers to compare providers on overall cost and quality of care. Beginning July 1, 2009 the commissioner shall begin collecting encounter level data from all health plans on cost and pricing. Next, the

commissioner shall develop a uniform method calculating providers' relative cost of care, and relative quality, and develop a peer grouping system to be used by consumers and purchasers. This information will be used to create incentives for health care providers to innovate on ways to deliver health care with higher quality and lower cost. The data will also be used to establish consumer incentives to use high-quality, low-cost providers.

In developing the uniform method of calculating cost and quality the commissioner must address the following issues: provider attribution of costs and quality, appropriate adjustment for catastrophic cases, risk adjustment mechanisms, the types of providers and types of services to include, adjustments for payment rate variations, what level of provider to be analyzed (physician, clinic, system level, etc.), payer mix adjustments, and other factors needed to ensure validity of the data. No data shall be publically disseminated until after June 1, 2010. Prior to public dissemination, providers will have time to review their own data and appeal any disputes the provider may have with the data.

Another concept designed to promote transparency and accountability is the establishment of "baskets" of health care services. The act requires the commissioner to establish uniform definitions for a minimum of seven baskets of care to allow consumers to more easily compare cost and quality of care across providers, and to promote provider innovation on cost and quality. The act directs the commissioner to consider coronary artery and heart disease, diabetes, asthma, and depression when selecting conditions for the baskets of care. Beginning January 1, 2010 providers may establish package prices for the baskets of care defined by the commissioner. If a provider voluntarily establishes a package price, the provider must charge that same package price to all private payers. Exempt from this single-price requirement are Medicare, all state public health care programs, workers' compensation, and no-fault auto insurance.

The act also directs the commissioner to convene a workgroup to develop strategies for engaging consumers in understanding the importance of health care cost and quality, specifically as it relates to health care outcomes, consumer out-of-pocket costs, and variations in cost and quality across providers. The work group shall develop strategies to assist consumers in becoming advocates for higher value health care. They shall make recommendations to the legislature by January 1, 2010.

To review the progress of implementation of all the payment reform initiatives, Chapter 358 establishes a Health Care Reform Review Council. This council allows for stakeholder review and input on implementation of the payment reform provisions of the bill. The composition of the council includes two physicians appointed by the MMA, two members appointed by the Minnesota Hospital Association, and one member each appointed by the Minnesota Nurses Association, Minnesota Academy of Physician Assistants, Minnesota Business Partnership, Minnesota Chamber of Commerce, Service Employees International Union, AFL-CIO, Smart Buy Alliance, Minnesota Medical Group Management Association, and AARP Minnesota. At least two members must represent rural Minnesota.

Administrative Efficiencies

Chapter 358 aims to reduce costs and improve quality through administrative simplification. The act enhances health care quality, patient safety, and Minnesota's ability to achieve interoperable electronic health records by ensuring that providers use nationally certified electronic health record systems when available. It requires that electronic health record systems be certified by the Certification Commission for Healthcare Information Technology.

The act also advances the use of health information technology by requiring that by 2011 all prescriptions that are ordered electronically comply with the national standards that are being developed for electronic prescriptions. Every prescriber must have a compatible electronic prescription system in place by this date.

Finally in the area of administrative efficiency, Chapter 358 requires a study and report on reducing claims adjudication costs for health care providers and health plans by adopting more uniform methods of processing claims. The commissioner shall establish a work group including representatives of the MMA, Minnesota Hospital Association, and Minnesota Council of Health Plans to study the impact of establishing uniform prices that would replace the current prices negotiated individually between providers and payers. They shall make recommendations to the commissioner by January 1, 2010.

Other Studies

With Chapter 358 laying out a road map for the direction of our health care system over the next five years, there are a number of studies, work groups, and task forces established in addition to those already mentioned. The act requires the commissioner of health to make recommendations by December 15, 2009 on a “community benefit standard” to be required of nonprofit health plans doing business in the state. The expectations of community benefit are related to supporting public health, improving the art and science of medical care, and addressing the need for financial assistance to access coverage. The act clearly states that community benefit is not related to general philanthropic endeavors. The recommendation must include a procedure by which a health plan would periodically and uniformly report to the state the company’s compliance with the community benefit requirements and recommend a fair and effective enforcement mechanism.

The act also requires a study and report on health care coverage for long-term care workers. The report should recommend how to affect state-set rate increases for long-term care employers that would be dedicated to employee health insurance. The commissioner shall report to the legislature by December 15, 2008.

Various Effective Dates

Section IV **Legal and Ethics**

Automobile-Injured Patient Solicitation Prohibited

Chapter 214

(S.F.2765 – Sparks/H.F. 2721 – Dominguez)

Chapter 214 prohibits licensed health care providers from initiating direct contact, in person, over the telephone, or by other electronic means, with any person who has suffered an injury arising out of the maintenance or use of an automobile, for the purpose of influencing that person to receive treatment or to purchase any item from the licensee or anyone associated with the licensee.

Exceptions are provided for situations in which direct contact is initiated for the purpose of rendering emergency care. Existing relationships are also exempted when the person has selected the provider as the provider from who they choose to receive care or if they received treatment related to the accident, as could be the case for a medical home. Allowance is made for advertising, general marketing, lectures, and social settings.

Initiated by the Minnesota Chiropractic Association, the act is targeted at cleaning up public perception of health care providers by restricting so-called “ambulance chasers”.

Effective Date: August 1, 2008

**Electronic Image Transfer of Hospital Records
and Transportation of the Deceased**

Chapter 228

(S.F.3263 – Prettner Solon/H.F. Bunn – 3710)

Chapter 228 updates the medical record statute to permit hospitals to transfer records to electronic images or other state-of-the-art electronic preservation technology for the purpose of preservation. The act states that an electronic copy of a record has the same force and effect as the original file when admitted and received as evidence, even if the original is no longer in existence. Once the original records are transferred and preserved electronically, the act allows hospitals to destroy original records with the consent and approval of the board of directors or other governing body of the hospital. Formerly, the law provided only for photographic or photostatic copies. Hospitals sought the change to update the statute to reflect new technologies.

