CHAPTER 345—H.F.No. 1178

An act relating to health; implementing recommendations of the Minnesota health care commission; defining and regulating integrated service networks; requiring regulation of health care services not provided through integrated service networks; establishing data reporting and collection requirements; establishing other cost containment measures; providing for classification of certain tax data; requiring certain studies; appropriating money; amending Minnesota Statutes 1992, sections 3.732, subdivision 1; 43A.17, by adding a subdivision; 43A.317, subdivision 5; 60K.14, by adding a subdivision; 62A.021, subdivision 1; 62A.65; 62C.16, by adding a subdivision; 62D.042, subdivision 2; 62D.12, by adding a subdivision; 62E.11, subdivision 12; 62J.03, subdivisions 6, 8, and by adding a subdivision; 62J.04, subdivisions 1, 2, 3, 4, 5, 7, and by adding subdivisions; 62J.05, by adding a subdivision; 62J.09, subdivisions 2, 5, 8, and by adding subdivisions; 62J.15, subdivision 1, and by adding a subdivision; 62J.17, subdivision 2, and by adding subdivisions; 62J.23, by adding a subdivision; 62J.30, subdivisions 1, 6, 7, and 8; 62J.32, subdivision 4; 62J.33; 62J.34, subdivision 2; 62L.02, subdivisions 19, 26, and 27; 62L.03, subdivisions 3 and 4; 62L.04, subdivision 1; 62L.05, subdivisions 2, 3, 4, and 6; 62L.08, subdivisions 4 and 8; 62L.09, subdivision 1; 62L.11, subdivision 1; 124C.62; 136A.1355, subdivisions 1, 3, 4, and by adding a subdivision; 136A.1356, subdivisions 2 and 5; 136A.1357; 137.38, subdivisions 2, 3, and 4; 137.39, subdivisions 2 and 3; 137.40, subdivision 3; 144.147, subdivision 4; 144.1484, subdivisions 1 and 2; 144.335, by adding a subdivision; 151.21; 151.47, subdivision 1; 214.16, subdivision 3; 256.9351, subdivision 3; 256.9352, subdivision 3; 256.9353; 256.9354, subdivisions 1, 4, and by adding a subdivision; 256.9356; 256.9357, subdivision 1; 256.9657, subdivision 3; 256B.057, subdivisions 1, 2a, and by adding a subdivision; 256B.0625, subdivision 13; 256B.0644; 256D.03, subdivision 3; 270B.01, subdivision 8; 295.50, subdivisions 3, 4, 7, 14, and by adding subdivisions; 295.51, subdivision 1; 295.52, by adding subdivisions; 295.53, subdivisions 1, 2, 3, and by adding a subdivision; 295.54; 295.55, subdivision 4; 295.57; 295.58; and 295.59; Laws 1992, chapter 549, article 7, section 9, and article 9, section 19; proposing coding for new law in Minnesota Statutes, chapters 62A; 62J; 136A; 144; 151; 256; and 295; proposing coding for new law as Minnesota Statutes, chapters 62N; and 62P; repealing Minnesota Statutes 1992, sections 62J.15, subdivision 2; 62J.17, subdivisions 4, 5, and 6; 62J.29; 62L.09, subdivision 2; 295.50, subdivisions 5 and 10; and 295.51, subdivision 2.

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

ARTICLE 1

INTEGRATED SERVICE NETWORKS

Section 1. Minnesota Statutes 1992, section 62J.04, is amended by adding a subdivision to read:

Subd. 8. **IMPLEMENTATION PLAN.** (a) The commissioner, in consultation with the commission, shall develop and submit to the legislature and the governor by January 15, 1994, a detailed implementation plan, including proposed rules and legislation, to implement the cost containment plan recom-

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mended by the commission as described in the summary report of the commission issued on January 25, 1993, as further modified by this act. The goal of the implementation plan must be to allow integrated service networks to form beginning July 1, 1994, and to begin a phased-in implementation of an all-payer system over a two-year period beginning July 1, 1994.

(b) To ensure a wide range of choices for purchasers, consumers, and providers, the rules and legislation must encourage and facilitate the formation of locally controlled integrated service networks, in addition to networks sponsored by statewide health plan companies.

(c) Financial solvency, net worth, and reserve requirements for integrated service networks must facilitate the formation of new networks, including networks sponsored by providers, employers, community organizations, local governments, and other locally based organizations, while protecting enrollees from undue risk of financial insolvency. The rules and legislation shall authorize alternative financial solvency, net worth, and reserve requirements for networks sponsored by providers that are based on the operational capacity, facilities, personnel, and financial capability to provide the services that it has contracted to provide to enrollees during the term of the contract provided the requirements are based on sound actuarial, financial, and accounting principles. The criteria for allowing integrated service networks and participating providers and health care providing entities to satisfy financial requirements through alternative means may authorize consideration of:

(1) the level of services to be provided by a provider relative to its existing service capacity;

(2) the provider's debt rating;

(3) certification by an independent consulting actuary;

(4) the availability of allocated or restricted funds;

(5) net worth;

(6) the availability of letters of credit;

(7) the taxing authority of the entity or governmental sponsor;

(8) net revenues;

(9) accounts receivable;

(10) the number of providers under contract;

(11) indebtedness; and

(12) other factors the commissioner may reasonably establish to measure the ability of the provider or health care providing entity to provide the level of services.

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(d) The implementation plan may include a requirement that an integrated service network may not contract for management services with a separate entity unless:

(1) the contract complies with section 62D.19; and

(2) if the management contract exceeds five percent of gross revenues of the integrated service network, provisions requiring holdbacks or other risk related provisions must be no more favorable to the separate entity under the management contract than comparable terms contained in any contract between the integrated service network and any health care providing entity or provider.

(e) The implementation plan must include technical assistance and financial assistance to promote the creation of locally controlled networks to serve rural areas and special populations. The commissioner and the commission shall consider including in the implementation plan the establishment of a management cooperative that will provide planning, organization, administration, billing, legal, and support services to integrated service networks that are members of the cooperative.

(f) The implementation plan must address problems of provider recruitment and retention in rural areas. Rules and legislation must be designed to improve the ability of rural communities to maintain an effective local delivery system.

(g) The implementation plan must include a method to create an option for health care providers and health care plans who meet or fall below the limits set by the commissioner under section 62J.04 to obtain a waiver from the applicability of the all-payer rules.

(h) In developing the implementation plan, the commissioner and the commission shall consider medical malpractice liability in terms of an entity operating an integrated service network and possible medical malpractice committed by its employees and make recommendations on any statutory changes that may be necessary. The commissioner may also consider whether a network and its participating entities should be allowed to reallocate between themselves the risk of malpractice liability.

(i) The implementation plan must identify the entities to whom an integrated service network may provide health care services, and persons or methods through whom or which an integrated service network may offer or sell its services.

(j) The implementation plan may consider the obligations that an integrated service network should have to the comprehensive health association established under section 62E.10. If obligations are to be required of an integrated service network, the implementation plan may provide for a phase-in of the assessments under section 62E.11. The implementation plan should clearly specify the rights and duties of integrated service networks with respect to the comprehensive health association.

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(k) In developing the implementation plan, the commissioner and the commission shall consider how enrollees should be protected in the event of the insolvency of a network, how prospective enrollees should be informed of the consequences to enrollees of an insolvency, and the form of the hold harmless clause that must be contained in every network enrollee contract.

(l) In developing the implementation plan, the commissioner and the commission shall consider the liquidation, rehabilitation, and conservation procedures that would be appropriate for networks.

(m) The rules and legislation must include provisions authorizing integrated service networks to bear the risk of providing coverage either by retaining the risk or by transferring all or part of the risk by purchasing reinsurance or other appropriate methods.

(n) The implementation plan must recommend the solvency requirements appropriate for a network, including net worth and deposit requirements, any reduced or phased-in net worth or deposit requirements that might be appropriate for new networks, government-sponsored networks, networks that use accredited capitated providers, or that have other particular features that provide a rationale for adjusting the solvency requirements.

(o) The commissioner shall determine the possible relationships between providers and integrated service networks, including requirements for the contractual relationships that may be required in order to ensure flexible arrangements between integrated service networks and providers.

Sec. 2. **[62N.01] CITATION AND PURPOSE.**

Subdivision 1. **CITATION.** Sections 62N.01 to 62N.24 may be cited as the "Minnesota integrated service network act."

Subd. 2. **PURPOSE.** Sections 62N.01 to 62N.24 allow the creation of integrated service networks that will be responsible for arranging for or delivering a full array of health care services, from routine primary and preventive care through acute inpatient hospital care, to a defined population for a fixed price from a purchaser.

Each integrated service network is accountable to keep its total revenues within the limit of growth set by the commissioner of health under section 62N.05, subdivision 2, clause (1). Integrated service networks can be formed by health care providers, health maintenance organizations, insurance companies, employers, or other organizations. Competition between integrated service networks on the quality and price of health care services is encouraged.

Sec. 3. **[62N.02] DEFINITIONS.**

Subdivision 1. **APPLICATION.** The definitions in this section apply to sections 62J.04, subdivision 8, and 62N.01 to 62N.24.

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Subd. 2. **ACCREDITED CAPITATED PROVIDER.** "Accredited capitated provider" means a financially responsible health care providing entity paid by a network on a capitated basis.

Subd. 3. **COMMISSION.** "Commission" means the health care commission established under section 62J.05.

Subd. 4. **COMMISSIONER.** "Commissioner" means the commissioner of health or the commissioner's designated representative.

Subd. 5. **ENROLLEE.** "Enrollee" means an individual, including a member of a group, to whom a network is obligated to provide health services under this chapter.

Subd. 6. **HEALTH CARE PROVIDING ENTITY.** "Health care providing entity" means a participating entity that provides health care to enrollees through an integrated service network.

Subd. 6a. **HEALTH CARRIER.** "Health carrier" has the meaning given in section 62A.011.

Subd. 7. **HEALTH PLAN.** "Health plan" means a health plan as defined in section 62A.011 or coverage by an integrated service network.

Subd. 8. **INTEGRATED SERVICE NETWORK.** "Integrated service network" means a formal arrangement permitted by this chapter and licensed by the commissioner for providing health services under this chapter to enrollees for a fixed payment per time period.

Subd. 9. **NETWORK.** "Network" means an integrated service network as defined in this section.

Subd. 10. **PARTICIPATING ENTITY.** "Participating entity" means a health care providing entity, a risk-bearing entity, or an entity providing other services through an integrated service network.

Subd. 11. **PRICE.** "Price" means the actual amount of money paid, after discounts or other adjustments, by the person or organization paying money to buy health care coverage and health care services. "Price" does not mean the cost or costs incurred by a network or other entity to provide health care services to individuals.

Subd. 12. **RISK-BEARING ENTITY.** "Risk-bearing entity" means an entity that participates in an integrated service network so as to bear all or part of the risk of loss. "Risk-bearing entity" includes an entity that provides reinsurance, stop-loss, excess-of-loss, and similar coverage.

Sec. 4. **[62N.03] APPLICABILITY OF OTHER LAW.**

Chapters 60A, 60B, 60G, 61A, 61B, 62A, 62C, 62D, 62E, 62H, 62L, 62M, and 64B do not, except as expressly provided in this chapter or in those other

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chapters, apply to integrated service networks, or to entities otherwise subject to those chapters, with respect to participation by those entities in integrated service networks. Chapters 72A and 72C apply to integrated service networks, except as otherwise expressly provided in this chapter.

