MNASCA

Minnesota Ambulatory Surgery Center Association

2024 Legislative Session Summary

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Session Overview

The 2024 legislative session started February 12 due to the Legislature's need to manage their legislative days. Each biennium the Minnesota Legislature is allotted 120 days to meet. During the 2023 session, they used 77 of their 120 legislative days, leaving 43 days to meet on the floor during the 2024 session.

The week before the start of the session, Senate Majority Leader Kari Dziedzic (DFL-Minneapolis) announced her cancer had returned, and she was stepping down from her leadership role to focus on her health. Senator Erin Murphy (DFL-St. Paul) was elected by the Caucus to serve as the new Senate Majority Leader. Senator Murphy served as the Chair of the State and Local Government and Veterans Committee during the 2023 session and named Senator Dziedzic as the new chair of the committee. Vice Chair Nicole Mitchell (DFL-Woodbury) ended up running many of the State and Local Government and Veterans Committee hearings as Senator Dziedzic was forced to participate remotely due to health complications.

The House also dealt with membership changes when former Speaker of the House Representative Kurt Daudt (R-Crown) announced his intent to resign effective February 11, 2024, to take a new job. Representative Daudt's resignation meant his seat was vacant on the first day of the session (February 12) until April 2, 2024. The resignation led the Governor to call for a special election and on March 19, Bryan Lawrence, a cattle farmer, businessperson, and former local politician in Baldwin Township was elected.

Early in the session, the Office of Minnesota Management and Budget (MMB) announced in their February Forecast that the biennium was projected to end with a surplus of $3.715 billion, and if the legislature did not spend that surplus, the next biennium would end with a surplus of $2.237 billion. However, MMB cautioned if the legislature spent the entire current surplus, there would be the potential of a $1.48 billion structural imbalance for FY26-27. Following MMB's caution related to spending, Governor Walz presented supplemental budget recommendations just shy of $200 million for FY24-25. After Governor Walz released his proposed supplemental budget, leadership in the House and Senate met with the Governor to create global spending targets which were agreed upon and announced on March 22; the agreement proposed spending $477.5 million of the surplus.

This session committee deadlines were different than previous years. Normally there are three separate deadlines, the first two for policy bills and the third for finance bills. In an unpopular move the first and second deadlines were combined and set for March 22, 2024 with the third committee deadline scheduled for April 19, 2024. Deadlines were not the only thing outside of the norm this year as the session included three legislative breaks. While past sessions saw a one-week break taking place over Easter, this year the legislature took three shorter breaks during Eid, Easter, and Passover.

During the legislative break for Passover, Monday April 22, Senator Nicole Mitchell (DFL-Woodbury) was arrested in Detroit Lakes, Minnesota and booked into the Becker County Jail on first-degree burglary charges. Senator Mitchell returned to the Capitol to the dismay of her

colleagues, constituents, and the public. She was ultimately relieved of her committee assignments, ousted from attending Senate DFL Caucus meetings, and was the subject of an ethics complaint with the Senate Rules Committee's Subcommittee on Ethics. A preliminary hearing was held, and the Subcommittee decided it would reconvene on the issue after Senator Mitchell's next court hearing, scheduled for June 10, 2024.

Senator Mitchell continued to vote with DFL members on the floor for the rest of session. Senate Republicans called for Mitchell's expulsion from the Senate almost daily and made many motions to try to remove the Senate DFL's 34 vote which would have left the Senate tied with 33 Democrats and 33 Republicans serving in the body.

The last week of session was hectic with vehicle bills being added to calendars, conference committees meeting and gaveling in for the first time with behind-the-scenes agreements presented, and all-night floor sessions. The final day and night of session saw an epic meltdown when both the House and Senate leaders made motions to "move the previous question". Under Mason's Manual of Legislative Procedure, that is a non-debatable, non-amendable procedural tool that had not been used in over fifteen years in the Minnesota Senate and five years in the Minnesota House of Representatives. It allows the individual calling the question to close debate, preventing the movement of any amendment or any other subsidiary motion, and demands an immediate vote on the issue before the body. This was how the chambers passed a final tax and catch-all omnibus bill, described below, in seven minutes in the House and ten minutes in the Senate. An attempt was made using the same procedural motions fifteen minutes before midnight to pass an all-cash bonding bill. The bill passed the House but not the Senate.

At 9:45 pm on the final day of the session, the Tax Conference Committee met to adopt a delete-everything (DE) amendment and the A24 amendment. The DE amendment was nearly 1,500 pages, and included all the language found in the following omnibus bills that had yet to pass both the House and Senate:

- HF5242: Transportation, Housing, and Labor Finance and Policy
- HF4247: Health Scope of Practice Bill
- HF4024: Higher Education Finance and Policy
- HF2609: Increased Penalties for Firearm Straw Purchases and a Ban on Binary Triggers
- SF4942: Energy and Agriculture Finance and Policy
- SF5335: Human Services Finance
- SF4699: Health and Human Services Finance
- HF5363: Paid Family Medical Leave Fix Bill

The final "Tax Conference Committee Report" included twenty-nine pages of tax provisions, which were included in the A24 amendment. The amendments were adopted, and the report passed out of the Conference Committee with Senator Weber (R-Luverne) raising concerns about the lack of process and transparency. This final hearing took a total of eight minutes.

Quickly thereafter the Tax Conference Committee Report was brought to the House Foor. Majority Leader Long (DFL-Minneapolis) announced a brief overview of the contents of the report and Speaker Hortman (DFL-Champlain) made a motion to bypass debate by calling the

question. Hard copies of the bill were not available to members and while it appeared to be posted online for the public to see, it was almost impossible to download and review. With fifteen hands raised to second the Speaker's motion and many Republican members speaking to gain the Speaker's attention, the House floor erupted in pandemonium. Members of the Republican Caucus were yelling about process, offering motions, and shouting other frustrations, with one voice referring to the bill as: Grand Theft Omnibus. The bill passed despite the vocal objections of the minority. After the final vote on the report, Majority Leader Long moved a recess of the House.

A few minutes following the House's recess a remarkably similar series of events followed on the Senate Floor. In the Senate, the members of the GOP Caucus began trying to get the attention of President Bobby Joe Champion (DFL-Minneapolis). Senator Rest (DFL-Golden Valley) made a motion to present the Tax Conference Committee Report and Senate DFL Leadership called the question. President Champion was not able gavel the Senate to recess after the Tax Conference Committee Report passed due to significant yelling, motion making, and chanting to prevent him from taking control and allowing other bills to reach the Senate Floor. The yelling lasted for thirty minutes.