In addition, the act includes a provision related to the transfer of dead bodies. The act allows the deceased persons’ advance directive or will, or the family of the deceased to specify how the decedent’s body is transported to the place of final disposition.

Various Effective Dates

Minnesota Responds Medical Reserve Corps

Chapter 202

(S.F.3135 – Higgins/H.F. 3654 – Winkler)

Chapter 202 allows for the establishment of a volunteer medical reserve corps that can be deployed during a natural disaster or an emergency. The act makes Minnesota eligible for federal funding for the establishment of this corps and the registry of volunteers. If the commissioner of health deploys volunteers, they become eligible for state workers’ compensation benefits and tort claim defense and indemnification by the state of Minnesota.

The commissioner of health shall make a determination of public interest prior to deployment of Minnesota Responds Medical Reserve Corps. In the event volunteers are deployed, efforts will be coordinated with the division of homeland security and emergency management. The act provides for Minnesota Responds Medical Reserve Corps volunteers to receive reimbursement for travel and subsistence expenses during a deployment approved by the commissioner according to reimbursement limits established for paid state employees.

Effective Date: April 18, 2008

Omnibus Data Practices Bill

Chapter 315

(S.F.3235 – Olson, M./H.F. 3553 – Simon)

Chapter 315 institutes a number of changes pertaining to criminal background checks, the use of social security numbers and government entities. Among the changes, the act amends the Data Practices Act to grant authority to Hennepin County Medical Center to participate in a health information exchange and share medical data with other provider entities within its facility for treatment, payment or general health care operations.

Various Effective Dates

**Prescription Information for Vehicle Window
Tinting Modified**

Chapter 235

(S.F.3336 – Foley/H.F. 3204 – Cornish)

Chapter 235 addresses restrictions on tinted vehicle windows by requiring additional information to be included on a physician prescription stating medical need. Current law only requires a person to receive a doctor's prescription for tinted windows without any specifics on limitations on the prescription. This act requires a prescription to state the minimum percentage that light transmittance may be reduced to satisfy the prescription or medical needs of the patient (driver or passenger) and must contain an expiration date no more than two years from the date of issue.

Effective Date: August 1, 2008

Section V **Public Health**

Blood Donation Minimum Age Lowered

Chapter 157

(S.F.2471 – Sheran/H.F. 1066 – Fritz)

Chapter 157 lowers the age limit for blood donations to allow 16 year olds to donate blood with written permission of a parent or guardian. Current law requires a donor to be 17 years old.

This act was supported by the Red Cross, Memorial Blood Centers, Mayo Clinic and other organizations to increase the blood supply by expanding the number of eligible donors. Testimony indicated that high schools are a successful location for donor drives, and that donating blood often becomes a lifelong habit when begun as a teenager. Minnesota will become the 15th state to allow 16-year-olds to give blood.

Effective Date: July 1, 2008

Public Safety Omnibus Bill: **Graduated Driver’s License**

Chapter 350

(H.F.3800 – Hornstein/S.F. 1520 – Murphy, S.)

Chapter 350 is the second omnibus transportation policy bill passed in 2008. The first bill was a continuation of 2007 efforts. A number of driver and vehicle safety provisions are included in the act. First, the act expands the provisional drivers’ license for teenagers and enacts a “Graduated Driver’s License”. For the first six months after a teenager obtains his or her license a teen driver is prohibited from driving between 12 midnight and 5 a.m. unless for work or school functions. A teen driver is also limited to having no more than one other non-family member under the age of 20 as a passenger in the vehicle. For the second six months a teen driver may have no more than three other non-family members under the age of 20 as passengers in the vehicle.

Graduated Driver’s License is supported by many physicians in response to data showing that no state in the country has a higher percentage of teenagers behind the wheel in deadly crashes than Minnesota. In the 47 other states that have similar laws, there was a documented reduction in teen fatalities.

The act also restricts the use of wireless communication devices while operating a motor vehicle. Specifically, the act prohibits the use of wireless communication devices such as cell phones and PDAs to “compose, read or send an electronic message when the vehicle is in motion or a part of traffic.”

There were efforts once again to make not wearing a seat belt a primary offense. This provision passed the Senate and nearly passed the House. Unfortunately, in the end, it did not pass. The same was true with an update to the child restraint laws. Legislation passed the Senate but not the House to require children up to age nine to use booster seats when riding in a motor vehicle, consistent with the recommendations of the National Highway Traffic Safety Administration.

Various Effective Dates

Taconite Workers' Lung Health Study

Chapter 248

(H.F.3569 – Rukavina/S.F. 3300 – Tomassoni)

Chapter 248 appropriates \$4.9 million from the state workers' compensation assigned risk plan to the University of Minnesota to conduct comprehensive scientific and evidence-based studies of workers' lung health, including industry-specific worker mortality and morbidity studies, clinical disease studies, exposure assessments, case-control screening of current and former workers and environmental studies that assess health impacts on workers and communities. The University must coordinate with the Department of Health, Department of Natural Resources, Pollution Control Agency, business, industry, local health care providers and others.

The act is in response to revelations that the Minnesota Department of Health withheld for a year the names of 35 taconite mine employees who died of mesothelioma between 1998 and 2005.

Effective Date: April 29, 2008

Section VI

Scope of Practice

Naturopathic Doctor Registration

Chapter 348

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

Chapter 348 creates a process to register naturopathic doctors with graduate-level degrees. The act establishes a scope of practice and training requirements as well continuing education requirements for registered naturopathic doctors. The title “naturopathic doctor” is protected under this new chapter.