Integrated service networks are in "the business of insurance" for purposes of the federal McCarren-Ferguson Act, United States Code, title 15, section 1012, are "domestic insurance companies" for purposes of the federal Bankruptcy Reform Act of 1978, United States Code, title 11, section 109, and are "insurance" for purposes of the federal Employee Retirement Income Security Act, United States Code, title 29, section 1144.

Sec. 5. **[62N.04] REGULATION.**

Integrated service networks are under the supervision of the commissioner, who shall enforce this chapter. The commissioner has, with respect to this chapter, all enforcement and rulemaking powers available to the commissioner under section 62D.17.

Sec. 6. **[62N.05] RULES GOVERNING INTEGRATED SERVICE NETWORKS.**

Subdivision 1. **RULES.** The commissioner, in consultation with the commission, may adopt emergency and permanent rules to establish more detailed requirements governing integrated service networks in accordance with this chapter.

Subd. 2. **REQUIREMENTS.** The commissioner shall include in the rules requirements that will ensure that the annual rate of growth of an integrated service network's aggregate total revenues received from purchasers and enrollees, after adjustments for changes in population size and risk, does not exceed the growth limit established in section 62J.04. A network's aggregate total revenues for purposes of these growth limits are net of the contributions, surcharges, taxes, and assessments listed in section 62P.04, subdivision 2, that the network pays. The commissioner may include in the rules the following:

(1) requirements for licensure, including a fee for initial application and an annual fee for renewal;

(2) quality standards;

(3) requirements for availability and comprehensiveness of services;

(4) requirements regarding the defined population to be served by an integrated service network;

(5) requirements for open enrollment;

(6) provisions for incentives for networks to accept as enrollees individuals who have high risks for needing health care services and individuals and groups with special needs;

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(7) prohibitions against disenrolling individuals or groups with high risks or special needs;

(8) requirements that an integrated service network provide to its enrollees information on coverage, including any limitations on coverage, deductibles and copayments, optional services available and the price or prices of those services, any restrictions on emergency services and services provided outside of the network's service area, any responsibilities enrollees have, and describing how an enrollee can use the network's enrollee complaint resolution system;

(9) requirements for financial solvency and stability;

(10) a deposit requirement;

(11) financial reporting and examination requirements;

(12) limits on copayments and deductibles;

(13) mechanisms to prevent and remedy unfair competition;

(14) provisions to reduce or eliminate undesirable barriers to the formation of new integrated service networks;

(15) requirements for maintenance and reporting of information on costs, prices, revenues, volume of services, and outcomes and quality of services;

(16) a provision allowing an integrated service network to set credentialing standards for practitioners employed by or under contract with the network;

(17) a requirement that an integrated service network employ or contract with practitioners and other health care providers, and minimum requirements for those contracts if the commissioner deems requirements to be necessary to ensure that each network will be able to control expenditures and revenues or to protect enrollees and potential enrollees;

(18) provisions regarding liability for medical malpractice;

(19) provisions regarding permissible and impermissible underwriting criteria applicable to the standard set of benefits;

(20) a method or methods to facilitate and encourage appropriate provision of services by midlevel practitioners and pharmacists;

(21) a method or methods to assure that all integrated service networks are subject to the same regulatory requirements. All health carriers, including health maintenance organizations, insurers, and nonprofit health service plan corporations shall be regulated under the same rules, to the extent that the health carrier is operating an integrated service network or is a participating entity in an integrated service network;

(22) provisions for appropriate risk adjusters or other methods to prevent or

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compensate for adverse selection of enrollees into or out of an integrated service network; and

(23) rules prescribing standard measures and methods by which integrated service networks shall determine and disclose their prices, copayments, deductibles, out-of-pocket limits, enrollee satisfaction levels, and anticipated loss ratios.

Subd. 3. **CRITERIA FOR RULEMAKING.** (a) **APPLICABILITY.** The commissioner shall adopt rules governing integrated service networks based on the criteria and objectives specified in this subdivision.

(b) **COMPETITION.** The rules must encourage and facilitate competition through the collection and distribution of reliable information on the cost, prices, and quality of each integrated service network in a manner that allows comparisons between networks.

(c) **FLEXIBILITY.** The rules must allow significant flexibility in the structure and organization of integrated service networks. The rules must allow and facilitate the formation of networks by providers, employers, and other organizations, in addition to health carriers.

(d) **EXPANDING ACCESS AND COVERAGE.** The rules must be designed to expand access to health care services and coverage for all Minnesotans, including individuals and groups who have preexisting health conditions, who represent a higher risk of requiring treatment, who require translation or other special services to facilitate treatment, who face social or cultural barriers to obtaining health care, or who for other reasons face barriers to access to health care and coverage. Enrollment standards must ensure that high risk and special needs populations will be included and growth limits and payment systems must be designed to provide incentives for networks to enroll even the most challenging and costly groups and populations. The rules must be consistent with the principles of health insurance reform that are reflected in Laws 1992, chapter 549.

(e) **ABILITY TO BEAR FINANCIAL RISK.** The rules must allow a variety of options for integrated service networks to demonstrate their ability to bear the financial risk of serving their enrollees, to facilitate diversity and innovation and the entry into the market of new networks. The rules must allow the phasing in of reserve requirements and other requirements relating to financial solvency.

(f) **PARTICIPATION OF PROVIDERS.** The rules must not require providers to participate in an integrated service network and must allow providers to participate in more than one network and to serve both patients who are covered by an integrated service network and patients who are not. The rules must allow significant flexibility for an integrated service network and providers to define and negotiate the terms and conditions of provider participation. The rules must encourage and facilitate the participation of midlevel practitioners, allied health care practitioners, and pharmacists, and eliminate inappropriate

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barriers to their participation. The rules must encourage and facilitate the participation of disproportionate share providers in integrated service networks and eliminate inappropriate barriers to this participation.

(g) **RURAL COMMUNITIES.** The rules must permit a variety of forms of integrated service networks to be developed in rural areas in response to the needs, preferences, and conditions of rural communities, utilizing to the greatest extent possible current existing health care providers and hospitals.

(h) **LIMITS ON GROWTH.** The rules must include provisions to enable the commissioner to enforce the limits on growth in health care total revenues for each integrated service network and for the entire system of integrated service networks.

(i) **STANDARD BENEFIT SET.** The commission shall make recommendations to the commissioner regarding a standard benefit set.

(j) **CONFLICT OF INTEREST.** The rules shall include provisions the commissioner deems necessary and appropriate to address integrated service networks' and participating providers' relationship to section 62J.23 or other laws relating to provider conflicts of interest.

Sec. 7. **[62N.06] AUTHORIZED ENTITIES.**

Subdivision 1. **AUTHORIZED ENTITIES.** (a) An integrated service network may be organized as a separate nonprofit corporation under chapter 317A or as a cooperative under chapter 308A.

(b) A nonprofit health carrier, as defined in section 62A.011, may establish and operate one or more integrated service networks without forming a separate corporation or cooperative, but only if all of the following conditions are met:

(i) a contract between the health carrier and a health care provider, for a term of less than seven years, that was executed before June 1, 1993, does not bind the health carrier or provider as applied to integrated service network services, except with the mutual consent of the health carrier and provider entered into on or after June 1, 1993. This clause does not apply to contracts between a health carrier and its salaried employees;

(ii) the health carrier shall not apply toward the net worth, working capital, or deposit requirements of this chapter any assets used to satisfy net worth, working capital, deposit, or other financial requirements under any other chapter of Minnesota law;

(iii) the health carrier shall not include in its premiums for health coverage provided under any other chapter of Minnesota law, an assessment or surcharge relating to net worth, working capital, or deposit requirements imposed upon the integrated service network under this chapter; and

(iv) the health carrier shall not include in its premiums for integrated ser-

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vice network coverage under this chapter an assessment or surcharge relating to net worth working capital or deposit requirements imposed upon health coverage offered under any other chapter of Minnesota law.

Subd. 2. **SEPARATE ACCOUNTING REQUIRED.** Any entity operating one or more integrated service networks shall maintain separate accounting and record keeping procedures, acceptable to the commissioner, for each integrated service network.

Subd. 3. **GOVERNMENTAL SUBDIVISION.** A political subdivision may establish and operate an integrated service network directly, without forming a separate entity. Unless otherwise specified, a network authorized under this subdivision must comply with all other provisions governing networks.

Sec. 8. **[62N.065] ADMINISTRATIVE COST CONTAINMENT.**

Subdivision 1. **UNREASONABLE EXPENSES.** No integrated service network shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62N.01 to 62N.22; in order to safeguard the underlying nonprofit status of integrated service networks; and to ensure that payment of integrated service network money to any person or organization results in a corresponding benefit to the integrated service network and its enrollees; when determining whether an integrated service network has incurred an unreasonable expense in relation to payments made to a person or organization, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the integrated service network have acted with good faith and in the best interests of the integrated service network in entering into, and performing under, a contract under which the integrated service network has incurred an expense. In addition to the compliance powers under subdivision 3, the commissioner has standing to sue, on behalf of an integrated service network, officers or trustees of the integrated service network who have breached their fiduciary duty in entering into and performing such contracts.

Subd. 2. **DATA ON CONTRACTS.** Integrated service networks shall keep on file in the offices of the integrated service network copies of all contracts regulated under subdivision 1, and data on the payments, salaries, and other remuneration paid to for-profit firms, affiliates, or to persons for administrative expenses, service contracts, and management of the integrated service network, and shall make these records available to the commissioner upon request.

Subd. 3. **COMPLIANCE AUTHORITY.** The commissioner may review any contract, arrangement, or agreement to determine whether it complies with the provisions contained in subdivision 1. The commissioner may suspend any provision that does not comply with subdivision 1 and may require the integrated service network to replace those provisions with provisions that do comply.

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Sec. 9. **[62N.07] PURPOSE.**

The legislature finds that previous cost containment efforts have focused on reducing benefits and services, eliminating access to certain provider groups, and otherwise reducing the level of care available. Under a system of overall spending controls, these cost containment approaches will, in the absence of controls on cost shifting, shift costs from the payer to the consumer, to government programs, and to providers in the form of uncompensated care. The legislature further finds that the integrated service network benefit package should be designed to promote coordinated, cost-effective delivery of all health services an enrollee needs without cost shifting. The legislature further finds that affordability of health coverage is a high priority and that lower cost coverage options should be made available through the use of copayments, coinsurance, and deductibles to reduce premium costs rather than through the exclusion of services or providers.

Sec. 10. **[62N.075] COVERED SERVICES.**

(a) An integrated service network must provide to each person enrolled a set of appropriate and necessary health services. For purposes of this chapter, "appropriate and necessary" means services needed to maintain the enrollee in good health including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, outpatient health services, and preventive health services. The commissioner may modify this definition to reflect changes in community standards, development of practice parameters, new technology assessments, and other medical innovations. These services must be delivered by authorized practitioners acting within their scope of practice. An integrated service network is not responsible for health services that are not appropriate and necessary.

(b) A network may define benefit levels through the use of consumer cost sharing but remains financially accountable for the cost of the set of required health services.

(c) A network may offer any Medicare supplement, Medicare select, or other Medicare-related product otherwise permitted for any type of health carrier in this state. Each Medicare-related product may be offered only in full compliance with the requirements in chapters 62A, 62D, and 62E that apply to that category of product.

(d) Networks must comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(e) Networks must comply with sections 62A.047, 62A.27, and any other coverage of newborn infants, dependent children who do not reside with a covered person, handicapped children and dependents, and adopted children. A network providing dependent coverage must comply with section 62A.302.