The House returned from its recess and passed a $71 million all-cash bonding bill in the final minutes of session. The process to pass the cash bonding bill was remarkably like the rapid processing of the Tax Conference Committee Report. The Majority Leader quickly called the question, Republicans yelled their concerns and made motions that were ignored, and the bill passed and was sent to the Senate. There were only minutes left on the clock for the Senate to process the bill. Senate Republicans made motions to adjourn and points of parliamentary inquiry that were not recognized by the Senate President. Unable to control the motion-making minority, President Champion did not close the roll and secure a final vote on the cash bonding bill before the clock struck midnight—when the legislature can no longer pass bills. Although the Senate DFL had the votes, the bill did not pass.

Despite the hectic end to session, there were a number of items that passed, including a law to protect Transportation Network Company drivers and preempt the Minneapolis City Council's policy that would have forced Uber and Lyft out of the Twin Cities and surrounding areas. They also passed laws providing emergency funding for Emergency Medical Service providers, banning junk fees, establishing energy infrastructure permitting reforms, and increasing penalties for firearm straw purchasers.

Looking Ahead

It is an election year with a 2024 presidential election rematch between Republican presidential candidate and former President Donald Trump and Democrat presidential candidate and incumbent President Joe Biden. In Minnesota, this year's ballot will also include a U.S. Senate seat, all the United States House of Representatives, the Minnesota State House of Representatives, and Judicial races. Minnesota State Senators are not up for reelection until 2026. Candidate filings open May 21, and close June 4, at 5 pm. The primary election is Tuesday, August 13 and the general election is on November 5.

Senator Kelly Morrison, DFL-Deephaven, is running for Minnesota's Third Congressional District. This seat is currently held by U.S. Representative Dean Philips, who ran for the Democratic Nomination for President earlier this year. Senator Morrison's Senate term ends in 2026, and she will need to step down from her state Senate seat if she wins the Congressional seat. A special election will decide her replacement. She is expected to resign from the Minnesota Senate this summer to allow the Senate District 45 seat to be on the general election ballot this November.

All 134 Minnesota State House of Representative seats are up for re-election this year. To have a majority, a party needs 68 seats. Currently, the DFL holds the majority by a margin of 70-64. Twenty sitting members have announced they are not seeking re-election.

The 2025 legislative session begins January 14, 2025, and the legislature will need to adopt a budget for the upcoming biennium.

Budget Targets

Joint Budget Targets 2024 Session

Supplemental Budget

General Fund, Dollars in Thousands

		FY 2024-25	FY 2026-27
6	Agriculture	4,545	2,576
7	Capital Investment	40,000	0
8	Children and Families	34,370	24,780
9	Climate and Energy	1,000	0
10	Commerce	(5,499)	1,738
11	Economic Development	1,000	0
12	Education	43,000	18,050
13	Elections	500	200
14	Environment and Natural Resources	17,000	0
15	Health	4,500	5,000
16	Higher Education	500	0
17	Housing	10,000	1,000
18	Human Services	42,130	14,860
19	Judiciary	36,000	3,000
20	Labor and Industry	1,000	0
21	Legacy	0	0
22	Public Safety	17,900	14,220
23	State and Local Government	2,500	0
24	Tax Aids & Credits	53,000	5,230
25	Transportation	2,000	0
26	Veterans and Military Affairs	0	0
27	Workforce Development	0	(4,000)
28			
29			
30	*Other Items*		
31	Claims Bill	200	0
32	Educator Pensions	31,458	0
33	Emergency Medical Services	16,000	0
34	Net Operating Loss - HF 3769	14,800	0
35	School Safety Center - Laws 2024, Chapter 78	640	980
36	Tyler Settlement	109,000	(26,727)
37	Inflation Estimate	0	1,836
38			
39	**Total Spending**	**477,544**	**62,743**

2023-2024 Legislative Retirements

DISTRICT	BODY	PARTY	NAME	NOTE
01B	House	R	Debra Kiel	R-Lead on Human Services Policy
02A	House	R	Matt Grossell	
08A	House	DFL	Liz Olson	Chair of Ways and Means
16A	House	R	Dean Urdahl	R-Lead on Capital Investment
19A	House	R	Brian Daniels	R-Lead on Children and Families
19B	House	R	John Petersburg	R-Lead on Transportation Finance and Policy
22B	House	R	Brian Pfarr	
26A	House	DFL	Gene Pelowski	Chair of Higher Education
28B	House	R	Anne Neu Brindley	R-Lead on Human Services Finance
35B	House	DFL	Jerry Newton	Chair of Veterans Affairs
38A	House	DFL	Michael Nelson	Chair of Labor and Industry Finance and Policy
40B	House	DFL	Jamie Becker-Finn	Chair of Judiciary and Civil Law
41B	House	R	Shane Hudella	
49A	House	DFL	Laurie Pryor	Chair of Education Policy
58B	House	R	Pat Garofalo	R-Lead on Ways and Means
61A	House	DFL	Frank Hornstein	Chair on Transportation Finance and Policy
62B	House	DFL	Hodan Hassan	Chair on Economic Development Finance and Policy

Legislators Running for Other Offices

DISTRICT	BODY	PARTY	NAME	NOTE
41A	House	R	Mark Wiens	Running for Washinton County Commissioner District 3.
45	Senate	DFL	Kelly Morrison	Running for Minnesota's Third Congressional District (Dean Phillips seat). Note her Senate term does not end until November 2026.
50A	House	DFL	Heather Edelson	Running for Hennepin County Commissioner District 6.

Legislators Who Retired Early

DISTRICT	BODY	PARTY	NAME	NOTE
27B	House	R	Kurt Daudt	Resigned effective February 11. Brian Lawrence was elected to serve the remaining part of Rep. Daudt's term.
52B	House	DFL	Ruth Richardson	Resigned effective September 2023 causing a special election Fall of 2023. Bianca Virnig was elected to complete Rep. Richardson's term.

Health Care Legislation

Omnibus Health and Human Services bill – PASSED
HF 4571 (Liebling)/SF 4699 (Wiklund)
Effective Date: Various
View the Health and Human Services Conference Committee Report
Chapter 127

The Omnibus Health and Human Services Finance and Policy Conference Committee met for the first time publicly after 6:00 pm on the final day of the 2024 legislative session. The language from the Health and Human Services Omnibus Finance and Policy Conference Committee report was folded into the final Omnibus Tax Conference Committee report (see HF 5247/SF 5234).

