State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 1251

03/21/2011 Authored by Gruenhagen, Lohmer, Barrett, McDonald and Woodard
The bill was read for the first time and referred to the Committee on Civil Law

A bill for an act

relating to accountability in health care program contracts; requiring competitive bids and audits; proposing coding for new law in Minnesota Statutes, chapter 256B.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[256B.695] MANAGED CARE OVERSIGHT.**

Subdivision 1. **Purpose; intent.** (a) To provide coverage under the state's health care programs, Minnesota has large contracts totaling over $3,000,000,000 per year in state funds awarded without competitive bidding. The state began contracting these programs out in 1983 as a pilot project with the hope of saving money. However, the pilot project was never truly evaluated. The legislative auditor has twice called for greater scrutiny over these programs, but no state agency has conducted an audit of these contracts for quality and cost. Because there have been no audits, the state has no way of evaluating whether health care dollars are being wisely spent. Under current practice, the state covers all expenses that the health plans incur whether justified or not.

(b) In 2011, as the state enrolls 95,000 more residents into medical assistance it would be irresponsible to add these new enrollees into these unaccountable contracts that may cost significantly more than the state administering their coverage.

Subd. 2. **Enrollment.** Beginning March 1, 2011, all new medical assistance enrollees must be covered through the Department of Human Services directly and may not be placed into a prepaid health plan under section 256B.69.

Subd. 3. **Competitive bidding.** When the current state health plan contracts expire, the commissioner of human services must initiate a competitive bidding process in the 13-county metropolitan area for prepaid health plans, with the contract for the 13-county

metropolitan area awarded to the two managed care organizations that best meet the state's need to provide quality and cost-effective medical care to enrollees. The managed care organizations must not use market division or allocation methodologies or subcontract with other managed care organizations or any other scheme to undermine the competitive bidding process. A managed care organization or entity listed in section 256B.69 that violates any of the prohibitions in this subdivision shall be barred from contracting with the state for ten years.

Subd. 4. **Accounting process and definitions.** (a) Any health maintenance organization, community-integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T, that participates in the demonstration project under section 256B.69 or any managed health care program must use GAAP accounting principles for all contracts with the state. For purposes of this section, the terms in paragraphs (b) and (c) have the meanings given.

(b) "Administrative costs" means expenditures on loss-adjustment activities, prior authorizations, utilization reviews, underwriting activities, negotiating networks and contracts with providers, approvals and denials of claims, research activities, reserves, capital expenses, and all other expenses not included under paragraph (c).

(c) "Medical costs" means the payments to licensed health care professionals and health care entities for delivering to specific patients drugs, devices, supplies, and services, including educational services, or assisting them in accessing medical care. Assisting patients in accessing medical care includes, but is not limited to, such ancillary services as interpreter services and transportation.

Subd. 5. **Oversight.** The legislative auditor shall regularly audit all health program contracts using the definitions of administrative costs and medical costs under subdivision 4.

Subd. 6. **State health care program contracts.** For all state managed care contracts, in assessing actuarial soundness as referenced in federal law, the Department of Human Services shall cover only reasonable and appropriate costs incurred by the health plan contractors, not all costs as in past practice.

Subd. 7. **Data practices.** Notwithstanding chapter 13, data practices exemptions related to trade secrets and proprietary information do not apply to a contracting health plan providing health care coverage for a state health care program.

EFFECTIVE DATE. This section is effective retroactively from March 1, 2011.