The newly established scope of practice includes ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs,

glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease; performing or ordering physical examinations and physiological function tests; ordering clinical laboratory tests and performing waived tests as defined by the FDA Clinical Laboratory Improvement Amendments of 1988 (CLIA); referring a patient for diagnostic imaging to an appropriately licensed health care professional to conduct the test and interpret the results; prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; and prescribing or performing naturopathic physical medicine. Naturopathic doctors may have admitting rights at a hospital if they meet credentialing and privilege requirements of the facility.

The act creates an advisory council under the Board of Medical Practice which must include a licensed physician or osteopath with expertise in natural medicine. It also requires the commissioner of health to convene a work group to make recommendations on appropriate regulation for naturopathic medicine. The act allows the MMA to appoint one member to the work group.

Originally the bill would have licensed naturopaths under the Board of Medical Practice and included in their scope of practice ordering diagnostic imaging; prescribing all legend and schedule III, IV and V drugs; and performing office procedures such as removal of foreign bodies and surgical repair of superficial lesions. Under the original proposal, naturopaths would also have been allowed to perform naturopathic childbirth.

After the bill was dramatically scaled back, the only opposition that remained came from unlicensed complimentary and alternative medicine providers who were concerned their scope of practice would become more limited.

Various Effective Dates

Omnibus Health Professionals Licensing bill

Chapter 189

(H.F. 3708 – Murphy/S.F. 3427 – Hann)

Chapter 189 makes changes to the licensure provisions of a number of health professions including pharmacists, hearing instrument dispensers, speech-language pathologists, audiologists, and occupational therapy professionals. The act makes non-controversial modifications to practice and licensure provisions of other health professions, including unlicensed complementary and alternative health care practitioners, the board of medical practice, and marriage and family therapists.

Pharmacy

The act expands the vaccination authority of pharmacists by amending the definition of the practice of pharmacy to include the administration of influenza vaccine to all eligible individuals over ten years of age and all other FDA approved vaccines to patients 18 years of age and older under standing orders or written protocol with a physician. Previously pharmacists could administer only influenza and pneumococcal vaccine to persons over 18 years of age.

The Minnesota Pharmacists Association sought the change citing the need to increase access to critical vaccines. Earlier versions of the bill were opposed by physician groups but non opposed the final act.

Unlicensed and Complementary Health Practitioners

The act removes the prohibition against unlicensed and complimentary health care practitioners engaging in a sexual relationship with a former client. Formerly, the law prohibited a practitioner from having a sexual relationship with a former client for two years. The change was sought by a massage therapist who faced disciplinary action for marrying a former client.

Board of Medical Practice

The act provides a fallback for medical license applicants who fail to pass each of steps one, two and three of the United States Medical Licensing Examination within the required three attempts, by allowing the applicant a fourth attempt so long as the applicant has a license current in another state and is currently board certified by a specialty board, American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. The change was sought to provide a medical license to a specific applicant who had been previously denied a license.

Speech Language Pathology and Audiology

The act outlines additional information the commissioner of health may request of speech language pathology applicants with doctoral degrees to confirm that the applicant completed course work equivalent to or exceeding a master's degree prior to eligibility for enrollment in a doctoral externship.

The act expands the information required to be updated by licensees, defines the purpose of the audiologist surcharge fee, increases the number of times a temporary license may be renewed from one to two, provides a penalty for using protected titles, changes the term "hearing aid" to "hearing instruments", makes technical changes to continuing education requirements, and requires audiologists to sign and date audiograms. These items were sought by the Board of Speech Language Pathology and Audiology.

The MAO did not oppose these changes.

Occupational Therapy

The act expands the information required to be updated by licensees, clarifies the approval process from the commissioner prior to the use of physical modalities, requires hand therapists to prove certification, and clarifies continuing education requirements and penalty fees. These changes were sought by the Board of Occupational Therapy.

Physical Therapy

The act provides an exemption from the examination licensing criteria for an applicant applying for licensure prior to July 1, 2008, who has been issued a physical therapy license between 1980 and 1995 in at least three other states and one or more foreign countries. The change was sought by a physical therapist who was denied licensure because she failed to pass the licensing exam. It is unclear if others will qualify.

Various Effective Dates

Physical Therapy Direct Access Expanded

Chapter 199

(S.F.1018 – Prettner Solon/H.F. 1189 – Thissen)

Chapter 199 allows a physical therapist to treat patients up to 90 days without a referral from a physician or other health care provider. Existing law provides open access for 30 days. The new 90-day limitation of treatment by a physical therapist without an order or referral does not apply to prevention, wellness, education, or exercise.

As originally proposed the bill would have granted unlimited, open access for physical therapy and removed important patient safety and care coordination safeguards. It would have greatly expanded the scope of practice of physical therapists and allowed them to evaluate and treat patients indefinitely without a physician’s referral. It would have removed the current 30-day limitation on treatment from a physical therapist without a physician’s referral and allowed physical therapists to directly treat patient for an unlimited amount of time without any physician involvement. Earlier versions of the bill would have also deleted the statutory requirement that physical therapists practice one year under a physician’s orders before treating patients without a referral. Additionally, the original bill eliminated the requirement that a physical therapist communicate with the referring physician when the course of treatment is modified from an original prescription.

A compromise was reached following five years of contentious work on the bill by groups including the Minnesota Orthopedic Society, Minnesota Academy of Family Physicians and Minnesota Medical Association. The extension from 30 to 90 days was deemed acceptable to concerned physicians since patient safety mechanisms are left in place. Physical therapists had refused to adopt this compromise in past years.