(f) Networks must comply with the equal access requirements of section 62A.15, subdivision 2.

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Sec. 11. **[62N.08] AVAILABILITY OF SERVICES.**

(a) An integrated service network is financially responsible to provide to each person enrolled all appropriate and necessary health services required by statute, by the contract of coverage, or otherwise required under sections 62N.075 to 62N.085.

(b) The commissioner shall require that networks provide all appropriate and necessary health services within a reasonable geographic distance for enrollees. The commissioner may adopt rules providing a more detailed requirement, consistent with this paragraph.

Sec. 12. **[62N.085] ESTABLISHMENT OF STANDARDIZED BENEFIT PLANS.**

(a) The commissioner of health shall adopt permanent rules and may adopt emergency rules to establish not more than five standardized benefit plans which must be offered by integrated service networks. The plans must comply with the requirements of sections 62N.07 to 62N.08 and the other requirements of this chapter. The plans must vary only on the basis of enrollee cost sharing and encompass a range of cost sharing options from (1) lower premium costs combined with higher enrollee cost sharing, to (2) higher premium costs combined with lower enrollee cost sharing.

(b) The purposes of this section, "consumer cost sharing" or "cost sharing" means copayments, deductibles, coinsurance, and other out-of-pocket expenses paid by the individual consumer of health care services.

(c) The commissioner shall consider whether the following principles should apply to cost sharing in an integrated service network:

(1) consumers must have a wide choice of cost sharing arrangement;

(2) consumer cost sharing must be administratively feasible and consistent with efforts to reduce the overall administrative burden of the health care system;

(3) cost sharing must be based on income and an enrollee's ability to pay for services and should not create a barrier to access to appropriate and effective services;

(4) cost sharing must be capped at a predetermined annual limit to protect individuals and families from financial catastrophe and to protect individuals with substantial health care needs;

(5) child health supervision services, immunizations, prenatal care, and other prevention services must not be subjected to cost sharing;

(6) additional requirements for networks should be established to assist enrollees for whom an inducement in addition to the elimination of cost sharing

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is necessary in order to encourage them to use cost-effective preventive services. These requirements may include the provision of educational information, assistance or guidance, and opportunities for responsible decision making by enrollees that minimize potential out-of-pocket costs;

(7) cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services; and

(8) cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

Sec. 13. **[62N.10] LICENSING.**

Subdivision 1. **REQUIREMENTS.** All integrated service networks must be licensed by the commissioner. Licensure requirements are:

(1) the ability to be responsible for the full continuum of required health care and related costs for the defined population that the integrated service network will serve;

(2) the ability to satisfy standards for quality of care;

(3) financial solvency; and

(4) the ability to fully comply with this chapter and all other applicable law.

The commissioner may adopt rules to specify licensure requirements for integrated service networks in greater detail, consistent with this subdivision.

Subd. 2. **FEES.** Licensees shall pay an initial fee and a renewal fee each following year to be established by the commissioner of health.

Subd. 3. **LOSS OF LICENSE.** The commissioner may fine a licensee or suspend or revoke a license for violations of rules or statutes pertaining to integrated service networks.

Subd. 4. **PARTICIPATION; GOVERNMENT PROGRAMS.** Integrated service networks shall, as a condition of licensure, participate in the medical assistance, general assistance medical care, and MinnesotaCare programs. The commissioner shall adopt rules specifying the participation required of the networks. The rules must be consistent with Minnesota Rules, parts 9505.5200 to 9505.5260, governing participation by health maintenance organizations in public health care programs.

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Subd. 5. **APPLICATION.** Each application for an integrated service network license must be in a form prescribed by the commissioner.

Subd. 6. **DOCUMENTS ON FILE.** A network shall agree to retain in its files any documents specified by the commissioner. A network shall permit the commissioner to examine those documents at any time and shall promptly provide copies of any of them to the commissioner upon request.

Sec. 14. **[62N.11] EVIDENCE OF COVERAGE.**

Subdivision 1. **APPLICABILITY.** Every integrated service network enrollee residing in this state is entitled to evidence of coverage or contract. The integrated service network or its designated representative shall issue the evidence of coverage or contract. The commissioner shall adopt rules specifying the requirements for contracts and evidence of coverage. "Evidence of coverage" means evidence that an enrollee is covered by a group contract issued to the group.

Subd. 2. **FILING.** No evidence of coverage or contract or amendment of coverage or contract shall be issued or delivered to any individual in this state until a copy of the form of the evidence of coverage or contract or amendment of coverage or contract has been filed with and approved by the commissioner.

Sec. 15. **[62N.12] ENROLLEE RIGHTS.**

The cover page of the evidence of coverage and contract must contain a clear and complete statement of an enrollee's rights as a consumer. The commissioner shall adopt rules specifying enrollee rights and required disclosures to enrollees.

Sec. 16. **[62N.13] ENROLLEE COMPLAINT SYSTEM.**

Every integrated service network must establish and maintain an enrollee complaint system, including an impartial arbitration provision, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services. The commissioner shall adopt rules specifying requirements relating to enrollee complaints.

Sec. 17. **[62N.16] UNDERWRITING AND RATING.**

Subdivision 1. **APPLICABILITY.** Except as provided in subdivision 3, this section applies to the standard benefit plans under section 62N.085 and does not apply to additional benefits. This section does not require coverage by an integrated service network of any group or individual residing outside of the network's service area. A network's service area is a geographic service region agreed to by the commissioner and the network at the time of licensure. This section does not apply to any group that the commissioner determines is organized or functions primarily to provide coverage to one or more high risk individuals. The commissioner may adopt rules specifying other types of groups to which this section does not apply.

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Subd. 2. **GROUP MEMBERS.** Integrated service networks shall charge the same rate for each individual in a group, except as appropriate to provide dependent or family coverage. Rates for managed care plans as described in section 256.9363 shall be determined through contract between the department of human services and the integrated service network.

Subd. 3. **SMALL EMPLOYERS.** To provide services to employees of a small employer as defined in section 62L.02, integrated service networks shall comply with chapter 62L.

Sec. 18. **[62N.22] DISCLOSURE OF COMMISSIONS.**

Before selling, or offering to sell, any coverage or enrollment in an integrated service network, a person selling the coverage or enrollment shall disclose to the prospective purchaser the amount of any commission or other compensation the person will receive as a direct result of the sale. The disclosure may be expressed in dollars or as a percentage of the premium. The amount disclosed need not include any anticipated renewal commissions.

Sec. 19. **[62N.23] TECHNICAL ASSISTANCE; LOANS.**

(a) The commissioner shall provide technical assistance to parties interested in establishing or operating an integrated service network. This shall be known as the integrated service network technical assistance program (ISNTAP).

The technical assistance program shall offer seminars on the establishment and operation of integrated service networks in all regions of Minnesota. The commissioner shall advertise these seminars in local and regional newspapers, and attendance at these seminars shall be free.

The commissioner shall write a guide to establishing and operating an integrated service network. The guide must provide basic instructions for parties wishing to establish an integrated service network. The guide must be provided free of charge to interested parties. The commissioner shall update this guide when appropriate.

The commissioner shall establish a toll-free telephone line that interested parties may call to obtain assistance in establishing or operating an integrated service network.

(b) The commissioner, in consultation with the commission, shall provide recommendations for the creation of a loan program that would provide loans or grants to entities forming integrated service networks or to networks less than one year old. The commissioner shall propose criteria for the loan program.

Sec. 20. **[62N.24] REVIEW OF RULES.**

The commissioner of health shall mail copies of all proposed emergency and permanent rules that are being promulgated under this chapter to each member of the legislative commission on health care access prior to final adoption by the commissioner.

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Sec. 21. Minnesota Statutes 1992, section 256.9657, subdivision 3, is amended to read:

Subd. 3. **HEALTH MAINTENANCE ORGANIZATION; INTEGRATED SERVICE NETWORK SURCHARGE.** Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each integrated service network licensed by the commissioner under sections 62N.01 to 62N.22 shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization or integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

Sec. 22. **BORDER COMMUNITIES.**

The commissioner of health shall monitor the effects of integrated service networks and the regulated all-payer system in communities in which a substantial proportion of health care services provided to Minnesota residents are provided in states bordering Minnesota and may amend the rules adopted under this article or article 2 to minimize effects that inhibit Minnesota residents' ability to obtain access to quality health care. The commissioner shall report to the Minnesota health care commission and the legislature any effects that the commissioner intends to address by amendments to the rules adopted under this article or article 2.

Sec. 23. **STUDY OF REQUIREMENTS FOR HEALTH CARRIERS FORMING INTEGRATED SERVICE NETWORKS.**

The Minnesota health care commission shall study the desirability and appropriateness of the provisions in Minnesota Statutes, section 62N.06, subdivision 1, which prohibit health carriers from establishing and operating integrated service networks other than through a separate entity except under specified conditions. The commission shall report its findings, conclusions, and recommendations to the commissioner and the legislative commission on health care access by November 1, 1993. If, in the development of rules and proposed legislation, the commissioner intends to depart from the commission's recommendations on this issue, the notification procedures in Minnesota Statutes, section 62J.04, subdivision 4, apply.

Sec. 24. **EFFECTIVE DATE.**

Sections 1 to 23 are effective the day following final enactment, but no integrated service network may provide health care services prior to July 1, 1994.

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ARTICLE 2

REGULATED ALL-PAYER SYSTEM

Section 1. Minnesota Statutes 1992, section 62D.042, subdivision 2, is amended to read:

Subd. 2. **BEGINNING ORGANIZATIONS.** (a) Beginning organizations shall maintain net worth of at least 8-1/3 percent of the sum of all expenses expected to be incurred in the 12 months following the date the certificate of authority is granted, or $1,500,000, whichever is greater.

(b) After the first full calendar year of operation, organizations shall maintain net worth of at least 8-1/3 percent and at most 16-2/3 percent of the sum of all expenses incurred during the most recent calendar year, ~~or $1,000,000, whichever is greater~~ but in no case shall net worth fall below $1,000,000.

Sec. 2. **[62P.01] REGULATED ALL-PAYER SYSTEM.**

The regulated all-payer system established under this chapter governs all health care services that are provided outside of an integrated service network. The regulated all-payer system is designed to control costs, prices, and utilization of all health care services not provided through an integrated service network while maintaining or improving the quality of services. The commissioner of health shall adopt rules establishing controls within the system to ensure that the rate of growth in spending in the system, after adjustments for population size and risk, remains within the limits set by the commissioner under section 62J.04. All providers that serve Minnesota residents and all health carriers that cover Minnesota residents shall comply with the requirements and rules established under this chapter for all health care services or coverage provided to Minnesota residents.

Sec. 3. **[62P.03] IMPLEMENTATION.**

(a) By January 1, 1994, the commissioner of health, in consultation with the Minnesota health care commission, shall report to the legislature recommendations for the design and implementation of the all-payer system. The commissioner may use a consultant or other technical assistance to develop a design for the all-payer system. The commissioner's recommendations shall include the following:

(1) methods for controlling payments to providers such as uniform fee schedules or rate limits to be applied to all health plans and health care providers with independent billing rights;

(2) methods for controlling utilization of services such as the application of standardized utilization review criteria, incentives based on setting and achieving volume targets, recovery of excess spending due to overutilization, or required use of practice parameters;

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(3) methods for monitoring quality of care and mechanisms to enforce the quality of care standards;

(4) requirements for maintaining and reporting data on costs, prices, revenues, expenditures, utilization, quality of services, and outcomes;

(5) measures to prevent or discourage adverse risk selection between the regulated all-payer system and integrated service networks;

(6) measures to coordinate the regulated all-payer system with integrated service networks to minimize or eliminate barriers to access to health care services that might otherwise result;

(7) an appeals process;

(8) measures to encourage and facilitate appropriate use of midlevel practitioners and eliminate undesirable barriers to their participation in providing services;

(9) measures to assure appropriate use of technology and to manage introduction of new technology;

(10) consequences to be imposed on providers whose expenditures have exceeded the limits established by the commissioner; and

(11) restrictions on provider conflicts of interest.