Notable Health and Human Services Finance provisions:

- $2,036,000 for the Central Office: Behavioral Health, Deaf and Hard of Hearing, Housing Services
- $7,350,000 for Child Mental Health Grants
- $210,000 in Stillbirth Prevention Grants
- $191,000 for Reports on Prior Authorization Requests
- $100,000 for Insulin Safety Net Programs
- $2,330,000 for information technology to implement federal Deferred Action for Childhood Arrivals regulatory requirements

Significant Health and Human Services Policy provisions:

- Prior authorization reform (see summary below for details)
- Requires that health plans provide coverage for abortion-related services, including pre-abortion services and follow-up services
- Requires health plans covering orthotic & prosthetic care
- Requires medical assistance to cover whole genome sequencing testing
- Defines physician wellness program and clarifies that any record of a person's participation in such a program is confidential and not subject to discovery, subpoena, or a reporting requirement to the physician's applicable board
- Requires the Commissioner of Health to provide a report to the legislature on all 340B entities who's net 340B revenue constitutes a significant share of all net 340B revenue across all 340B covered entities in Minnesota
- Establishes a Health Professional Workforce Advisory Council within the Minnesota Department of Health
- Requires the Commissioner of Health to publish a Request for Information (RFI) to assist the Commissioner in a future comprehensive analysis of statewide healthcare needs, capacity, and projections of future healthcare needs in Minnesota
- Requires Health Maintenance Organizations (HMO) oversight by Minnesota Department of Health (MDH)
- Prohibits HMOs from being for-profit entities
- Prohibits nonprofit health coverage entities from performing certain conversion transactions
- Lowers the cost a provider may require a patient to pay to retrieve the patient's record for purposes of reviewing medical records

Prior authorization reform – PASSED
Prior authorization reforms in the mega-omnibus bill include:

- Health carrier may not retroactively deny services for which prior authorization (PA) was not required by the health carrier
- Health plans cannot deny coverage for a service an enrollee already received solely because of a lack of PA if the service would have been covered had PA not been obtained

Prior authorization will no longer be required for:

- Outpatient substance use disorder or outpatient mental health treatment (except for treatment which is a medication)
- Antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network
- Services currently rated A or B by the United State Preventative Services Taskforce and recommended by the Advisory Committee on Immunization Practices (CDC)
- Pediatric hospice services
- Treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care specialist
- Treatment for a chronic condition

The bill states:

An authorization for treatment of a chronic health condition does not expire unless the standard of treatment for that health condition changes. A chronic health condition is a condition that is expected to last one year or more and:
(1) requires ongoing medical attention to effectively manage the condition or prevent an adverse health event; or
(2) limits one or more activities of daily living.

The Prior Authorization reform provisions are effective January 1, 2026, for plans offered, sold, issues, or renewed on or after that date. There is a new requirement for URO, Health Plan Companies, and Claim Administrators to have and maintain a PA application programming interface (API) that automates the PA process for healthcare services. This requirement goes into effect on January 1, 2027.

The bill states:

For health benefit plans offered, sold, issued, or renewed on or after 1/1/2027, utilization review organizations, health plan companies, and claims administrators must have and maintain a prior authorization application programming interface (API) that automates the prior authorization process for health care services, excluding prescription drugs and medications. The API must allow providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from provider electronic health records or practice management systems. The API must use the Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR) standard in accordance with Code of Federal Regulations, title 45, section 170.215(a)(1), and the most recent standards and guidance adopted by the United States Department of Health and Human Services to implement that section. Prior authorization submission requests for prescription drugs and medications must comply with the requirements of section 62J.497.

Included in the bill was a Clinical Criteria Change, meaning prior authorization does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical

guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to previously unknown and imminent patient harm.

On or before September 1 each year, each utilization review organization must report to the Commissioner of Health, in a form and manner specified by the commissioner, information on prior authorization requests for the previous calendar year. The report submitted under this subdivision includes the following data:

> **ANNUAL REPORT TO COMMISSIONER OF HEALTH; PRIOR AUTHORIZATIONS.**
> On or before September 1 each year, each utilization review organization must report to the commissioner of health, in a form and manner specified by the commissioner, information on prior authorization requests for the previous calendar year. The report submitted under this subdivision must include the following data:
> (1) the total number of prior authorization requests received;
> (2) the number of prior authorization requests for which an authorization was issued;
> (3) the number of prior authorization requests for which an adverse determination was issued;
> (4) the number of adverse determinations reversed on appeal;
> (5) the 25 codes with the highest number of prior authorization requests and the percentage of authorizations for each of these codes;
> (6) the 25 codes with the highest percentage of prior authorization requests for which an authorization was issued and the total number of the requests;
> (7) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued but which was reversed on appeal and the total number of the requests;
> (8) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued and the total number of the requests; and
> (9) the reasons an adverse determination to a prior authorization request was issued, expressed as a percentage of all adverse determinations. The reasons listed may include but are not limited to:
> (i) the patient did not meet prior authorization criteria;
> (ii) incomplete information was submitted by the provider to the utilization review organization;
> (iii) the treatment program changed; and
> (iv) the patient is no longer covered by the health benefit plan.

Physician wellness programs and confidentiality – PASSED
This new law addresses physician burnout and wellbeing by protecting confidentiality and providing civil liability immunity for physician wellness programs. It specifically:

- Defines a "physician wellness program" as a program to address career fatigue, wellness, or work stress issues for licensed physicians, administered by a statewide association representing physicians and osteopaths of multiple specialties
- Mandates that records of a person's participation in such a physician wellness program are confidential and not subject to discovery, subpoena, or reporting requirements to the applicable licensing board, unless the person provides written consent or is obligated to report under the state's mandatory reporting law
- Grants civil liability immunity to any person, agency, institution, facility, or organization operating a physician wellness program for actions related to their duties when acting in good faith

340B covered entity report modifications – PASSED
The federal 340B Drug Pricing Program enables qualified healthcare providers, known as "covered entities," to obtain discounted prices on outpatient prescription drugs. In 2023, the Minnesota Legislature mandated that all 340B covered entities must submit annual reports to the Commissioner of Health by April 1, 2024. The new law required the Commissioner to compile an aggregated report and present it to the Legislature by November 15, 2024. In the 2024 session, the legislature modified these reporting requirements to streamline the reporting process.

The recent changes will also help address Medicaid losses by giving providers the flexibility to work with more than one pharmacy.

Abortion coverage required – PASSED
Includes mandatory insurance coverage for abortions and abortion-related services.

Orthotic & prosthetic coverage required – PASSED
Establishes comprehensive requirements for health plans to cover orthotic and prosthetic devices, supplies, and services.

Rapid whole genome sequencing coverage – PASSED
Mandates health plans to cover rapid whole genome sequencing under specific conditions.

Health professions workforce advisory council created – PASSED
Requires the Minnesota Commissioner of Health to collaborate with the University of Minnesota and the Minnesota State HealthForce Center of Excellence to provide recommendations to the legislature for establishing a health professions workforce advisory council.

DIRECTION TO COMMISSIONER OF HEALTH; HEALTH PROFESSIONS WORKFORCE ADVISORY COUNCIL.