Effective Date: August 1, 2008

Section VII

Third-Party Payers

Prepaid Health Plans and County-Based Purchasing

Chapter 364

(S.F.3322 – Prettner Solon/H.F. 3809 – Huntley)

Chapter 364 addresses the financial management of state health care programs through contracts with managed care companies and county-based purchasing entities. The act places into statute recommendations from the Office of the Legislative Auditor regarding regulations for county-based purchasing entities. While the legislative auditor’s evaluation concluded that Minnesota should continue to administer state health care programs for low-

income people through a combination of private and public managed care organizations, in addition to fee-for-service care, the report recommends a need for greater scrutiny of costs and health outcomes under these approaches. Therefore, the act sets forth fiscal solvency requirements for county-based purchasing as well as requirements for how these entities are allowed to use excess reserves. The act also sets limits for administrative expenses to five percent of the plan's total revenue for the preceding year. The act outlines penalties for exceeding these limits. Additionally, health plans and county-based plans are required to submit information on payment rates made to vendors for administrative services under contract with the plan.

The act calls for the commissioner of human services to study and make recommendations to the legislature by January 15, 2009 on the adoption of a single method to compute and publicly report managed health care performance measures in order to avoid confusion about the plans' performance levels. It also directs the commissioner to explore the feasibility of using or coordinating with the credentialing collaborative between Minnesota payers, providers, and hospitals in order to make the provider enrollment process for Minnesota health care programs more efficient.

Various Effective Dates

Uniform Claims Processing

Chapter 305

(H.F.3372 – Thissen/S.F. 3245 – Lourey)

Chapter 305 modifies requirements for uniform billing and electronic claims filing transactions aimed at cost containment through administrative simplification. The Minnesota Health Care Administrative Simplification Act of 1994 provides a framework for standardizing administrative processes and reducing costs for health care providers and payers. In 2007 the Legislature mandated electronic exchange of information using a single standard for content and format. Once implemented, these requirements will produce significant administrative savings in the health care system. Providers and payers serving on the Administrative Uniformity Committee will continue to advise the Department of Health on changes and updates to the law.

This chapter adopts most the 2008 legislative recommendations of the Administrative Uniformity Committee. In addition to technical changes and corrections suggested by providers and payers, the act allows the commissioner to temporarily exempt workers' compensation insurers, property and casualty insurers, and auto insurers from requirements for which they are currently incapable of exchanging the required data or for which another national standard is more appropriate and effective. Exemptions must be reviewed annually. In the event an insurer is exempt from one or more of the requirements, providers are then exempt from electronic exchange requirements with that insurer.

The act also provides a complaint-driven compliance mechanism that ensures payers and providers implement the requirements enacted in 2007. The mechanism is based on federal compliance requirements and emphasizes technical assistance and cooperation with providers and payers.

The Minnesota Department of Health estimates that administrative costs associated with billing and claims processing will cost the health care system in Minnesota approximately \$750 million in fiscal year 2008. The department also estimates that once fully implemented, the requirements enacted by the 2007 Legislature will reduce billing and claims processing costs by \$60-70 million per year by fiscal year 2011.

Effective Date: August 1, 2008

Workers' Compensation

Chapter 250

(S.F.3218 – Bakk/H.F. 3566 – Nelson)

Chapter 250 implements the recommendations of the Workers' Compensation Advisory Council. In addition to raising benefit levels for injured workers, the act provides for a more regular update of the relative value fee schedule for workers' compensation reimbursement for medical services. At least every three years, the Department of Labor and Industry must adopt by reference the most current relative value fee schedule tables used by Medicare. To accommodate the changes in relative value units (RVUs) associated with the updating process, the act allows conversion factors to be adjusted to hold costs constant for each group of services under both the prior and the new fee schedule. The conversion factors will be adjusted on a total-dollar cost neutral basis within each provider category (medical/surgical, physical medicine and rehabilitation, path/lab and chiropractic).

The current workers' comp fee schedule is currently based on the 1998 federal RVUs, which are out of date and not reflective of the revaluation of services that have occurred over time. Therefore physician groups did not oppose the change.

The act also increases the maximum hourly rate for rehabilitation services and ceases compensation for treatment provided by an unlicensed complementary and alternative health care practitioner. Additionally, the act makes housekeeping changes provided by the department of labor and industry concerning in-home attendant care providers, Minnesota Medical Reserve Corps volunteers, electronic filing, and solvency of insurers, and it provides for the use of alternative identification numbers to social security numbers.

Various Effective Dates

BILLS THAT FAILED TO PASS

Section VIII **Appropriations**

Constitutional Amendment to Dedicate Provider Tax

(S.F.3835- Berglin /H.F. 4241 – Huntley)

This bill would have amended the Minnesota Constitution to dedicate the proceeds of the provider tax to MinnesotaCare and health care access. The proposed amendment would have stated:

The proceeds of a tax on the revenue from providing health care services to Minnesota Residents must be credited to the health care access fund in the state treasury. The assets of the health care access fund must be used only to support the MinnesotaCare program and to increase access to health care in underserved populations and geographical areas of the state. The proceeds must not be used to supplant general funds.

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

Shall the Minnesota Constitution be amended to dedicate the proceeds of the MinnesotaCare provider tax to increase access to affordable health care for Minnesotans?

While the bill was intended to counter frequent attempts to raid the Health Care Access Fund, the Minnesota Medical Association did not support the Constitutional amendment and instead urged legislators not to permanently establish the provider tax in the Minnesota Constitution.

The bill received a hearing in the Senate Finance Committee but was not heard in the Senate Rules Committee or in the House.

Health Care Access Fund Transfers Eliminated

(S.F. 3411 – Erickson Ropes/H.F. 3325 – Tshumper)

This bill would have inserted a purpose section into statute governing the Health Care Access Fund to specify that the purpose of the fund is to finance affordable health care services for low-

income Minnesotans and their families. It specified that money in the fund may not be used to replace existing spending on subsidized health care programs going forward.

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

Provider Tax Contingent Reduction

(H.F. 275 – Brod/ S.F. 667 – Michel)

(H.F. 1985 – Liebling/S.F. 1690 – Lynch)

These bills would have provided for a contingent rate reduction for the 2 percent provider tax. On September 1st of each odd-numbered year beginning in 2007, the commissioner of finance would have been required to determine the projected balance of the Health Care Access Fund at the end of the current biennium. If the commissioner projected a surplus, then the provider tax would have been reduced by increments of one-tenth of 1 percent, or one-quarter of 1 percent, to a rate that would maintain adequate levels but eliminate any excess surplus.