(b) On July 1, 1994, the regulated all-payer system shall begin to be phased in with full implementation by July 1, 1996. During the transition period, expenditure limits for health carriers shall be established in accordance with section 4 and health care provider revenue limits shall be established in accordance with section 5.

Sec. 4. **[62P.04] EXPENDITURE LIMITS FOR HEALTH CARRIERS.**

Subdivision 1. **DEFINITIONS.** (a) For purposes of this section, the following definitions apply.

(b) "Health carrier" has the definition provided in section 62A.011.

(c) "Total expenditures" mean incurred claims or expenditures on health care services, administrative expenses, charitable contributions, and all other payments made by health carriers out of premium revenues, except taxes and assessments, and payments or allocations made to establish or maintain reserves. Total expenditures are equivalent to the amount of total revenues minus taxes and assessments. Taxes and assessments means payments for taxes, contributions to the Minnesota comprehensive health association, the provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the health coverage reinsurance association, assessments by the Minnesota life and health insurance guaranty association, and any new assessments imposed by federal or state law.

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Subd. 2. **ESTABLISHMENT.** The commissioner of health shall establish limits on the increase in total expenditures by each health carrier for calendar years 1994 and 1995. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). Health carriers that are affiliates may elect to meet one combined expenditure limit.

Subd. 3. **DETERMINATION OF EXPENDITURES.** Health carriers shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993, and by April 1, 1995, for calendar year 1994, all information the commissioner determines to be necessary to implement and enforce this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health carriers. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health carrier to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments and the election to meet one expenditure limit for affiliated health carriers must be submitted to the commissioner by September 1, 1993.

Subd. 4. **MONITORING OF RESERVES.** (a) The commissioner of health shall monitor health carrier reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, to ensure that savings resulting from the establishment of expenditure limits are passed on to consumers in the form of lower premium rates.

(b) Health carriers shall fully reflect in the premium rates the savings generated by the expenditure limits and the health care provider revenue limits. No premium rate increase may be approved for those health carriers unless the health carrier establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

Subd. 5. **NOTICE.** The commissioner of health shall publish in the State Register and make available to the public by July 1, 1995, a list of all health carriers that exceeded their expenditure target for the 1994 calendar year. The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health carriers that exceeded their combined expenditure limit for calendar years 1994 and 1995. The commissioner shall notify each health carrier that the commissioner has determined that the carrier exceeded its expenditure limit, at least 30 days before publishing the list, and shall provide each carrier with ten days to provide an explanation for exceeding the expenditure target. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

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Subd. 6. **ASSISTANCE BY THE COMMISSIONER OF COMMERCE.** The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health carriers regulated by the commissioner of commerce. The commissioner of commerce, in consultation with the commissioner of health, shall enforce compliance by those health carriers.

Subd. 7. **ENFORCEMENT.** The commissioners of health and commerce shall enforce the reserve limits referenced in subdivision 4, with respect to the health carriers that each commissioner respectively regulates. Each commissioner shall require health carriers under the commissioner's jurisdiction to submit plans of corrective action when the reserve requirement is not met. Each commissioner may adopt rules necessary to enforce this section. Carriers that exceed the expenditure limits based on two-year average expenditure data or whose reserves exceed the limits referenced in subdivision 4 shall be required by the appropriate commissioner to pay back the amount overspent through an assessment on the carrier. The appropriate commissioner may approve a different repayment method to take into account the carrier's financial condition.

Sec. 5. **[62P.05] HEALTH CARE PROVIDER REVENUE LIMITS.**

Subdivision 1. **DEFINITION.** For purposes of this section, "health care provider" has the definition given in section 62J.03, subdivision 8.

Subd. 2. **ESTABLISHMENT.** The commissioner of health shall establish limits on the increase in revenue for each health care provider, for calendar years 1994 and 1995. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). The commissioner may adjust final revenue figures for case mix complexity, inpatient to outpatient conversion, payer mix, out-of-period settlements, taxes, donations, grants, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health care provider to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments must be submitted to the commissioner by September 1, 1993. A health care provider's revenues for purposes of these growth limits are net of the contributions, surcharges, taxes, and assessments listed in section 62P.04, subdivision 2, that the health care provider pays.

Subd. 3. **MONITORING OF REVENUE.** The commissioner of health shall monitor health care provider revenue, to ensure that savings resulting from the establishment of revenue limits are passed on to consumers in the form of lower charges. The commissioner shall monitor hospital revenue by examining net patient revenue per adjusted admission. The commissioner shall monitor the revenue of physicians and other health care providers by examining revenue per patient per year or revenue per encounter. If this information is not available, the commissioner may enforce an annual limit on the rate of growth of the provider's current fees based on the limits on the rate of growth established for calendar years 1994 and 1995.

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Subd. 4. **MONITORING AND ENFORCEMENT.** Health care providers shall submit to the commissioner of health, in the form and at the times required by the commissioner, all information the commissioner determines to be necessary to implement and enforce this section. Health care providers shall submit to audits conducted by the commissioner. The commissioner shall regularly audit all health clinics employing or contracting with over 100 physicians. The commissioner shall also audit, at times and in a manner that does not interfere with delivery of patient care, a sample of smaller clinics, hospitals, and other health care providers. Providers that exceed revenue limits based on two-year average revenue data shall be required by the commissioner to pay back the amount overspent during the following calendar year. The commissioner may approve a different repayment schedule for a health care provider that takes into account the provider's financial condition. For those providers subject to fee limits established by the commissioner, the commissioner may adjust the percentage increase in the fee schedule to account for changes in utilization. The commissioner may adopt rules in order to enforce this section.

Sec. 6. **APPLICABILITY OF OTHER LAWS.**

Except as expressly provided in rules adopted under this chapter, to the extent that a provider provides services in the regulated all-payer system, the provider is subject to all other statutes and rules that apply to providers of that type on the effective date of this section, including, as applicable, Minnesota Statutes, sections 62J.17 and 62J.23.

Sec. 7. **STUDY OF THE TRANSITION TO AN ALL-PAYER SYSTEM.**

The Minnesota health care commission shall study issues related to the transition to an all-payer system and shall report to the legislature and the governor by February 1, 1994. The report must include, but is not limited to, recommendations to minimize any financial and administrative burden of an all-payer system on providers in areas of the state without integrated service networks, increase the availability of integrated service networks in rural areas of the state, encourage the development of provider-managed integrated service networks, and ensure continued access to necessary health care services in all areas of the state.

Sec. 8. **EFFECTIVE DATE.**

Sections 1 to 7 are effective the day following final enactment.

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ARTICLE 3

DATA COLLECTION AND COST CONTROL INITIATIVES

Section 1. Minnesota Statutes 1992, section 62J.03, subdivision 6, is amended to read:

Subd. 6. **GROUP PURCHASER.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Sec. 2. Minnesota Statutes 1992, section 62J.04, subdivision 1, is amended to read:

Subdivision 1. **~~COMPREHENSIVE BUDGET~~ LIMITS ON THE RATE OF GROWTH.** (a) The commissioner of health shall set ~~an~~ annual ~~limit~~ limits on the rate of growth of public and private spending on health care services for Minnesota residents, as provided in paragraph (b). The ~~limit~~ limits on growth must be set at ~~a level~~ levels the commissioner determines to be realistic and achievable but that will ~~slow~~ reduce the ~~current~~ rate of growth in health care spending by at least ten percent per year ~~using the spending growth rate for 1991 as a base year. This limit must be achievable through good faith, cooperative efforts of health care consumers, purchasers, and providers~~ for the next five years. The commissioner shall set limits on growth based on available data on spending and growth trends, including data from group purchasers, national data on public and private sector health care spending and cost trends, and trend information from other states.

(b) The commissioner shall set the following annual limits on the rate of growth of public and private spending on health care services for Minnesota residents:

(1) for calendar year 1994, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1993 plus 6.5 percentage points;

(2) for calendar year 1995, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1994 plus 5.3 percentage points;

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(3) for calendar year 1996, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1995 plus 4.3 percentage points;

(4) for calendar year 1997, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1996 plus 3.4 percentage points; and

(5) for calendar year 1998, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1997 plus 2.6 percentage points.

If the health care financing administration forecast for the total growth in national health expenditures for a calendar year is lower than the rate of growth for the calendar year as specified in clauses (1) to (5), the commissioner shall adopt this forecast as the growth limit for that calendar year. The commissioner shall adjust the growth limit set for calendar year 1995 to recover savings in health care spending required for the period July 1, 1993 to December 31, 1993. The commissioner shall publish:

(1) the projected limits in the State Register by April 15 of the year immediately preceding the year in which the limit will be effective except for the year 1993, in which the limit shall be published by July 1, 1993;

(2) the quarterly change in the regional consumer price index for urban consumers; and

(3) the health care financing administration forecast for total growth in the national health care expenditures. In setting an annual limit, the commissioner is exempt from the rulemaking requirements of chapter 14. The commissioner's decision on an annual limit is not appealable.

Sec. 3. Minnesota Statutes 1992, section 62J.04, is amended by adding a subdivision to read:

Subd. 1a. **ADJUSTED GROWTH LIMITS AND ENFORCEMENT.** (a) The commissioner shall publish the final adjusted growth limit in the State Register by January 15 of the year that the expenditure limit is to be in effect. The adjusted limit must reflect the actual regional Consumer Price Index for urban consumers for the previous calendar year, and may deviate from the previously published projected growth limits to reflect differences between the actual regional Consumer Price Index for urban consumers and the projected Consumer Price Index for urban consumers. The commissioner shall report to the legislature by January 15 of each year on the projected increase in health care expenditures, the implementation of growth limits, and the reduction in the trend in the growth based on the limits imposed.

(b) The commissioner shall enforce limits on growth in spending and revenues for integrated service networks and for the regulated all-payer system. If the commissioner determines that artificial inflation or padding of costs or prices has occurred in anticipation of the implementation of growth limits, the

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commissioner may adjust the base year spending totals or growth limits or take other action to reverse the effect of the artificial inflation or padding.

(c) The commissioner shall impose and enforce overall limits on growth in revenues and spending for integrated service networks, with adjustments for changes in enrollment, benefits, severity, and risks. If an integrated service network exceeds a spending limit, the commissioner may reduce future limits on growth in aggregate premium revenues for that integrated service network by up to the amount overspent. If the integrated service network system exceeds a systemwide spending limit, the commissioner may reduce future limits on growth in premium revenues for the integrated service network system by up to the amount overspent.

(d) The commissioner shall set prices, utilization controls, and other requirements for the regulated all-payer system to ensure that the overall costs of this system, after adjusting for changes in population, severity, and risk, do not exceed the growth limits. If spending growth limits for a calendar year are exceeded, the commissioner may reduce reimbursement rates or otherwise recoup overspending for all or part of the next calendar year, to recover in savings up to the amount of money overspent. To the extent possible, the commissioner may reduce reimbursement rates or otherwise recoup overspending from individual providers who exceed the spending growth limits.