Subdivision 1. Health professions workforce advisory council. The commissioner of health, in consultation with the University of Minnesota and the Minnesota State HealthForce Center of Excellence, shall provide recommendations to the legislature for the creation of a health professions workforce advisory council to:
(1) research and advise the legislature and the Minnesota Office of Higher Education on the status of the health workforce who are in training and on the need for additional or different training opportunities;
(2) provide information and analysis on health workforce needs and trends, upon request, to the legislature, any state department, or any other entity the advisory council deems appropriate;
(3) review and comment on legislation relevant to Minnesota's health workforce; and
(4) study and provide recommendations regarding the following:
(i) health workforce supply, including:
(A) employment trends and demand;
(B) strategies that entities in Minnesota are using or may use to address health workforce shortages, recruitment, and retention; and
(C) future investments to increase the supply of health care professionals, with particular focus on critical areas of need within Minnesota;
(ii) options for training and educating the health workforce, including:
(A) increasing the diversity of health professions workers to reflect Minnesota's communities;
(B) addressing the maldistribution of primary, mental health, nursing, and dental providers in greater Minnesota and in underserved communities in metropolitan areas;
(C) increasing interprofessional training and clinical practice;
(D) addressing the need for increased quality faculty to train an increased workforce; and
(E) developing advancement paths or career ladders for health care professionals;
(iii) increasing funding for strategies to diversify and address gaps in the health workforce, including:
(A) increasing access to financing for graduate medical education;
(B) expanding pathway programs to increase awareness of the health care professions among high school, undergraduate, and community college students and engaging the current health workforce in those programs;
(C) reducing or eliminating tuition for entry-level health care positions that offer opportunities for future advancement in high-demand settings and expanding other existing financial support programs such as loan forgiveness and scholarship programs;
(D) incentivizing recruitment from greater Minnesota and recruitment and retention for providers practicing in greater Minnesota and in underserved communities in metropolitan areas; and
(E) expanding existing programs, or investing in new programs, that provide wraparound support services to the existing health care workforce, especially people of color and professionals from other underrepresented identities, to acquire training and advance within the health care workforce; and

(iv) other Minnesota health workforce priorities as determined by the advisory council.
Subd. 2. Report to the legislature. On or before February 1, 2025, the commissioner of health shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and higher education finance and policy with recommendations for the creation of a health professions workforce advisory council as described in subdivision 1. The report must include recommendations regarding:
(1) membership of the advisory council;
(2) funding sources and estimated costs for the advisory council;
(3) existing sources of workforce data for the advisory council to perform its duties;
(4) necessity for and options to obtain new data for the advisory council to perform its duties;
(5) additional duties of the advisory council;
(6) proposed legislation to establish the advisory council;
(7) similar health workforce advisory councils in other states; and
(8) advisory council reporting requirements.

RFI for healthcare needs, capacity, and projections of future needs – PASSED
Requires the commissioner of health to publish a request for information to assist in conducting a future comprehensive evaluation of current health care needs and capacity in Minnesota.

HMO oversight by Minnesota Department of Health (MDH) – PASSED
Establishes requirements for the conversion of non-profit HMOs and gives the Commissioner of Health explicit authority to review and approve such transactions involving HMO assets.

For profit HMOs prohibited – PASSED
Blocks the Department of Human Services (DHS) from awarding contracts to for-profit HMOs and prohibits for-profit HMOs from contracting to provide state-paid health benefits to state employees.

Nonprofit health coverage entity transactions prohibited – PASSED
This new law imposes several requirements on conversion transactions of nonprofit health coverage entities to ensure that such transactions are conducted fairly and transparently and protect public benefit assets. It prohibits certain conversion transactions and includes valuation and notification requirements, as well as a 60-day waiting period and enforcement mechanisms.

Medical records cost (per patient request) – PASSED
Modifies the maximum charges for medical record requests and per page/retrieval charges.

Surgical smoke evacuation policies – PASSED
Requires healthcare providers to adopt and implement policies to prevent exposure to surgical smoke by requiring the use of a smoke evacuation systems during procedures that may produce surgical smoke. The law will take effect on January 1, 2025, making Minnesota the 18th state to enact surgical smoke evacuation legislation. Pushed at the state level primarily by the Association of periOperative Registered Nurses (AORN), the surgical smoke legislation passed as part of the Labor Policy Omnibus bill (SF 3852) (Chapter 110).

Medical debt requirements – PASSED
The medical debt compromise language negotiated by the bill authors (Rep. Reyer and Sen. Boldon), the Attorney General's Office, Legal Aid, health care providers and debt collection professionals was included in the Commerce Omnibus Bill (SF 4097/HF 4077) (Chapter 114). See below for a brief summary of the medical debt provisions:

- **Medically necessary treatments:** The definition is taken for CMS and is the treatment that is covered for medical debt.
- **Policy for collection of medical debt:** Healthcare providers must make available their policy for debt collection must be posted on website and provided to any individual who requests it.
- **Denial of health treatment or services due to outstanding debt:** We spent the most time negotiating this provision. The authors and advocates did not want to allow providers the ability to deny care so we had to sensitively negotiate a path where a provider could stop providing treatment if a patient was not communicating or paying on the outstanding debt. This language will allow a provider to require a patient enroll in a payment plan for outstanding medical debt. The payment plan must be reasonable and take into account information disclosed by the patient regarding their ability to pay. Before entering into the payment plan, a health care provider must notify the patient that if they are unable to make all or part of the agreed upon payments, the patient must communicate the patient's situation to the health care provider and must pay an amount the patient can afford. Thus, if the patient does not communicate with the provider and is not making payments, treatment can be stopped.
- **Billing errors:** If a health care provider or health plan company determines or receives notice that a treatment or service contains a billing error, they must review the bill and correct any errors. While the review is being conducted, the patient must not be billed. If the patient overpaid as a result of the review, a healthcare provider must refund the payment within 30 days following the review. If a health care provider or health plan company determines or receives notice of a billing error, they must notify the patient of the error, that a review will occur and that they will not be billed during the review. This notice must be transmitted to the patient within 30 days of notice of the billing error. The patient must also be notified of a completed review with a detailed explanation on how the errors were corrected or explain why the bill was not modified with relevant information and support. The notice must be transmitted to the patient within 30 days of a completed review.
- **Effective date:** These provisions are effective October 1, 2024
- **Additional debt collection provisions**:
    - Medical debt includes charges to a credit card that is primarily for medically necessary treatments (offered specifically for payment of health care services)
    - Prohibition from reporting medical debt to a consumer reporting agency
    - Attorney General enforcement
    - Spouse is not liable for medical debts of the other spouse
    - Update on collection and garnishments provisions

Licensure compacts – PASSED
HF 4247 (Liebling)/SF 4570 (Wiklund)
Effective Date: Various
View the Health Scope of Practice Conference Committee Report
Chapter 127

As a member of the Healthcare Workforce Support Policy Coalition, MNASCA supported licensure compacts as a way to streamline the licensure processes, ensuring high credentialing standards while reducing administrative burden for healthcare professionals. The mega-omnibus bill (HF 5247/SF 5234) passed on the final night of the session includes licensure compacts for:

- Physician assistants
- Occupational therapists
- Physical therapists
- Social workers
- Licensed professional counselors
- Audiologists and speech language pathologists
- Dentists and dental hygienists

Scope of practice changes – PASSED
HF 4247 (Liebling)/SF 4570 (Wiklund)
Effective Date: Various
View the Health Scope of Practice Conference Committee Report
Chapter 127

The Health Scope of Practice Omnibus Bill was initially intended to be included in the Health and Human Services Omnibus bill. Instead, a Conference Committee dedicated to Scope of Practice items was set up and met for the first, and only time, the Saturday before the end of the session. The Conference Committee Report received unanimous support in the Minnesota House of Representatives. The Senate did not have time to consider the bill, so the bill was included in the mega-amendment attached to the Tax Conference Committee report. The final bill included these scope of practice changes:

- Establishes registration for transfer care specialists
- Establishes licensure for behavior analysts
- Establishes licensure for veterinary technicians and a veterinary institutional license
- Modifies provisions of veterinary supervision
- Modifies specialty dentist licensure and dental assistant licensure by credentials
- Removes additional collaboration requirements for physician assistants to provide certain psychiatric treatment
- Modifies social worker provisional licensure
- Establishes guest licensure for marriage and family therapists
- Modifies pharmacy provisions for certain reporting requirements and change of ownership or relocation

These proposals were considered by the 2024 legislature but did not pass:

Public option language and funding – DID NOT PASS
While the House included language creating a public option health insurance system in their Omnibus Agriculture, Energy, and Commerce Finance and Policy bill (HF 4975/SF 4942), these provisions ultimately did not move forward.

Equitable Healthcare Services Commission – DID NOT PASS
A bill (SF 4346/HF 4046) that would have established a Minnesota Commission for Equitable Health Care Services to develop a plan to provide accessible, affordable health care services to all Minnesota residents was heard in the Senate State and Local Government Committee in early April but did not pass this year.

Private equity/real estate investment trust health care services prohibition – DID NOT PASS

This session, the legislature considered a proposal (HF 4206/SF 4392) to regulate the influence of private equity firms and real estate investment trusts (REITs) in the healthcare sector. The bill would have prohibited private equity companies and REITs from acquiring or increasing their operational, financial control, or ownership interests in specified healthcare providers operating within the state. While it did not pass in 2024, we expect the bill will be reintroduced next year.

Other Legislation of Interest to MNASCA

New EMS office and emergency EMS funding -- PASSED
HF 4738 (Huot)/SF 4835 (Seeberger)
Effective date: Various (see description for details)
View the bill summary | Chapter 122

The bill replaces the existing Emergency Medical Services Regulatory Board with a new agency called the Office of Emergency Medical Services. This office will oversee Minnesota's EMS network, taking over the responsibilities of the previous board on January 1, 2025. The legislation also allocates $24 million in emergency aid to support EMS providers in greater Minnesota and $6 million for a pilot program to improve EMS delivery in the Northeastern part of the state. The $24 million in one-time EMS provider aid will be certified and allocated to eligible providers by December 26, 2024.

Paid family and medical leave modifications – PASSED
HF 5363 (Frazier)/SF 5430 (Mann)
Effective Date: Various
View the bill summary | Chapter 127

This bill makes various technical, clarifying, and substantive changes to Paid Family and Medical Leave benefits under chapter 268B. The provisions included in the Tax Omnibus bill that passed on the final night of session:

- Rename Chapter 268B as the Minnesota Paid Leave Law
- Expand the definition of "child" to include children of a domestic partner and children that the covered employee may be a custodian of
- Clarify how covered individuals who have changed employers withing the base period are paid
- Establish one calendar day as the minimum increment of leave
- Clarify that an applicant is ineligible for leave benefits for any portion of a typical workweek for which the applicant is incarcerated or for which the applicant is receiving unemployment insurance benefits
- Create a robust appeals process that may be utilized by an employee or an employer
- Establish a reduced small employer premium rate for employers with 30 or fewer employees and with their employees' average wage is less than or equal to 150 percent of the state's average wage in covered employment
- Allow the Commissioner of Employment and Economic Development to adjust the annual premium rates based on program historical experience and sound actuarial principles
- Provide data privacy protections for data collected under the Minnesota Paid Leave Law

According to the Minnesota Chamber, DEED's bill proposes adjusting the payroll tax rate away from the original formula and basing it on routine actuarial analyses. Consequently, the payroll tax rate, set in last year's law at 0.7%, must rise to 0.88% in 2026 to accommodate their proposed changes and sustain the program, rising to at least 0.93% by 2029. The original actuarial analysis revealed significant discrepancies in the cost projections for the PFML program. The state initially allocated around $800 million for start-up costs, but actual expenses exceeded estimates by $628 million over the program's first three years.

Earned safe and sick time modifications – PASSED
The Labor and Industry Policy Omnibus bill, Chapter 110, expands employer obligations related to the Earned Sick and Safe Time law that passed in 2023. Changes adopted in 2024:

- Establish remedies if an employer does not provide earned sick and safe time
- Clarify that earned that volunteer firefighters, elected officials, and farmers do not qualify for Earned Sick and Safe Time
- Add the need to plan for or attend funeral services or a memorial or address financial or legal matters that arise after the death of a family member to the approved uses of sick time
- Clarify that sick and safe time may not be used in weather events

Disclosure of salary ranges in job postings – PASSED
The Labor and Industry Policy Omnibus bill, Chapter 110, requires employers that employ 30 or more employees in Minnesota to disclose in each posting for each job opening the starting salary range and a general description of all benefits and other compensation.

Worker misclassification provisions – PASSED
The Transportation, Labor and Housing Omnibus bill, Chapter 127, includes provisions addressing a practice known as worker misclassification which occurs when employees are wrongly labeled as independent contractors, denying them crucial benefits and protections. Key components include:

- Clearly defining criteria for who qualifies as an independent contractor
- Increasing penalties and fines for companies engaged in worker misclassification fraud
- Holding individuals and successor companies liable for violations
- Creating an inter-agency partnership to share data and coordinate enforcement efforts
- Establishing a new multi-part independent contractor test for building construction and improvement services

Prohibiting restrictive employment covenants in service contracts – PASSED
Effective July 1, 2024, provisions in the Labor and Industry Policy Omnibus bill, Chapter 110, prohibit service providers from including non-compete clauses in their customer contracts that restrict customers from hiring the service provider's employees, contractors, or other workers. Key provisions include:

- Service providers cannot enforce contract provisions that prohibit customers from soliciting or hiring their workers.
- Any such non-compete clauses will be considered void and unenforceable.
- Service providers must notify their workers of any existing non-compete clauses that violate the new law.

The ban does not apply to business consultants in computer software development and related services who are hired through a service provider with the intent of being hired by the customer at a later date. Existing contracts with non-compete clauses signed before July 1, 2024, are not subject to the new law.