This bill did not receive a hearing in either body.

Provider Tax Repealed

(H.F. 317 – DeLaForest/S.F. 341 – Ortman)

This bill would have repealed the 2 percent tax on health care services provided by physicians, hospitals, dentists, and other health care providers. The bill did not recommend a replacement of these funds, however, so the MinnesotaCare program would have been funded out of existing General Fund dollars.

This bill did not receive a hearing in either body.

Section IX **Health Care Delivery**

Constitutional Amendment for Affordable Health Care

(H.F. 683 – Huntley/S.F. 204 – Berglin)

This bill would have amended the Minnesota Constitution affirming that every resident in Minnesota has the right to affordable health care. The proposed amendment would have stated:

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

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

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

If adopted by the voters, the bill would have required the legislature and the governor to enact and implement legislation to implement the amendment by July 1, 2011 to ensure affordable health care for all.

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

Constitutional Amendment for Freedom of Choice in Health Care

(S.F. 3371 – Hann/H.F.4043 - Emmer)

This bill would have amended the Minnesota Constitution to provide citizens the right to make all decisions about their own health care. The interpretation of this language would have allowed unlimited open access to any medical service including complementary and alternative medicine, allowed the purchase of private health plans from out of state, and prohibited disincentives such as limited provider networks and differing copays for obtaining care outside a particular health care system. The proposed amendment would have stated:

Because all people should have the right to make decisions about their health care, no law shall be passed that restricts a person's freedom of choice of private health care systems or private plans of any type. No law shall interfere with a person's or entity's right to pay directly for lawful medical services, nor shall any law impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan.

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

Shall the Minnesota Constitution be amended to state that because all people should have the right to make decisions about their health care, no law shall be passed that restricts a person's freedom of choice of private health care systems or private plans of any type? No law shall interfere with a person's or entity's right to pay directly for lawful medical services, nor shall any

law impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan.

If adopted by the voters, the bill would have required the legislature and the governor to enact and implement legislation to implement the amendment by July 1, 2009.

The bill did not receive a hearing in either body.

Safe Patient Handling in Clinical Settings

(H.F. 3870 – Fritz/S.F. 3559 - Higgins)

This bill would have expanded safe patient handling requirements passed in 2007 to include clinical settings where patients needed to be moved. Current law outlines safe patient handling requirements for inpatient facilities and outpatient surgical settings. The bill defined clinical settings to include physician, dental and other outpatient facilities where service requires movement of patients from point to point as part of the scope of service. These facilities would have been required to develop a written safe patient handling plan to minimize manual lifting. Facilities with an existing safe patient handling plan that meets the outlined elements would have been in compliance with the requirement.

The bill was a result of legislation passed last year requiring a Safe Patient Handling Advisory Committee to convene and make a recommendation to the legislature. The committee included a representative from the Minnesota Medical Association on behalf of physicians.

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

Section X **Legal and Ethics**

Board of Medical Practice Membership Removal Criteria

(H.F. 3640 – Madore/S.F.3670 - Gerlach)

This bill would have revised statutory provision for removal of members of the Board of Medical Practice to allow the appointing authority, which is the governor, to remove members not only for cause but also for failing to make conflict-of-interest disclosure, failing to submit required reports, and for failure to attend meetings if the member is absent from three consecutive meetings.

The bill did not receive a hearing in either body.

Inappropriate Disciplinary Action for Treatment of Lyme Disease

(H.F. 4054 – Dettmer/S.F.3538 – Vandever)

This bill would have prohibited disciplinary action by the Board of Medical Practice against a physician who prescribed long-term antibiotic therapy for the treatment of Lyme disease. By prohibiting disciplinary action, the bill would have established a standard of care in state law.

The bill did not receive a hearing in either body.

Marijuana for Medical Use

(H.F. 655 – Huntley/S.F. 345 – Murphy, S.)

This bill would have provided for the regulated use of small amounts of marijuana for medical purposes for debilitating medical conditions. Twelve states currently allow for the legal use of marijuana for medical purposes.

Qualifying patients and caregivers would have been required to register as legal users and obtain identification cards issued by the commissioner of health. Debilitating medical conditions were defined to include conditions such as cancer, glaucoma, hepatitis C, HIV, Tourette's Syndrome and other chronic diseases and conditions that the commissioner could deem as a debilitating medical condition such as severe nausea, intractable pain (more than six months), epilepsy, multiple sclerosis, Crohn's Disease, and Alzheimer's. The allowable amount of marijuana for patients would have been 2.5 ounces of usable marijuana and any amount of the other parts of the plant. The bill would have allowed primary caregivers to also have up to 2.5 ounces of usable marijuana.

Following failure to pass from the House floor in 2007, the bill was returned to the House Committee on Ways and Means where it was repassed as amended. Again the bill died awaiting final action on the House floor under threat of a veto from the Governor.

Medical Debt Privacy Protection

Chapter 279 – Vetoed

(H.F. 3610 – Loeffler/S.F.3132 – Schied)

Chapter 279 would have prohibited a health care provider from sharing patients' medical debt information with anyone other than patients, their insurer, or a third-party debt collector. Providers would have been prohibited from obtaining financial information about a patient until after services have been provided. The bill provided exceptions to allow providers to process payment, discuss payment options or insurance coverage with patients, and obtain patient financial information to determine eligibility for public programs. The bill would only have applied to services and treatment that were medically necessary.

An initiative of the Attorney General, the bill was introduced in anticipation of a highly publicized product from Fair Isaac Corporation, called MedFICO, which provides health care providers with information on medical debt. The product is designed to help hospitals and others determine the likelihood of a patient paying outstanding bills, or whether the cost would have to be written off as bad debt.