Sec. 4. Minnesota Statutes 1992, section 62J.04, subdivision 2, is amended to read:

Subd. 2. **DATA COLLECTION BY COMMISSIONER.** For purposes of ~~setting~~ forecasting rates of growth in health care spending and setting limits under ~~this section~~ subdivisions 1 and 1a, the commissioner ~~shall~~ may collect from ~~all~~ Minnesota health care providers data on patient revenues and health care spending received during a time period specified by the commissioner. The commissioner ~~shall~~ may also collect data on health care revenues and spending from ~~all~~ group purchasers of health care. ~~All~~ Health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. Professional licensing boards and state agencies responsible for licensing, registering, or regulating providers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements.

Subd. 2a. **FAILURE TO PROVIDE DATA.** The intentional failure to provide ~~reports~~ the data requested under this ~~section~~ chapter is grounds for revocation of a license or other disciplinary or regulatory action against a regulated provider. The commissioner may assess a fine against a provider who refuses to provide ~~information~~ data required by the commissioner ~~under this section~~. If a provider refuses to provide ~~a report or information~~ the data required ~~under this section~~, the commissioner may obtain a court order requiring the provider to produce documents and allowing the commissioner to inspect the records of the provider for purposes of obtaining the ~~information~~ data required ~~under this section~~.

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Subd. 2b. **DATA PRIVACY.** All data received under this section or under section 62J.37, 62J.38, 62J.41, or 62J.42 is private or nonpublic, ~~trade secret information under section 13.37~~ as applicable. The commissioner shall establish procedures and safeguards to ensure that data ~~provided to the Minnesota health care commission~~ released by the commissioner is in a form that does not identify ~~individual~~ specific patients, providers, employers, purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter.

Sec. 5. **[62J.045] MEDICAL EDUCATION AND RESEARCH COSTS.**

Subdivision 1. **PURPOSE.** The legislature finds that all health care stakeholders, as well as society at large, benefit from medical education and health care research. The legislature further finds that the cost of medical education and research should not be borne by a few hospitals or medical centers but should be fairly allocated across the health care system.

Subd. 2. **DEFINITION.** For purposes of this section, "health care research" means research that is not subsidized from private grants, donations, or other outside research sources but is funded by patient out-of-pocket expenses or a third party payer and has been approved by an institutional review board certified by the United States Department of Health and Human Services.

Subd. 3. **COST ALLOCATION FOR EDUCATION AND RESEARCH.** By January 1, 1994, the commissioner of health, in consultation with the health care commission and the health technology advisory committee, shall:

(1) develop mechanisms to gather data and to identify the annual cost of medical education and research conducted by hospitals, medical centers, or health maintenance organizations;

(2) determine a percentage of the annual rate of growth established under section 62J.04 to be allocated for the cost of education and research and develop a method to assess the percentage from each group purchaser;

(3) develop mechanisms to collect the assessment from group purchasers to be deposited in a separate education and research fund; and

(4) develop a method to allocate the education and research fund to specific health care providers.

Sec. 6. Minnesota Statutes 1992, section 62J.09, is amended by adding a subdivision to read:

Subdivision 1a. **DUTIES RELATED TO COST CONTAINMENT.** (a) **ALLOCATION OF REGIONAL SPENDING LIMITS.** Regional coordinating boards may advise the commissioner regarding allocation of annual regional limits on the rate of growth for providers in the regulated all-payer system in order to:

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(1) achieve communitywide and regional public health goals consistent with those established by the commissioner; and

(2) promote access to and equitable reimbursement of preventive and primary care providers.

(b) **TECHNICAL ASSISTANCE.** Regional coordinating boards, in cooperation with the commissioner, shall provide technical assistance to parties interested in establishing or operating an integrated service network within the region. This assistance must complement assistance provided by the commissioner under section 62N.23.

Sec. 7. Minnesota Statutes 1992, section 62J.33, is amended to read:

62J.33 ~~TECHNICAL ASSISTANCE~~ **INFORMATION ON COST AND QUALITY FOR PURCHASERS.**

Subdivision 1. **HEALTH CARE ANALYSIS UNIT.** The health care analysis unit shall provide ~~technical assistance~~ information to ~~health plan and health care~~ assist group purchasers and consumers in making informed decisions regarding purchasing of health care services. The unit shall provide information allowing comparisons between integrated service networks and between health care services and systems. The unit shall collect information about:

(1) premiums, benefit levels, patient or enrollee satisfaction, managed care procedures, health care outcomes, and other features of ~~popular~~ integrated service networks, health plans, and health carriers; ~~and~~

(2) prices, outcomes, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses; and

(3) information on health care services not provided through integrated service networks, including information on prices, costs, expenditures, utilization, quality of care, and outcomes.

The commissioner shall publicize this information in an easily understandable format.

Subd. 2. **INFORMATION CLEARINGHOUSE.** The commissioner of health shall establish an information clearinghouse within the department of health to facilitate the ability of consumers, employers, providers, health carriers, and others to obtain information on health care costs and quality in Minnesota. The commissioner shall make available through the clearinghouse information developed or collected by the department of health on practice parameters, outcomes data and research, the costs and quality of integrated service networks, reports or recommendations of the health technology advisory committee and other entities on technology assessments, worksite wellness and prevention programs, other wellness programs, consumer education, and other initiatives. The clearinghouse shall, upon request, make available information submitted voluntarily by health plans, providers, employers, and others if the

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information clearly states that an entity other than the state submitted the information, identifies the entity, and states that distribution by the clearinghouse does not imply endorsement of the entity or the information by the commissioner of health or the state of Minnesota. The clearinghouse shall also refer requesters to sources of further information or assistance. The clearinghouse is subject to chapter 13.

Sec. 8. **[62J.35] DATA COLLECTION.**

Subdivision 1. **CONTRACTING.** The commissioner may contract with private organizations to carry out the data collection initiatives required by this chapter. The commissioner shall require in the contract that organizations under contract adhere to the data privacy requirements established under this chapter and chapter 13.

Subd. 2. **EMERGENCY RULES.** The commissioner shall adopt permanent rules and may adopt emergency rules to implement the data collection and reporting requirements in this chapter. The commissioner may combine all data reporting and collection requirements into a unified process so as to minimize duplication and administrative costs.

Sec. 9. **[62J.37] DATA FROM INTEGRATED SERVICE NETWORKS.**

The commissioner shall require integrated service networks operating under section 62N.06, subdivision 1, to submit data on health care spending and revenue for calendar year 1994 by February 15, 1995. Each February 15 thereafter, integrated service networks shall submit to the commissioner data on health care spending and revenue for the preceding calendar year. The data must be provided in the form specified by the commissioner. To the extent that an integrated service network is operated by a group purchaser under section 62N.06, subdivision 2, the integrated service network is exempt from this section and the group purchaser must provide data on the integrated service network under section 62J.38.

Sec. 10. **[62J.38] DATA FROM GROUP PURCHASERS.**

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for calendar years 1990, 1991, and 1992, and for calendar year 1993 and successive calendar years. Group purchasers shall submit data for the 1993 calendar year by February 15, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data, including raw data from claims, must be provided separately for the following categories: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services,

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emergency and out-of-area care, pharmacy services and prescription drugs, mental health services, chemical dependency services, other expenditures, and administrative costs.

(c) State agencies and all other group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

Sec. 11. **[62J.40] DATA FROM STATE AGENCIES.**

In addition to providing the data required under section 62J.38, the commissioners of human services, commerce, labor and industry, and employee relations and all other state departments or agencies that administer one or more health care programs shall provide to the commissioner of health any additional data on the health care programs they administer that is requested by the commissioner of health, including data in unaggregated form, for purposes of developing estimates of spending, setting spending limits, and monitoring actual spending. The data must be provided at the times and in the form specified by the commissioner of health.

Sec. 12. **[62J.41] DATA FROM PROVIDERS.**

Subdivision 1. **DATA TO BE COLLECTED FROM PROVIDERS.** The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on:

(1) the total number of patients served;

(2) the total number of patients served by state of residence and Minnesota county;

(3) the site or sites where the health care provider provides services;

(4) the number of individuals employed, by type of employee, by the health care provider;

(5) the services and their costs for which no payment was received;

(6) total revenue by type of payer, including but not limited to, revenue from Medicare, medical assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, integrated service networks, health maintenance organizations, and individual patients;

(7) revenue from research activities;

(8) revenue from educational activities;

(9) revenue from out-of-pocket payments by patients;

(10) revenue from donations; and

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(11) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs and quality.

Subd. 2. **ANNUAL MONITORING AND ESTIMATES.** The commissioner shall require health care providers to submit the required data for the period July 1, 1993 to December 31, 1993, by February 15, 1994. Health care providers shall submit data for the 1994 calendar year by February 15, 1995, and each February 15 thereafter shall submit data for the preceding calendar year. The commissioner of revenue may collect health care service revenue data from health care providers, if the commissioner of revenue and the commissioner agree that this is the most efficient method of collecting the data. The commissioner of revenue shall provide any data collected to the commissioner of health.

Subd. 3. **PUBLIC HEALTH GOALS.** The commissioner shall establish specific public health goals including, but not limited to, increased delivery of prenatal care, improved birth outcomes, and expanded childhood immunizations. The commissioner shall consider the community public health goals and the input of the statewide advisory committee on community health in establishing the statewide goals. The commissioner shall require health care providers and integrated service networks to maintain and periodically report information on changes in health outcomes related to specific public health goals. The information must be provided at the times and in the form specified by the commissioner.

Subd. 4. **REGIONAL PUBLIC HEALTH GOALS.** The regional coordinating boards shall adopt regional public health goals, taking into consideration the relevant portions of the community health service plans, plans required by the Minnesota comprehensive adult mental health act and the Minnesota comprehensive children's mental health act, and community social service act plans developed by county boards or community health boards in the region under chapters 145A, 245, and 256E.

Sec. 13. **[62J.42] QUALITY, UTILIZATION, AND OUTCOME DATA.**

The commissioner shall also require group purchasers and health care providers to maintain and periodically report information on quality of care, utilization, and outcomes. The information must be provided at the times and in the form specified by the commissioner.

Sec. 14. **[62J.44] PUBLICATION OF DATA.**

(a) Notwithstanding section 62J.04, subdivision 2b, the commissioner may publish data on health care costs and spending, quality and outcomes, and utilization for health care institutions, individual health care professionals and groups of health care professionals, group purchasers, and integrated service networks, with a description of the methodology used for analysis, in order to provide information to purchasers and consumers of health care. The commissioner shall not reveal the name of an institution, group of professionals, individual health care professional, group purchaser, or integrated service network until

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after the institution, group of professionals, individual health care professional, group purchaser, or integrated service network has had 15 days to review the data and comment. The commissioner shall include any comments received in the release of the data.

(b) Summary data derived from data collected under this chapter may be provided under section 13.05, subdivision 7, and may be released in studies produced by the commissioner or otherwise in accordance with chapter 13.

Sec. 15. **[62J.45] DATA INSTITUTE.**

Subdivision 1. **STATEMENT OF PURPOSE.** It is the intention of the legislature to create a public-private mechanism for the collection of health care costs, quality, and outcome data, to the extent administratively efficient and effective. This integrated data system will provide clear, usable information on the cost, quality, and structure of health care services in Minnesota.

The health reform initiatives being implemented rely heavily on the availability of valid, objective data that currently are collected in many forms within the health care industry. Data collection needs cannot be efficiently met by undertaking separate data collection efforts.