Uber/Lyft agreement – PASSED
After prolonged negotiations, Governor Walz, DFL legislative leaders, Minneapolis officials, and the two largest ride-share companies, Uber and Lyft, reached a deal to establish statewide standards for ride-share drivers' pay and working conditions. The agreement, which averted the threat of service termination in Minnesota by the companies, was included in the Transportation, Labor and Housing Omnibus bill, Chapter 127, and will take effect on January 1, 2025.
Key provisions of the new law include:

- A wage floor which will increase driver pay by more than 14%
- Minimum pay for drivers statewide at $1.28 per mile and 31 cents per minute
- Requiring that drivers earn at least $5 per trip and are entitled to 80% of any cancellation fee if they have already left to pick up the rider
- Driver pay rates to increase each year with inflation
- Allowing drivers to appeal being fired or "deactivated" and ride share companies are required to review and make a determination of such a request within 30 days
- Requiring rideshare companies have insurance coverage for up to $1 million for drivers
- Prohibiting cities from enacting their own standards including pay, insurance, and data transparency

Local governments may still license Transportation Network Companies (TNCs) and can refuse or revoke licenses if a company is found to be in violation state law or local licensing requirements.

Cannabis licensing and policy changes – PASSED
The legislature passed significant updates to the recreational cannabis law enacted last year. These changes were included in the Cannabis and Commerce Omnibus Finance and Policy bill, Chapter 114, and address various aspects of cannabis regulation, licensing, and policy. Key provisions include:

- Establishing a lottery system to distribute licenses when the number of applicants exceeds the available licenses
- Allowing an individual seeking a cannabis license to apply for a license without having secured a physical premises for the business at the time of application
- Setting a maximum number of licenses the Office of Cannabis Management (OCM) may issue in each category for all applicants and for social equity applicants
- Requiring OCM to issue licenses to cities or counties seeking to establish municipal cannabis stores
- Expanding the list of qualifying medical conditions for medical cannabis prescriptions, including Alzheimer's disease, autism spectrum disorder, chronic pain, post-traumatic stress disorder, and others
- Permitting hemp growers to sell hemp plant parts to cannabis businesses
- Prohibiting the sale of lower-potency hemp edibles to visibly intoxicated individuals
- Removing the previous restriction on serving THC beverages and alcoholic drinks within five hours at bars and restaurants, aligning with standard intoxication rules
- Allowing retailers to sell cannabis infused beverages outside of the product's packaging.
- Enabling medical cannabis patients to assign a registered caregiver to cultivate plants on their behalf if unable to do so themselves, with a limit of eight plants per patient

Appendix:
Written Testimony

February 14, 2024

RE: SF 3532/HF 3578 – Prior Authorization Reforms

Dear Senator Morrison and Representative Bahner

Thank you for authoring legislation aimed at reforming the complex and excessively cumbersome prior authorization (PA) process. The Minnesota Ambulatory Surgery Center Association (MNASCA) and Healthcare Leaders Association of Minnesota (HLAMN formerly MMGMA) join other stakeholders, including the Minnesota Medical Association, the Minnesota Hospital Association, and many specialty clinics and provider groups in supporting SF 3532/HF 3578.

MNASCA, a statewide association representing Minnesota's Ambulatory Surgery Centers (ASCs), promotes high-quality, value-driven surgical services to provide the best possible care to patients. Healthcare Leaders Association of Minnesota is an organization of healthcare business leaders and executives who work together to improve the health status of the community and patients they serve. However, in recent years, the PA process has significantly hindered our members' ability to provide effective therapies to patients, consequently leading to compromised health outcomes in certain instances. As the legislature considers prior authorization reforms, we would like to highlight two critical issues with the existing PA system:

Prior authorization is time-consuming and overly burdensome. The current system requires doctors to jump through multiple hoops to obtain an insurer's approval before it will agree to pay for a prescription medication, medical test, or procedure. Prior authorization requirements and submission processes also vary widely among insurers, often requiring providers to expend valuable staff time and resources completing manual forms and furnishing additional information. Finally, our doctors are often working with insurer physicians who lack specialized knowledge of our surgery centers' specialties and recommended therapies and, therefore, do not have the expertise to make informed decisions regarding patient care.

Overuse of prior authorization is also harmful to patients. The PA review process frequently forces patients to wait days for insurers to issue approvals, and weeks or months to resolve denials. Minnesota doctors report that prior authorization has led to care delays, treatment abandonment, and even serious adverse events for patients.

Without legislative action, the overuse of prior authorization will continue to delay needed patient care, increase administrative costs, and contribute to physician burnout. MNASCA and HLAMN support legislative changes that will:

- Prohibit insurers from retrospectively denying coverage of a healthcare service for which prior authorization was not required by the health carrier.
- Require insurers to create and maintain an interface to streamline the prior authorization process and facilitate the exchange of information between providers and insurers.

- Prohibit prior authorization for critical services by expanding Minnesota Statutes 2022, section 62M.07, subdivision 2 to include additional services.
- Limit the use of prior authorization for chronic conditions to one-time only approvals.
- Require insurers to annually report prior authorization frequency, denial rates, and approval rates.
- Implement a "gold card" program for physicians attaining prior authorization approval rates exceeding the 70th percentile.

MNASCA and HLAMN greatly appreciate the legislature's consideration of these prior authorization reforms.

Sincerely,

Tracy Mills, President
Minnesota Ambulatory Surgery Centers Association

Melissa Larson, President
Healthcare Leaders Association of Minnesota

MNASCA

March 4, 2024

RE: HF 4100/SF 4065 Minnesota Debt Fairness

Dear Chair Stephenson, Vice Chair Kotyza-Witthuhn, Rep. Reyer, and Members of the Committee,

The Minnesota Ambulatory Surgery Center Association (MNASCA) is a statewide association representing Minnesota's ASCs in their commitment to delivering high-quality, value-driven surgical services and exceptional patient care. MNASCA appreciates the opportunity to comment on HF 4100 and Rep. Reyer's willingness to engage with stakeholders to address concerns with the bill as currently written.

We understand the underlying goals of the proposed legislation to clarify and modernize the debt collection process to better protect consumers. However, the legislation as drafted would make it excessively difficult for ASCs to recover debts for elective medical procedures. Our ASCs prioritize transparency by clearly informing patients about anticipated out-of-pocket expenses for elective surgeries. And if a patient has trouble covering a remaining balance, our centers work with them on a reasonable payment plan to avoid turning the outstanding bill over to a debt collection agency. This legislation would prevent providers from specifying the consequences of nonpayment and restrict who they may use to help recover debt. Significantly changing the debt collection process in these ways could have many unintended consequences for ASCs, including impacting access to elective surgical procedures for everyone.

We urge the committee not to make it even harder for Minnesota's ASCs to recover legitimate debts for elective procedures. We look forward to discussing the best ways to ensure Minnesota's collections process provides proper consumer protections, while balancing the need for these debts to be paid.