The bill was passed by the Legislature but was vetoed by the Governor. Among the concerns outlined in the veto message was the absence of a definition for “medically necessary”.

Medical Liability for Emergency Care and Expert Review Affidavits

(H.F. 4179 – Dean/No Senate File)

This bill would have provided immunity from civil liability for care provided to patients entering the hospital through the emergency room or trauma center with serious medical conditions demanding immediate medical attention. This included obstetrical care. Additionally, the bill would have required the affidavit of expert review provided by a physician expert witness for the plaintiff to be board certified, and currently practicing in the same specialty for which the standard of care is applicable.

The bill did not receive a hearing in either body.

Newborn Screening Program Modifications

Chapter 345 – Vetoed

(H.F. 3438 – Thissen/S.F.3138 – Lynch)

Chapter 345 would have amended the genetic privacy law passed in 2005 to specify that current Department of Health's collection, storage, use, and dissemination of genetic information and blood specimens for testing infants for heritable and congenital disorders (the newborn screening program) is governed by separate newborn screening laws. The bill would have also expanded parental notification and parental rights to refuse testing. Additionally, the bill would have restricted the research that could be done with dried blood spots obtained through the newborn screening program to calibrating newborn screening equipment, evaluating existing newborn screening tests to reduce the number of false positive and false negative results, studying the development of new newborn screening tests for heritable and congenital disorders, and other population-based health studies. Finally, the bill required the Department of Health to update the legislature on its current efforts to ensure that parents of newborns are fully informed of their rights and options about the newborn screening program.

Promoted by the Minnesota Department of Health, the bill was in response to a discovery that there was a conflict between state laws concerning the storage of dried blood spots. Much of the bill addresses reports that parents were not receiving information about their rights to refuse testing or storage in an effort to expand the rights of parents, ensure they

obtain information on the program prior to testing, and have a documented personal interaction with a provider including the opportunity to ask questions.

Physicians including those from the Minnesota Medical Association, Minnesota Chapter - American Academy of Pediatrics, Mayo Clinic, University of Minnesota, and the Minnesota Department of Health worked together to pass the bill.

The act passed unanimously in the House and by a wide margin in the Senate. While the bill was in conference committee opposition to it grew. The opposition was led by the Citizen's Council on Health Care which believes the entire newborn screening program should require parents to "opt in" to the program instead of the current law which allows any parent to opt out if there are objections. No concerns were raised over the newborn hearing test as part of the newborn screening program.

The act was vetoed by the Governor because of concerns about informed consent for uses of the stored samples. The issue exemplifies growing distrust of science and medical research among political representatives.

Pharmaceutical and Device Manufacturer Payment Disclosure and Gift Ban

(S.F. 3843 – Marty/No House File)

This bill would have made significant changes to existing state restrictions on gifts to practitioners. The bill would have amended the gift ban to remove the allowance for up to \$50 of gifts from pharmaceutical manufacturers, thereby prohibiting all gifts to physicians. It also extended the ban to clinic employees and family members. Medical device manufacturers would have been included in the ban as well. The bill would have restricted the distribution of free samples and medical supplies to only uninsured and low-income patients and only when there is evidence showing superiority of the drug or device over less costly alternatives. It also clarified the provision of unrestricted grants for meeting sponsorship.

Practitioners serving as employees or agents of manufacturers would have been required to report any compensation to the Board of Medical Practice and disclose the relationship to patients prior to prescribing or recommending a product from that manufacturer.

The bill would have expanded annual reporting by manufacturers and distributors from payments over \$100 to all payments, honoraria, reimbursement or other compensation paid to practitioners, meeting sponsorships and educational programming. Finally, the bill would have prohibited members of the state Medicaid Formulary Committee from accepting gifts or professional samples from manufacturers. Members would also have been prohibited from being employees or agents of manufacturers or distributors.

The bill, supported by the Senior Federation, was heard in the Senate Health and Family Security Committee but was not heard in the House.

Prescription Information Confidentiality Required

(H.F. 4082 – Laine/S.F. 3699 – Doll)

This bill would have prohibited the sale of prescription records by any pharmacy benefits manager, insurance company, pharmacy or any other entity for commercial purpose including marketing, advertising, promotion or any activity aimed at evaluating prescribing behaviors or sales force effectiveness.

The bill was passed without recommendation by the Senate Health, Housing and Family Security Committee. It did not receive hearings in subsequent committees to advance and was not heard in the House.

Stem Cell Research

Chapter 357 – Vetoed

(H.F. 34 – Kahn/S.F. 100 – Cohen)

This bill would have created a state policy in support of stem cell research and explicitly allowed state funds to be used for stem cell research. The policy stated that research involving the derivation and use of human embryonic stem, germ and adult stem cells would be permitted, but it required a health care provider treating a patient for infertility to provide the patient with sufficient information to allow the patient to make an informed decision, based on the options presented, to discard, store or donate remaining embryos. The sale of embryonic or cadaveric fetal tissue for research purposes and the cloning of a human being were explicitly prohibited in this bill.

This bill passed the House and Senate but was vetoed by the Governor.

Section XI **Public Health**

Alcohol Tax

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

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

doubled the special gross receipts tax rate on retail sales of alcoholic beverages from 2.5 percent to 5 percent.

The bill did not receive a hearing in either body.

Child Passenger Restraint/Booster Seats

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

This bill would have increased the number of children using booster seats in cars by raising the age required for children to be in a proper restraint system in a motor vehicle from under the age of four to under the age of eight. Violation of this law would have been a petty misdemeanor. Fines collected for violations would have been allocated to a new Minnesota child passenger restraint and education account.

This provision passed the full Senate as part of the Senate Omnibus Transportation Policy Bill (SF3233) but was removed during final negotiations on the conference committee report.

Omnibus Public Health Bill

Chapter 301 – Vetoed

(H.F. 934 – Clark/S.F.651 – Marty)

Chapter 301 included a number of health-related bills. First, the bill would have banned the manufacture or sale of products that use a flame retardant chemical called commercial decabromodiphenyl ether. This product is often used for televisions, mattresses and textiles.