The data institute created in this section will be a partnership between the commissioner of health and a board of directors representing health carriers and other group purchasers, health care providers, and consumers. These entities will work together to establish a centralized cost and quality data system that will be used by the public and private sectors. The data collection advisory committee and the practice parameter advisory committee shall provide assistance to the institute through the commissioner of health.

Subd. 2. **DEFINITIONS.** For purposes of this section, the following definitions apply.

(a) "Board" means the board of directors of the data institute.

(b) "Encounter level data" means data related to the utilization of health care services by, and the provision of health care services to individual patients, enrollees, or insureds, including claims data, abstracts of medical records, and data from patient interviews and patient surveys.

(c) "Health carrier" has the definition provided in section 62A.011, subdivision 2.

Subd. 3. **OBJECTIVES OF THE DATA INSTITUTE.** The data institute shall:

(1) provide direction and coordination for public and private sector data collection efforts;

(2) establish a data system that electronically transmits, collects, archives,

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and provides users of data with the data necessary for their specific interests, in order to promote a high quality, cost-effective, consumer-responsive health care system;

(3) use and build upon existing data sources and quality measurement efforts, and improve upon these existing data sources and measurement efforts through the integration of data systems and the standardization of concepts, to the greatest extent possible;

(4) ensure that each segment of the health care industry can obtain data for appropriate purposes in a useful format and timely fashion;

(5) protect the privacy of individuals and minimize administrative costs; and

(6) develop a public/private information system to:

(i) make health care claims processing and financial settlement transactions more efficient;

(ii) provide an efficient, unobtrusive method for meeting the shared data needs of the state, consumers, employers, providers, and group purchasers;

(iii) provide the state, consumers, employers, providers, and group purchasers with information on the cost, appropriateness and effectiveness of health care, and wellness and cost containment strategies;

(iv) provide employers with the capacity to analyze benefit plans and work place health; and

(v) provide researchers and providers with the capacity to analyze clinical effectiveness.

The institute shall carry out these activities in accordance with the recommendations of the data collection plan developed by the data collection advisory committee, the Minnesota health care commission, and the commissioner of health, under subdivision 4.

Subd. 4. **DATA COLLECTION PLAN.** The commissioner, in consultation with the board of the institute and the data collection advisory committee, shall develop and implement a plan that:

(1) provides data collection objectives, strategies, priorities, cost estimates, administrative and operational guidelines, and implementation timelines for the data institute; and

(2) identifies the encounter level data needed for the commissioner to carry out the duties assigned in this chapter.

The plan must take into consideration existing data sources and data sources that can easily be made uniform for linkages to other data sets.

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This plan shall be prepared by October 31, 1993.

Subd. 5. **COMMISSIONER'S DUTIES.** (a) The commissioner shall establish a public/private data institute in conjunction with health care providers, health carriers and other group purchasers, and consumers, to collect and process encounter level data that are required to be submitted to the commissioner under this chapter. The commissioner shall not collect encounter level data from individual health care providers until standardized forms and procedures are available. The commissioner shall establish a board of directors comprised of members of the public and private sector to provide oversight for the administration and operation of the institute.

(b) Until the data institute is operational, the commissioner may collect encounter level data required to be submitted under this chapter.

(c) The commissioner, with the advice of the board, shall establish policies for the disclosure of data to consumers, purchasers, providers, integrated service networks, and plans for their use in analysis to meet the goals of this chapter, as well as for the public disclosure of data to other interested parties. The disclosure policies shall ensure that consumers, purchasers, providers, integrated service networks, and plans have access to institute data for use in analysis to meet the goals of this chapter at the same time that data is provided to the data analysis unit in the department of health.

(d) The commissioner, with the advice of the board, may require those requesting data from the institute to contribute toward the cost of data collection through the payments of fees. Entities supplying data to the institute shall not be charged more than the actual transaction cost of providing the data requested.

(e) The commissioner may intervene in the direct operation of the institute, if this is necessary in the judgment of the commissioner to accomplish the institute's duties. If the commissioner intends to depart from the advice and recommendations of the board, the commissioner shall inform the board of the intended departure, provide the board with a written explanation of the reasons for the departure, and give the board the opportunity to comment on the departure.

Subd. 6. **BOARD OF DIRECTORS.** The institute is governed by a 20-member board of directors consisting of the following members:

(1) two representatives of hospitals, one appointed by the Minnesota Hospital Association and one appointed by the Metropolitan HealthCare Council, to reflect a mix of urban and rural institutions;

(2) four representatives of health carriers, two appointed by the Minnesota Council of Health Maintenance Organizations, one appointed by Blue Cross Blue Shield, and one appointed by the Insurance Federation of Minnesota;

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(3) two consumer members, one appointed by the commissioner, and one appointed by the AFL-CIO as a labor union representative;

(4) five group purchaser representatives appointed by the Minnesota Consortium of Healthcare Purchasers to reflect a mix of urban and rural, large and small, and self-insured purchasers;

(5) two physicians appointed by the Minnesota Medical Association, to reflect a mix of urban and rural practitioners;

(6) one representative of teaching and research institutions, appointed jointly by the Mayo Foundation and the Minnesota Association of Public Teaching Hospitals;

(7) one nursing representative appointed by the Minnesota Nurses Association; and

(8) three representatives of state agencies, one member representing the department of employee relations, one member representing the department of human services, and one member representing the department of health.

Subd. 7. **TERMS; COMPENSATION; REMOVAL; AND VACANCIES.** The board is governed by section 15.0575.

Subd. 8. **STAFF.** The board may hire an executive director. The executive director is not a state employee but is covered by section 3.736. The executive director may participate in the following plans for employees in the unclassified service: the state retirement plan, the state deferred compensation plan, and the health insurance and life insurance plans. The attorney general shall provide legal services to the board.

Subd. 9. **DUTIES.** The board shall provide assistance to the commissioner in developing and implementing a plan for the public/private information system. In addition, the board shall make recommendations to the commissioner on:

(1) the purpose of initiating a data collection initiatives;

(2) the expected benefit to the state from the initiatives;

(3) the methodology needed to ensure the validity of the initiative without creating an undue burden to providers and payors;

(4) the most appropriate method of collecting the necessary data; and

(5) the projected cost to the state, health care providers, health carriers, and other group purchasers to complete the initiative.

Subd. 10. **DATA COLLECTION.** The commissioner, in consultation with the data institute board, may select a vendor to:

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(1) collect the encounter level data required to be submitted by group purchasers under sections 62J.38 and 62J.42, state agencies under section 62J.40, and health care providers under sections 62J.41 and 62J.42, using, to the greatest extent possible, standardized forms and procedures;

(2) collect the encounter level data required for the initiatives of the health care analysis unit, under sections 62J.30 to 62J.34, using, to the greatest extent possible, standardized forms and procedures;

(3) process the data collected to ensure validity, consistency, accuracy, and completeness, and as appropriate, merge data collected from different sources;

(4) provide unaggregated, encounter level data to the health care analysis unit within the department of health; and

(5) carry out other duties assigned in this section.

Subd. 11. **USE OF DATA.** (a) The board of the data institute, with the advice of the data collection advisory committee and the practice parameter advisory committee through the commissioner, is responsible for establishing the methodology for the collection of the data and is responsible for providing direction on what data would be useful to the plans, providers, consumers, and purchasers.

(b) The health care analysis unit is responsible for the analysis of the data and the development and dissemination of reports.

(c) The commissioner, in consultation with the board, shall determine when and under what conditions data disclosure to group purchasers, health care providers, consumers, researchers, and other appropriate parties may occur to meet the state's goals. The commissioner may require users of data to contribute toward the cost of data collection through the payment of fees. The commissioner shall require users of data to maintain the data according to the data privacy provisions applicable to the data.

Subd. 12. **CONTRACTING.** The commissioner, in consultation with the board, may contract with private sector entities to carry out the duties assigned in this section. The commissioner shall diligently seek to enter into contracts with private sector entities. Any contract must list the specific data to be collected and the methods to be used to collect and validate the data. Any contract must require the private sector entity to maintain the data collected according to the data privacy provisions applicable to the data.

Subd. 13. **DATA PRIVACY.** The board and the institute are subject to chapter 13.

Subd. 14. **STANDARDS FOR DATA RELEASE.** The data institute shall adopt standards for the collection, by the institute, of data on costs, spending, quality, outcomes, and utilization. The data institute shall also adopt standards for the analysis and dissemination, by private sector entities, of data on costs,

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spending, quality, outcomes, and utilization provided to the private sector entities by the data institute. Both sets of standards must be consistent with data privacy requirements.

Subd. 15. **INFORMATION CLEARINGHOUSE.** The commissioner shall coordinate the activities of the data institute with the activities of the information clearinghouse established in section 62J.33, subdivision 2.

Subd. 16. **FEDERAL AND OTHER GRANTS.** The commissioner, in collaboration with the board, shall seek federal funding and funding from private and other nonstate sources for the initiatives required by the board.

Sec. 16. **[62J.46] MONITORING AND REPORTS.**

Subdivision 1. **LONG-TERM CARE COSTS.** The commissioner, with the advice of the interagency long-term care planning committee established under section 144A.31, shall use existing state data resources to monitor trends in public and private spending on long-term care costs and spending in Minnesota. The commissioner shall recommend to the legislature any additional data collection activities needed to monitor these trends. State agencies collecting information on long-term care spending and costs shall coordinate with the interagency long-term care planning committee and the commissioner to facilitate the monitoring of long-term care expenditures in the state.

Subd. 2. **COST SHIFTING.** The commissioner shall monitor the extent to which reimbursement rates for government health care programs lead to the shifting of costs to private payers. By January 1, 1995, the commissioner shall report any evidence of cost shifting to the legislature and make recommendations on adjustments to the cost containment plan that should be made due to cost shifting.

Sec. 17. Laws 1992, chapter 549, article 7, section 9, is amended to read:

Sec. 9. **STUDY OF ADMINISTRATIVE COSTS.**

The ~~health care~~ data analysis unit shall study costs and requirements incurred by health carriers, group purchasers, and health care providers that are related to the collection and submission of information to the state and federal government, insurers, and other third parties. The data analysis unit shall also evaluate and make recommendations related to cost-savings and efficiencies that may be achieved through streamlining and consolidating health care administrative, payment, and data collection systems. The unit shall recommend to the commissioner of health and the Minnesota health care commission by January 1, 1994, any reforms that may ~~reduce these costs~~ produce cost-savings and efficiencies without compromising the purposes for which the information is collected.

Sec. 18. **INSTRUCTION TO REVISOR.**

(a) The revisor of statutes shall insert section 62J.04, subdivisions 2, 2a, and

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2b, as subdivisions 1, 2, and 3 in section 62J.35, and renumber the other subdivisions of section 62J.35 as subdivisions 4 and 5 of that section in the next and subsequent editions of Minnesota Statutes.

(b) The revisor of statutes is directed to change the words "health care analysis unit" to "data analysis unit" whenever they appear in the next edition of Minnesota Statutes.

Sec. 19. **EFFECTIVE DATE.**

Sections 1 to 17 are effective the day following final enactment.

ARTICLE 4

TECHNOLOGY ADVISORY COMMITTEE

Section 1. Minnesota Statutes 1992, section 62J.03, is amended by adding a subdivision to read:

Subd. 9. **SAFETY.** "Safety" means a judgment of the acceptability of risk of using a technology in a specified situation.