Sincerely,

Tracy Mills, President
Minnesota Ambulatory Surgery Centers Association

March 4, 2024

RE: SF 3532/HF 3578 – Prior Authorization Reforms

Dear Chair Klein, Vice Chair Seeberger, and Members of the Committee,

Thank you for hearing legislation aimed at reforming the complex and excessively cumbersome prior authorization (PA) process. The Minnesota Ambulatory Surgery Center Association (MNASCA) and Healthcare Leaders Association of Minnesota (HLAMN formerly MMGMA) join other stakeholders, including the Minnesota Medical Association, the Minnesota Hospital Association, and many specialty clinics and provider groups in supporting SF 3532/HF 3578.

MNASCA, a statewide association representing Minnesota's Ambulatory Surgery Centers (ASCs), promotes high-quality, value-driven surgical services to provide the best possible care to patients. Healthcare Leaders Association of Minnesota is an organization of healthcare business leaders and executives who work together to improve the health status of the community and patients they serve. However, in recent years, the PA process has significantly hindered our members' ability to provide effective therapies to patients, consequently leading to compromised health outcomes in certain instances. As the legislature considers prior authorization reforms, we would like to highlight two critical issues with the existing PA system:

Prior authorization is time-consuming and overly burdensome. The current system requires doctors to jump through multiple hoops to obtain an insurer's approval before it will agree to pay for a prescription medication, medical test, or procedure. Prior authorization requirements and submission processes also vary widely among insurers, often requiring providers to expend valuable staff time and resources completing manual forms and furnishing additional information. Finally, our doctors are often working with insurer physicians who lack specialized knowledge of our surgery centers' specialties and recommended therapies and, therefore, do not have the expertise to make informed decisions regarding patient care.

Overuse of prior authorization is also harmful to patients. The PA review process frequently forces patients to wait days for insurers to issue approvals, and weeks or months to resolve denials. Minnesota doctors report that prior authorization has led to care delays, treatment abandonment, and even serious adverse events for patients.

Without legislative action, the overuse of prior authorization will continue to delay needed patient care, increase administrative costs, and contribute to physician burnout. MNASCA and HLAMN support legislative changes that will:

- Prohibit insurers from retrospectively denying coverage of a healthcare service for which prior authorization was not required by the health carrier.
- Require insurers to create and maintain an interface to streamline the prior authorization process and facilitate the exchange of information between providers and insurers.

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- Require insurers to annually report prior authorization frequency, denial rates, and approval rates.
- Implement a "gold card" program for physicians attaining prior authorization approval rates exceeding the 70th percentile.

MNASCA and HLAMN greatly appreciate the legislature's consideration of these prior authorization reforms.

Sincerely,

Tracy Mills, President
Minnesota Ambulatory Surgery Centers Association

Melissa Larson, President
Healthcare Leaders Association of Minnesota

March 11, 2024

Dear Sen. Wiklund and members of the Senate Health and Human Services Finance Committee,

On behalf of the undersigned organizations, we have come together as the Healthcare Workforce Support Policy Coalition to identify policy opportunities that help address healthcare and social services industry workforce challenges. Our membership is composed of a broad representation of healthcare providers, including hospitals, dental providers, and ambulatory surgical centers to name a few. We believe that SF 4101 is an example of one way the state can help address a workforce challenge by providing support to those who pursue a career in healthcare, which often requires one or more advanced degrees.

The goals outlined by our coalition include making it easier to work in the state of Minnesota, upskilling and reskilling the current workforce, and encouraging new professionals to seek a career in healthcare. Determining solutions is an ongoing process, and we, as a coalition, endorse education support broadly as it helps to make it easier to work in the state, allows individuals to advance their career, and helps position the healthcare field as an enticing one to enter. The legislation's focus on loan forgiveness aligns with all of these goals and signifies to healthcare professionals that the state supports their efforts. SF 4101 is a positive approach to making professions in the industry more sustainable and attractive for not just nurses, but also technicians, EMS providers, doctors, dentists and other professionals.

Thank you for supporting education and prioritizing those who dedicate their careers to providing quality care for Minnesota's patients. These steps are vital to increasing the number of Minnesotans entering the healthcare workforce and supporting their growth throughout their careers.

Respectfully,

March 11, 2024

RE: SF 3532/HF 3578 – Prior Authorization reforms

Dear Senator Morrison and Representative Bahner,

Thank you for authoring legislation aimed at reforming the complex and excessively cumbersome prior authorization (PA) process. The Minnesota Ambulatory Surgery Center Association (MNASCA) and Healthcare Leaders Association of Minnesota (HLAMN formerly MMGMA) joins other stakeholders, including the Minnesota Medical Association, the Minnesota Hospital Association, and many specialty clinics and provider groups in supporting SF 3532/HF 3578.

MNASCA represents physicians serving in Minnesota's surgical centers who strive to deliver the best possible care to patients. Healthcare Leaders Association of Minnesota is an organization of healthcare business leaders and executives who work together to improve the health status of the community and patients they serve. However, in recent years, the PA process has significantly hindered our members' ability to provide effective therapies to patients, consequently leading to compromised health outcomes in certain instances. As the legislature considers prior authorization reforms, we would like to highlight two critical issues with the existing PA system:

Prior authorization is time-consuming and overly burdensome. The current system requires doctors to jump through multiple hoops to obtain an insurer's approval before it will agree to pay for a prescription medication, medical test, or procedure. Prior authorization requirements and submission processes also vary widely among insurers, often requiring providers to expend valuable staff time and resources completing manual forms and furnishing additional information. Finally, our doctors are often working with insurer physicians who lack specialized knowledge of our surgery centers' specialties and recommended therapies and, therefore, do not have the expertise to make informed decisions regarding patient care.

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Without legislative action, the overuse of prior authorization will continue to delay needed patient care, increase administrative costs, and contribute to physician burnout. MNASCA and HLAMN support legislative changes that will:

- Prohibit insurers from retrospectively denying coverage of a healthcare service for which prior authorization was not required by the health carrier.

- Require insurers to create and maintain an interface to streamline the prior authorization process and facilitate the exchange of information between providers and insurers.
- Prohibit prior authorization for critical services by expanding Minnesota Statutes 2022, section 62M.07, subdivision 2 to include additional services.
- Limit the use of prior authorization for chronic conditions to one-time only approvals.
- Require insurers to annually report prior authorization frequency, denial rates, and approval rates.

MNASCA and HLAMN greatly appreciate the legislature's consideration of these prior authorization reforms.