The act also included provisions related to doula services, S.F. 2825/H.F.3769 (Pappas/Laine). It would have amended the Patient's Bill of Rights to state that every patient receiving maternity care has the right to continuous support from a doula of her choice, in addition to her family, during her stay at the facility, so long as the doula performs services within an accepted scope of practice and the hospital's standard of care. The bill would have allowed a hospital to exclude a doula that has violated an accepted scope of practice or the hospital's standard of care. Additionally, physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women would have been required to include as part of their prenatal education, information regarding all methods of pain relief, including evidence-based nonpharmacological methods.

The chapter also included H.F.2100/S.F.1858 (Clark/Rummel), banning phthalates, a chemical used to make plastics pliable, from use in children's products.

The bill was vetoed by the Governor.

Physical Education Standards in School

(S.F. 3526 – Torres Ray/H.F. 3865 – Murphy, E.)

This bill would have amended the state standards for academic subjects for K-12 education by adding nutrition education as a requirement and requiring the commissioner of education to convene an advisory council to develop recommendation for a statewide curriculum standard for health, nutrition and physical education. The bill reflects an effort to compromise about earlier proposals to mandate physical education in high schools.

This bill was supported by the MMA, Minnesota Chapter - American Academy of Pediatrics, American Heart Association and many others as part of the Minnesota for Healthy Kids Coalition. Physical education in schools is one way to tackle childhood obesity in Minnesota. Although many school districts still require some physical education, Minnesota law no longer requires that a student take health or physical education in order to graduate from high school.

This provision was included in the Education Policy Omnibus Bill (S.F. 3001). The bill passed both the House and Senate but was vetoed by the Governor.

Seat Belt as a Primary Offense

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

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

The language in this bill passed as part of the Senate Omnibus Transportation Policy Bill (S.F. 3223) and although it was included in early versions of the conference report, it was removed during final negotiations. Supporters attempted to amend the measure to another transportation bill on the House floor, but the amendment was ruled out of order.

Smoking Allowed in Private Clubs and Bars with Ventilation Systems

(H.F. 4032 – Howes/S.F. 3727 – Skoe)

This bill would have provided for a broad roll-back of the 2007 Freedom to Breathe Act, enacting nearly all exceptions previously rejected including ones for private clubs, for bars and for smoking rooms with ventilation. The bill would have allowed smoking during adult-only periods at private clubs such as VFWs, American Legions, bingo halls, and country clubs and in restaurant and liquor establishments with alcoholic beverage sales higher than 50 percent of total gross sales. For establishments with liquor sales below 50 percent total gross sales, smoking

could be permitted in separate and enclosed rooms with an HVAC ventilation system. Establishments where smoking is permitted would have been required to post standard signs at entrances.

The bill did not receive a hearing in either body.

Smoking Exemption Removed for Locked Psychiatric Facilities

(H.F. 2587 – Huntley/No Senate File)

This bill would have removed an exemption in the Clean Indoor Air law passed as part of the Freedom to Breathe Act, which allows patients in locked psychiatric units with separate ventilated areas to smoke if, in the opinion of the treating physician, the benefits to be gained in obtaining patient cooperation with treatment outweigh the negative impacts of smoking.

Following concerns the bill could serve as a vehicle for efforts to erode the Freedom to Breathe Act, the bill did not receive a hearing.

Smoking Shelters Allowed Outdoors

(H.F. 4144 – Heidgerken/No Senate File)

This bill would have amended the Freedom to Breathe Act to allow smoking in structures located outside any establishment covered by the Clean Indoor Air Act, including bars and restaurants. It would have prohibited employees of the establishment from serving food or beverages to persons in the shelter.

Although the bill was introduced too late for a hearing, the language was amended on the Omnibus Supplemental Budget Bill (H.F. 1812) during House floor debate in the middle of the night. Although the amendment was described as only a provision to allow for shelter from rain, wind and snow, the actual language went far beyond that. The MMA opposed the change because it would have allowed bars, restaurants and virtually any employer to build a smoking room so long as it was outside the perimeter of the existing structure.

The language was not included in the final report from the Budget Conference Committee. The stand alone bill did not receive a hearing in either body.

Section XII

Scope of Practice

Athletic Trainer Licensing Modification

(H.F. 2399 – Thissen/S.F.2336- Prettner Solon)

This bill would have made changes to the Athletic Trainer Practice Act to recognize new accredited programs, shorten the temporary registration period from one year to six months, and allow a three-month grace period for new athletic trainers to obtain a physician-signed protocol so long as the primary employment site was monitoring the practice of the trainer. The controversial parts of the bill would have allowed treatment and evaluation in a corporate setting and changed the word “athlete” to “patient” throughout the practice act. The latter two provisions were opposed by occupational therapists and physical therapists.

Physician groups including the Minnesota Medical Association did not oppose the bill because athletic trainers must practice under a signed protocol with a licensed physician and are governed by the Board of Medical Practice. The Board of Medical Practice was also neutral on the change.

The bill received a hearing in the House Licensing Subcommittee but failed to pass on a tie vote.

Chiropractic Scope of Practice Expanded

(H.F. 3501 – Thao/S.F.3240- Koering)

This bill would have greatly expanded the scope of practice of chiropractors, beyond what many believed they were trained to do. The bill would have changed the definition of chiropractic to allow any treatment taught in accredited chiropractic educational institutions. Currently, “chiropractic” is defined as the science of adjusting abnormal articulations of the human body, especially those of the spinal column, for the purpose of giving freedom of action to impinged nerves that may cause pain for deranged function.

The bill was introduced late in session and did not receive a hearing in either body.