Sec. 2. Minnesota Statutes 1992, section 62J.15, subdivision 1, is amended to read:

Subdivision 1. **HEALTH ~~PLANNING~~ TECHNOLOGY ADVISORY COMMITTEE.** The Minnesota health care commission shall convene an advisory committee to ~~make recommendations regarding the use and distribution~~ conduct evaluations of existing research and technology assessments conducted by other entities of new and existing health care technologies ~~and procedures and major capital expenditures by providers~~. The advisory committee may include members of the state commission and other persons appointed by the commission. The advisory committee must include at least one person representing physicians, at least one person representing hospitals, and at least one person representing the health care technology industry. Health care technologies ~~and procedures~~ include high-cost ~~pharmaceuticals, organ and other high-cost transplants, high-cost~~ drugs, devices, procedures, or processes applied to human health care ~~procedures and devices excluding United States Food and Drug Administration approved implantable or wearable medical devices~~, such as high-cost transplants and expensive~~, large-scale technologies such as~~ scanners and imagers. The advisory committee is governed by section 15.0575, subdivision 3, except that members do not receive per diem payments.

Sec. 3. Minnesota Statutes 1992, section 62J.15, is amended by adding a subdivision to read:

Subd. 1a. **DEFINITION.** For purposes of sections 62J.15 to 62J.156, the

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terms "evaluate," "evaluation," and "evaluating" mean the review or reviewing of research and technology assessments conducted by other entities relating to specific technologies and their specific use and application.

Sec. 4. [62J.152] DUTIES OF HEALTH TECHNOLOGY ADVISORY COMMITTEE.

Subdivision 1. **GENERALLY.** The health technology advisory committee established in section 62J.15 shall:

(1) develop criteria and processes for evaluating health care technology assessments made by other entities;

(2) conduct evaluations of specific technologies and their specific use and application;

(3) report the results of the evaluations to the commissioner and the Minnesota health care commission; and

(4) carry out other duties relating to health technology assigned by the commission.

Subd. 2. **PRIORITIES FOR DESIGNATING TECHNOLOGIES FOR ASSESSMENT.** The health technology advisory committee shall consider the following criteria in designating technologies for evaluation:

(1) the level of controversy within the medical or scientific community, including questionable or undetermined efficacy;

(2) the cost implications;

(3) the potential for rapid diffusion;

(4) the impact on a substantial patient population;

(5) the existence of alternative technologies;

(6) the impact on patient safety and health outcome;

(7) the public health importance;

(8) the level of public and professional demand;

(9) the social, ethical, and legal concerns; and

(10) the prevalence of the disease or condition.

The committee may give different weights or attach different importance to each of the criteria, depending on the technology being considered. The committee shall consider any additional criteria approved by the commissioner and the Minnesota health care commission.

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Subd. 3. **CRITERIA FOR EVALUATING TECHNOLOGY.** In developing the criteria for evaluating specific technologies, the health technology advisory committee shall consider safety, improvement in health outcomes, and the degree to which a technology is clinically effective and cost-effective, and other factors.

Subd. 4. **TECHNOLOGY EVALUATION PROCESS.** (a) The health technology advisory committee shall collect and evaluate studies and research findings on the technologies selected for evaluation from as wide of a range of sources as needed, including, but not limited to: federal agencies or other units of government, international organizations conducting health care technology assessments, health carriers, insurers, manufacturers, professional and trade associations, nonprofit organizations, and academic institutions. The health technology advisory committee may use consultants or experts and solicit testimony or other input as needed to evaluate a specific technology.

(b) When the evaluation process on a specific technology has been completed, the health technology advisory committee shall submit a preliminary report to the health care commission and publish a summary of the preliminary report in the State Register with a notice that written comments may be submitted. The preliminary report must include the results of the technology assessment evaluation, studies and research findings considered in conducting the evaluation, and the health technology advisory committee's summary statement about the evaluation. Any interested persons or organizations may submit to the health technology advisory committee written comments regarding the technology evaluation within 30 days from the date the preliminary report was published in the State Register. The health technology advisory committee's final report on its technology evaluation must be submitted to the health care commission. A summary of written comments received by the health technology advisory committee within the 30-day period must be included in the final report. The health care commission shall review the final report and prepare its comments and recommendations. Before completing its final comments and recommendations, the health care commission shall provide adequate public notice that testimony will be accepted by the health care commission. The health care commission shall then forward the final report, its comments and recommendations, and a summary of the public's comments to the commissioner and information clearinghouse.

(c) The reports of the health technology advisory committee and the comments and recommendations of the health care commission should not eliminate or bar new technology, and are not rules as defined in the administrative procedure act.

Subd. 5. **USE OF TECHNOLOGY EVALUATION.** (a) The final report on the technology evaluation and the commission's comments and recommendations may be used:

(1) by the commissioner in retrospective and prospective review of major expenditures;

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(2) by integrated service networks and other group purchasers and by employers, in making coverage, contracting, purchasing, and reimbursement decisions;

(3) by government programs and regulators of the regulated all-payer system, in making coverage, contracting, purchasing, and reimbursement decisions;

(4) by the commissioner and other organizations in the development of practice parameters;

(5) by health care providers in making decisions about adding or replacing technology and the appropriate use of technology;

(6) by consumers in making decisions about treatment;

(7) by medical device manufacturers in developing and marketing new technologies; and

(8) as otherwise needed by health care providers, health care plans, consumers, and purchasers.

(b) At the request of the commissioner, the health care commission, in consultation with the health technology advisory committee, shall submit specific recommendations relating to technologies that have been evaluated under this section for purposes of retrospective and prospective review of major expenditures and coverage, contracting, purchasing, and reimbursement decisions affecting state programs and the all-payer system.

Subd. 6. **APPLICATION TO THE REGULATED ALL-PAYER SYSTEM.** The health technology advisory committee shall recommend to the Minnesota health care commission and the commissioner methods to control the diffusion and use of technology within the regulated all-payer system for services provided outside of an integrated service network.

Subd. 7. **DATA GATHERING.** In evaluating a specific technology, the health technology advisory committee may seek the use of data collected by manufacturers, health plans, professional and trade associations, nonprofit organizations, academic institutions, or any other organization or association that may have data relevant to the committee's technology evaluation. All information obtained under this subdivision shall be considered nonpublic data under section 13.02, subdivision 9, unless the data is already available to the public generally or upon request.

Sec. 5. **[62J.156] CLOSED COMMITTEE HEARINGS.**

Notwithstanding section 471.705, the health technology advisory committee may meet in closed session to discuss a specific technology or procedure that involves data received under section 62J.152, subdivision 7, that have been classified as nonpublic data, where disclosure of the data would cause harm to the competitive or economic position of the source of the data.

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Sec. 6. **USE AND DISTRIBUTION OF HEALTH TECHNOLOGY.**

The health care commission, in consultation with the health technology advisory committee, shall submit a report to the legislature and the governor by January 15, 1994, regarding the necessity of a health technology advisory committee to address the use and distribution of health technology under a system of integrated service networks with global limits on growth, and in a regulated all-payer system. The report may also include recommendations for the future role of the health technology advisory committee, and further changes, programs, or activities that may be necessary to ensure that the use and distribution of health technology in Minnesota is consistent with the state's cost containment goals. In preparing the report, the health care commission shall consult with the medical technology industry in Minnesota for its input and reactions.

Sec. 7. **REPEALER.**

Minnesota Statutes 1992, section 62J.15, subdivision 2, is repealed.

ARTICLE 5

MISCELLANEOUS

Section 1. Minnesota Statutes 1992, section 3.732, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** As used in this section and section 3.736 the terms defined in this section have the meanings given them.

(1) "State" includes each of the departments, boards, agencies, commissions, courts, and officers in the executive, legislative, and judicial branches of the state of Minnesota and includes but is not limited to the housing finance agency, the higher education coordinating board, the higher education facilities authority, the health technology advisory committee, the armory building commission, the zoological board, the iron range resources and rehabilitation board, the state agricultural society, the University of Minnesota, state universities, community colleges, state hospitals, and state penal institutions. It does not include a city, town, county, school district, or other local governmental body corporate and politic.

(2) "Employee of the state" means all present or former officers, members, directors, or employees of the state, members of the Minnesota national guard, members of a bomb disposal unit approved by the commissioner of public safety and employed by a municipality defined in section 466.01 when engaged in the disposal or neutralization of bombs outside the jurisdiction of the municipality but within the state, or persons acting on behalf of the state in an official capacity, temporarily or permanently, with or without compensation. It does not include either an independent contractor or members of the Minnesota national

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guard while engaged in training or duty under United States Code, title 10, or title 32, section 316, 502, 503, 504, or 505, as amended through December 31, 1983. "Employee of the state" includes a public defender appointed by the state board of public defense, and a member of the health technology advisory committee.

(3) "Scope of office or employment" means that the employee was acting on behalf of the state in the performance of duties or tasks lawfully assigned by competent authority.

(4) "Judicial branch" has the meaning given in section 43A.02, subdivision 25.

Sec. 2. Minnesota Statutes 1992, section 43A.17, is amended by adding a subdivision to read:

Subd. 12. **ACTUARIES.** Actuaries employed by the department of health, human services, or commerce are not subject to subdivision 1.

Sec. 3. Minnesota Statutes 1992, section 60K.14, is amended by adding a subdivision to read:

Subd. 7. Before selling, or offering to sell, any health insurance or a health plan as defined in section 62A.011, subdivision 3, an agent shall disclose to the prospective purchaser the amount of any commission or other compensation the agent will receive as a direct result of the sale. The disclosure may be expressed in dollars or as a percentage of the premium. The amount disclosed need not include any anticipated renewal commissions.

Sec. 4. **[62A.024] RATE DISCLOSURE.**

If any health carrier, as defined in section 62A.011, informs a policyholder or contract holder that a rate increase is due to a statutory change, the health carrier must disclose the specific amount of the rate increase directly due to the statutory change and must identify the specific statutory change. This disclosure must also separate any rate increase due to medical inflation or other reasons from the rate increase directly due to statutory changes in chapter 62A, 62C, 62D, 62E, 62H, 62J, 62L, or 64B.

Sec. 5. Minnesota Statutes 1992, section 62C.16, is amended by adding a subdivision to read:

Subd. 4. **RETALIATORY ACTION PROHIBITED.** No service plan corporation may take retaliatory action against a provider solely on the grounds that the provider disseminated accurate information regarding coverage of benefits or accurate benefit limitations of a subscriber's contract or accurate interpretations of the provider agreement that limit the prescribing, providing, or ordering of care.

Sec. 6. Minnesota Statutes 1992, section 62D.12, is amended by adding a subdivision to read:

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Subd. 17. **DISCLOSURE OF COMMISSIONS.** Any person receiving commissions for the sale of coverage or enrollment in a health maintenance organization shall, before selling or offering to sell coverage or enrollment, disclose to the prospective purchaser the amount of any commission or other compensation the person will receive as a direct result of the sale. The disclosure may be expressed in dollars or as a percentage of the premium. The amount disclosed need not include any anticipated renewal commissions.

Sec. 7. Minnesota Statutes 1992, section 62J.04, subdivision 3, is amended to read:

Subd. 3. **COST CONTAINMENT DUTIES.** After obtaining the advice and recommendations of the Minnesota health care commission, the commissioner shall:

(1) establish statewide and regional limits on growth in total health care spending under this section, monitor regional and statewide compliance with the spending limits, and take action to achieve compliance to the extent authorized by the legislature;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve spending limits;

(3) provide technical assistance to regional coordinating boards;

(4) monitor the quality of health care throughout the state, conduct consumer satisfaction surveys, and take action as necessary to ensure an appropriate level of quality;

(5) ~~develop~~ issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers ~~by January 1, 1993~~ and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Health Care Financing Administration 1500 form, or other standardized forms or procedures;

(6) undertake health planning responsibilities as provided in section 62J.15;

(7) monitor and promote the development and implementation of practice parameters;

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(8) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(9) designate referral centers ~~of excellence~~ for specialized and high-cost procedures and treatment and establish minimum standards and requirements for particular procedures or treatment;

(10) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(11) administer the health care analysis unit ~~under Laws 1992, chapter 549, article 7~~; and

(12) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans.