Sincerely,

Tracy Mills, President
MNASCA

Melissa Larson, President
Healthcare Leaders Association of Minnesota

MNASCA

March 12, 2024

RE: HF 4100/SF 4065 Minnesota Debt Fairness

Dear Chair Klein, Vice Chair Seeberger, Sen. Boldon, and Members of the Committee,

The Minnesota Ambulatory Surgery Center Association (MNASCA) is a statewide association representing Minnesota's ASCs in their commitment to delivering high-quality, value-driven surgical services and exceptional patient care. MNASCA appreciates the opportunity to comment on SF 4065, and Sen. Boldon's willingness to engage with stakeholders to address concerns with the bill as currently written.

We understand the underlying goals of the proposed legislation to clarify and modernize the debt collection process to better protect consumers. However, the legislation as drafted would make it excessively difficult for ASCs to recover debts for elective medical procedures. Our ASCs prioritize transparency by clearly informing patients about anticipated out-of-pocket expenses for elective surgeries. And if a patient has trouble covering a remaining balance, our centers work with them on a reasonable payment plan to avoid turning the outstanding bill over to a debt collection agency. This legislation would prevent providers from specifying the consequences of nonpayment and restrict who they may use to help recover debt. Significantly changing the debt collection process in these ways could have many unintended consequences for ASCs, including impacting access to elective surgical procedures for everyone.

We urge the committee not to make it even harder for Minnesota's ASCs to recover legitimate debts for elective procedures. We will continue working with the author to address our remaining concerns with the bill to ensure Minnesota's collections process provides proper consumer protections, while balancing the need for these debts to be paid.

Sincerely,

Tracy Mills, President
Minnesota Ambulatory Surgery Centers Association

March 13, 2024

Representative Zack Stephenson
Chairman, Commerce Finance and Policy Committee
449 State Office Building
St. Paul, MN 55155

Representative Jamie Long
Majority Leader
459 State Office Building
St. Paul, MN 55155

Representative Tim O'Driscoll
Republican Lead, Commerce Finance and Policy Committee
237 State Office Building
St. Paul, MN 55155

Dear Representatives:

We are writing to express our concerns regarding the proposal to create a new health insurance system—H.F. 4745 Minnesota Care Public Option.

We all agree that Minnesotans deserve access to affordable and high-quality health care, but rushing the public option is not the way to improve the state's health care system. We urge lawmakers to pause and take time to address the list of serious concerns and unanswered questions regarding the proposed public option.

As the Minnesota Department of Commerce has repeatedly acknowledged, the state's recent report on the public option does not express the full cost of creating, administering, and providing necessary technological support for this new state government program. On the contrary, the Department made clear that "the report does not capture the full fiscal impact to the state or the health care system more broadly."

In other words, lawmakers currently have no way of knowing the full scope of consequences this proposal could have for Minnesota patients, consumers, health care providers, employers, and taxpayers. One of the few things made clear in the state's report is that just a small percentage of Minnesota's uninsured population would be covered by the public option and enacting it would have a minimal impact on expanding coverage.

At the same time, a public option could negatively impact a wide range of Minnesotans' existing health coverage choices. Most clearly, the reliance on low payment rates to hospitals and clinics in order to achieve a marketable premium will result in cost shifting onto remaining commercial policyholders in the self and fully insured markets. Government-level provider payment rates could impact patients' ability to access vital health services close to home and in a timely manner, worsening the access problem for those in rural or underserved communities.

Rather than rushing ahead to pass legislation creating the public option, lawmakers should slow down and take the time to learn the answers to the many important questions that remain unanswered regarding the public option's potential costs and consequences.

Thank you for your consideration and your commitment to improving access to affordable, high-quality health care in Minnesota.

Sincerely,

April 17, 2024

Senator Melissa H. Wiklund
Chair, Health and Human Services Committee
2107 Minnesota Senate Bldg.
St. Paul, MN 55155

Senator Paul J. Utke
Ranking Minority Member, Health and Human Services Committee
2403 Minnesota Senate Bldg.
St. Paul, MN 55155

Dear Senators:

We are writing to express our concerns regarding the proposal to create a new public option health insurance system—S.F. 4699, the vehicle for the Committee's omnibus budget/policy bill.

We all agree that Minnesotans deserve access to affordable and high-quality health care, but rushing the public option is not the way to improve the state's health care system. We urge lawmakers to pause and take time to address the list of serious concerns and unanswered questions regarding the proposed public option.

As the Minnesota Department of Commerce has repeatedly acknowledged, the state's recent report on the public option does not express the full cost of creating, administering, and providing necessary technological support for this new state government program. On the contrary, the Department made clear that "the report does not capture the full fiscal impact to the state or the health care system more broadly."

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At the same time, a public option could negatively impact a wide range of Minnesotans' existing health coverage choices. Most clearly, the reliance on low payment rates to hospitals and clinics in order to achieve a marketable premium will result in cost shifting onto remaining commercial policyholders in the self and fully insured markets. Government-level provider payment rates could impact patients' ability to access vital health services close to home and in a timely manner, worsening the access problem for those in rural or underserved communities.

Rather than rushing ahead to pass legislation creating the public option, lawmakers should slow down and take the time to learn the answers to the many important questions that remain unanswered regarding the public option's potential costs and consequences.

Thank you for your consideration and your commitment to improving access to affordable, high-quality health care in Minnesota.

Sincerely,

MAYO CLINIC

MINNESOTA COUNCIL of HEALTH PLANS

Health Plan Partnership of Minnesota


HLA
HEALTHCARE
LEADERS
ASSOCIATION
MINNESOTA


Minnesota Hospital Association


Essentia Health


MedicalAlley


MINNESOTA
CHAMBER OF
COMMERCE
GROWING MINNESOTA


MINNESOTA
BUSINESS
PARTNERSHIP


NFIB


THE
CIGNA
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MNGI
DIGESTIVE HEALTH


M·A·H·U
BENEFITS
PROFESSIONALS
Insuring, Protecting, Educating & Advocating for Minnesotans.


MNASCA
MN Ambulatory Surgery Center Association


BIG i
MINNESOTA


SUMMIT
ORTHOPEDICS


CentraCare

May 2024

Honorable members of the Minnesota State Senate and House of Representatives,

On behalf of the undersigned organizations, we have come together as the Healthcare Workforce Support Policy Coalition to identify policy opportunities that help address healthcare and social services industry challenges. Our members represent a broad representation of healthcare providers, including hospitals, dental providers, and ambulatory surgical centers to name a few. As we sought to identify solutions that could help address some of the challenges for professionals working in healthcare, licensure compacts were identified as an opportunity. The coalition confirmed its support of licensure compacts to streamline licensure processes for healthcare professionals.

We are excited to see consideration for compacts related to physician assistants, occupational therapists, physical therapists, social workers, licensed professional counselors, audiologists and speech language pathologists, and dentists and dental hygienists. Additionally, we advocate for consideration and inclusion of the Nurse Licensure Compact.

We urge your support of implementing healthcare licensure compacts in the state of Minnesota as a means to ensure high credentialing standards while reducing administrative burden.

Respectfully,