Complementary and Alternative Health Care Client Bill of Rights Amended

(S.F. 3417 – Papas/H.F.3802 - Ruud)

This bill would have amended the client bill of rights requirements for unlicensed complementary and alternative health care practitioners. Existing law requires all unlicensed complementary and alternative health care practitioners to post and provide to each client, prior to providing treatment, a written copy of the complementary and alternative health care client bill of rights. Complementary and alternative health care practitioners employed by or serving as

volunteers in a hospital or hospice who provide services to a client in a hospital or under an appropriate hospice plan of care would have been exempt from the requirement under the bill. Instead, it would have required that patients receiving complementary and alternative health care services in an inpatient hospital or under an appropriate hospice plan of care be made aware of the right to file a complaint with the hospital or hospice provider through which the practitioner is employed or registered as a volunteer.

The bill passed the full Senate but did not receive a hearing in the House.

Laboratory Technician Licensure

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

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

The Minnesota Society of Pathologists expressed concerns about the bill. The bill was scheduled to be heard in the House Licensing Subcommittee but was removed from the agenda due to a lack of votes for passage.

Laser Use for Medical Treatment Regulated

(H.F. 3937 – Ruud/S.F. 3625 – Marty)

This bill would have regulated the use of lasers within the practice of medicine. Treatment with a laser, intense pulsed light device, and radio frequency device for ablative and nonablative use would have been restricted to physicians for the purpose of treating a medical condition. Performance of nonablative treatments would have been restricted to providers meeting specified training requirements and observing delegation agreements with physicians as defined by the bill.

The legislation was initiated by the Minnesota Dermatological Society to address concerns about patient safety particularly related to laser treatment for cosmetic procedures and laser eye surgery.

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

Psychologists Scope of Practice Expanded

(H.F. 3251 – Murphy, E./S.F. 3416 – Erickson Ropes)

This bill would have expanded the scope of practice for psychologists to allow them to discuss prescription or nonprescription medications and their effects with clients. Licensed psychologists would also have been able to discuss specific medications by trade, name and dosage and discuss the discontinuation of medications with their clients. Psychologists argued the bill reflects competencies now taught in educational programs.

The Minnesota Psychiatric Society opposed the bill. The prescription and management of pharmaceutical treatment for mental health conditions, and the high level of training required to do so, is a chief distinguishing factor between psychiatrists and psychologists. This legislation could have resulted in a psychologist recommending the discontinuation of medication without the authority to prescribe an alternative therapy.

The bill did not receive a hearing in either body.

Section XIII **Third-Party Payers**

County-Based Purchasing

Chapter 359 – Vetoes

(H.F. 2748 – Liebling/S.F.3199 – Lynch)

Chapter 359 would have instituted contract oversight for rural health cooperatives and modified the assignment of enrollee choice for the Prepaid Medical Assistance Program (PMAP) to establish the county-based purchasing plan as the default assignment for individuals over the age of 65 residing in Olmsted, Winona, Houston, Fillmore, and Mower counties.

The bill was vetoed by the Governor.

High Deductible Health Plans: Preventative Coverage

(H.F. 111 – Loeffler/S.F. 2229 – Olson)

This bill would have promoted preventive health care by requiring high-deductible health plans used in combination with a health savings account to cover preventive care without a deductible, co-payment or other patient-sharing. It was based on studies showing that covering preventive services is cost effective.

Following failure to pass the bill off the House floor in 2007, the bill was returned to the House Committee on Commerce and Labor. The committee again passed the bill, but it was not brought up for a vote on the House floor.

Medical Interpreter Services

(H.F. 1077 – Ruud/S.F. 827 – Higgins)

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

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

The Minnesota Chamber of Commerce and the Minnesota Council of Health Plans continue to oppose the legislation. As a result, the bill was not heard in either the House or Senate. Instead the legislature passed a provision developing a registry of interpreters and beginning the process to institute quality standards. This registry provision, also included in H.F.3592/S.F.3423, was passed as part of H.F. 1812, the Omnibus Supplemental Budget Bill.

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MINNESOTA CAPITOL INFORMATION

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

General Information

House Information: 651/296-2146
800/657-3550

Senate Information: 651/296-0504
888/234-1112

To order copies of bills

Chief Clerk of the House: 651/296-2314

Secretary of the Senate: 651/296-2344

Committee Information

(24-hour hotline)

House: 651/296-9283

Senate: 651/296-8088

Information about bills

(With or without bill numbers)

House Index: 651/296-6646

Senate Index: 651/296-2887

Governor Tim Pawlenty's Office

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FAX Numbers

House (DFL): 651/296-4165

House (R): 651/296-3949

Senate (DFL): 651/296-6511

Senate (R): 651/296-9441

Legislative Information Via the Internet

Minnesota Legislature Home Page:
www.leg.state.mn.us

MINNESOTA STATE AGENCIES

Department of Human Services

MinnesotaCare and Medicaid Questions
Commissioner: Greater Minnesota:
Cal Ludeman 651/431-2907

Medicaid Director: Metro Area:
Christine Bronson 651/431-2914

Department of Revenue

Provider Tax questions:
Michal Garber, Attorney 651/296-8231

Department of Health

Commissioner:
Sanne Magnan, M.D. 651/201-5810

Health Plan Regulation:
James Golden 651/201-4819

Department of Commerce

Commissioner:
Glenn Wilson 651/296-6025

Insurance Regulation:
John Gross 651/297-2319

Office of Rural Health

Rural Health Issues
Director:
Mark Schoenbaum 651/201-3859

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.

Federal Sites

ADMINISTRATIVE AGENCIES

Centers for Disease Control	www.cdc.gov/
Federal Drug Administration	www.fda.gov/
Centers for Medicare & Medicaid Services	www.cms.gov/
Office of Inspector General	www.dhhs.gov/progorg/oig
U.S. Census Bureau	www.census.gov/
U.S. General Accounting Office	www.gao.gov/

CONGRESS

Legal Links	www.compasscomputer.com/legal.htm
Library of Congress	www.loc.gov/
Thomas: Legislative Inf. 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/