Sec. 8. Minnesota Statutes 1992, section 62J.04, subdivision 4, is amended to read:

Subd. 4. **CONSULTATION WITH THE COMMISSION.** ~~Before~~ When the law requires the commissioner of health to consult with the Minnesota health care commission when undertaking any of the duties required under this chapter and chapter 62N, the commissioner ~~of health~~ shall consult with the ~~Minnesota health care~~ commission and obtain the commission's advice and recommendations. If the commissioner intends to depart from the commission's recommendations, the commissioner shall inform the commission of the intended departure, provide a written explanation of the reasons for the departure, and give the commission an opportunity to comment on the intended departure. If, after receiving the commission's comment, the commissioner still intends to depart from the commission's recommendations, the commissioner shall notify each member of the legislative ~~oversight~~ commission on health care access of the commissioner's intent to depart from the recommendations of the Minnesota health care commission. The notice to the legislative ~~oversight~~ commission must be provided at least ten days before the commissioner takes final action. If emergency action is necessary that does not allow the commissioner to obtain the advice and recommendations of the Minnesota health care commission or to provide advance notice and an opportunity for comment as required in this subdivision, the commissioner shall provide a written notice and explanation to the Minnesota health care commission and the legislative ~~oversight~~ commission at the earliest possible time.

Sec. 9. **[62J.212] COLLABORATION ON PUBLIC HEALTH GOALS.**

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The commissioner may increase regional spending limits if public health goals for that region are achieved.

Sec. 10. Minnesota Statutes 1992, section 151.21, is amended to read:

151.21 **SUBSTITUTION.**

Subdivision 1. Except as provided in ~~subdivision 2~~ this section, it shall be unlawful for any pharmacist, assistant pharmacist, or pharmacist intern who dispenses prescriptions, drugs, and medicines to substitute an article different from the one ordered, or deviate in any manner from the requirements of an order or prescription without the approval of the prescriber.

Subd. 2. When a pharmacist receives a written prescription on which the prescriber has personally written in handwriting "dispense as written" or "D.A.W.," or an oral prescription in which the prescriber has expressly indicated that the prescription is to be dispensed as communicated, the pharmacist shall dispense the brand name legend drug as prescribed.

Subd. ~~2~~ 3. ~~A pharmacist who receives a prescription for a brand name legend drug may, with the written or verbal consent of the purchaser, dispense any drug having the same generic name as the brand name drug prescribed if the prescriber has not personally written in handwriting "dispense as written" or "D.A.W." on the prescription or, when an oral prescription is given, has not expressly indicated the prescription is to be dispensed as communicated. A pharmacist who receives a prescription marked "D.A.W." or "dispense as written", or an oral prescription indicating that the prescription is to be dispensed as communicated, may substitute for the prescribed brand name drug a generically equivalent drug product which is manufactured in the same finished dosage form having the same active ingredients and strength by the same manufacturer as the prescribed brand name drug~~ When a pharmacist receives a written prescription on which the prescriber has not personally written in handwriting "dispense as written" or "D.A.W.," or an oral prescription in which the prescriber has not expressly indicated that the prescription is to be dispensed as communicated, and there is available in the pharmacist's stock a less expensive generically equivalent drug that, in the pharmacist's professional judgment, is safely interchangeable with the prescribed drug, then the pharmacist shall, after disclosing the substitution to the purchaser, dispense the generic drug, unless the purchaser objects. A pharmacist may also substitute pursuant to the oral instructions of the prescriber. A pharmacist may not substitute a generically equivalent drug product unless, in the pharmacist's professional judgment, the substituted drug is therapeutically equivalent and interchangeable to the prescribed drug. A pharmacist shall notify the purchaser if the pharmacist is dispensing a drug other than the brand name drug prescribed.

Subd. ~~3~~ 4. A pharmacist dispensing a drug under the provisions of subdivision ~~2~~ 3 shall not dispense a drug of a higher retail price than that of the brand name drug prescribed. If more than one safely interchangeable generic drug is available in a pharmacist's stock, then the pharmacist shall dispense the least

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expensive alternative. Any difference between acquisition cost to the pharmacist of the drug dispensed and the brand name drug prescribed shall be passed on to the purchaser.

Subd. 5. Nothing in this section requires a pharmacist to substitute a generic drug if the substitution will make the transaction ineligible for third-party reimbursement.

Subd. 6. When a pharmacist dispenses a brand name legend drug and, at that time, a less expensive generically equivalent drug is also available in the pharmacist's stock, the pharmacist shall disclose to the purchaser that a generic drug is available.

Subd. 7. This section does not apply to prescription drugs dispensed to persons covered by a health plan that covers prescription drugs under a managed care formulary or similar practices.

Subd. 8. The following drugs are excluded from this section: coumadin, dilantin, lanoxin, premarin, theophylline, synthroid, tegretol, and phenobarbital.

Sec. 11. **[151.461] GIFTS TO PRACTITIONERS PROHIBITED.**

It is unlawful for any manufacturer or wholesale drug distributor, or any agent thereof, to offer or give any gift of value to a practitioner. A medical device manufacturer that distributes drugs as an incidental part of its device business shall not be considered a manufacturer, a wholesale drug distributor, or agent under this section. As used in this section, "gift" does not include:

(1) professional samples of a drug provided to a prescriber for free distribution to patients;

(2) items with a total combined retail value, in any calendar year, of not more than $50;

(3) a payment to the sponsor of a medical conference, professional meeting, or other educational program, provided the payment is not made directly to a practitioner and is used solely for bona fide educational purposes;

(4) reasonable honoraria and payment of the reasonable expenses of a practitioner who serves on the faculty at a professional or educational conference or meeting;

(5) compensation for the substantial professional or consulting services of a practitioner in connection with a genuine research project;

(6) publications and educational materials; or

(7) salaries or other benefits paid to employees.

Sec. 12. Minnesota Statutes 1992, section 151.47, subdivision 1, is amended to read:

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Subdivision 1. **REQUIREMENTS.** All wholesale drug distributors are subject to the requirements in paragraphs (a) to ~~(e)~~ (f).

(a) No person or distribution outlet shall act as a wholesale drug distributor without first obtaining a license from the board and paying the required fee.

(b) No license shall be issued or renewed for a wholesale drug distributor to operate unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.

(c) The board may require a separate license for each facility directly or indirectly owned or operated by the same business entity within the state, or for a parent entity with divisions, subsidiaries, or affiliate companies within the state, when operations are conducted at more than one location and joint ownership and control exists among all the entities.

(d) As a condition for receiving and retaining a wholesale drug distributor license issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has and will continuously maintain:

(1) adequate storage conditions and facilities;

(2) minimum liability and other insurance as may be required under any applicable federal or state law;

(3) a viable security system that includes an after hours central alarm, or comparable entry detection capability; restricted access to the premises; comprehensive employment applicant screening; and safeguards against all forms of employee theft;

(4) a system of records describing all wholesale drug distributor activities set forth in section 151.44 for at least the most recent two-year period, which shall be reasonably accessible as defined by board regulations in any inspection authorized by the board;

(5) principals and persons, including officers, directors, primary shareholders, and key management executives, who must at all times demonstrate and maintain their capability of conducting business in conformity with sound financial practices as well as state and federal law;

(6) complete, updated information, to be provided to the board as a condition for obtaining and retaining a license, about each wholesale drug distributor to be licensed, including all pertinent corporate licensee information, if applicable, or other ownership, principal, key personnel, and facilities information found to be necessary by the board;

(7) written policies and procedures that assure reasonable wholesale drug distributor preparation for, protection against, and handling of any facility security or operation problems, including, but not limited to, those caused by natural disaster or government emergency, inventory inaccuracies or product

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shipping and receiving, outdated product or other unauthorized product control, appropriate disposition of returned goods, and product recalls;

(8) sufficient inspection procedures for all incoming and outgoing product shipments; and

(9) operations in compliance with all federal requirements applicable to wholesale drug distribution.

(e) An agent or employee of any licensed wholesale drug distributor need not seek licensure under this section.

(f) A wholesale drug distributor shall file with the board an annual report, in a form and on the date prescribed by the board, identifying all payments, honoraria, reimbursement or other compensation authorized under section 151.461, clauses (3) to (5), paid to practitioners in Minnesota during the preceding calendar year. The report shall identify the nature and value of any payments totaling $100 or more, to a particular practitioner during the year, and shall identify the practitioner. Reports filed under this provision are public data.

Sec. 13. **MEDICAL CARE SAVINGS ACCOUNTS.**

(a) The commissioner of health, in consultation with the commissioners of employee relations, commerce, and revenue and the Minnesota health care commission, shall conduct a study to determine the feasibility of establishing a medical and health care benefits plan such as one to help provide incentives for persons in Minnesota whose employers pay all or part of the cost of medical and health care benefits for their employees to forego unnecessary medical treatment and to shop for the best value in cases where treatment is necessary. The study must address, at a minimum, the advantages and disadvantages of establishing a medical and health care benefits plan and may contain the components and criteria in paragraphs (b) to (f).

(b) Employers each year shall set aside in an account for each of their employees a substantial percentage of the amount that the employers currently or would otherwise spend for medical and health care benefits for each employee. The account is an allowance for medical and health care for the employee during that year.

(c) Employers shall use the remaining percentage amount to purchase or self fund major medical and health care benefits for all employees, which shall pay 100 percent of the cost of any portion of an employee's medical and health care that exceeds the amount in the employee's medical and health care account.

(d) Any amount in an employee's medical and health care account that is unspent belongs to the employee with no restrictions on the purposes for which it may be used.

(e) The amount in an employee's medical and health care account is not subject to state income taxation while it remains in the account. Any amount

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spent from the account on medical and health care is totally exempt from state income taxation. Any amount spent from the account for any purpose other than medical and health care is subject to state income taxation.

(f) Employers that provide medical and health care benefits to their employees in accordance with the plan shall receive state tax credits against their income for each year that the benefits are provided.

(g) The results of the study must be submitted to the legislature by January 15, 1994.

Sec. 14. **REQUESTS FOR FEDERAL ACTION.**

The commissioner of health shall seek changes in or waivers from federal statutes or regulations as necessary to implement the provisions of this act. The commissioner of human services shall request and diligently pursue waivers from the federal laws relating to health coverages provided under the medical assistance and Medicare programs, so as to permit the state to provide medical assistance benefits through integrated service networks and permit Medicare to be provided in Minnesota through integrated service networks.

Sec. 15. **PRESCRIPTION DRUG STUDY.**

The commissioner of health shall prepare and submit to the legislature by February 15, 1994, a study of the manufacturing, wholesale, and retail prescription drug market in Minnesota. In conducting the study, the commissioner of health shall consult with the commissioners of administration, employee relations, and human services, the Minnesota health care commission, and the University of Minnesota pharmaceutical research, management, and economics programs. The commissioner shall also consult with representatives of retail and other pharmacists, drug manufacturers, consumers, senior citizen organizations, hospitals, nursing homes, physicians, health maintenance organizations, and other stakeholders and persons with relevant expertise.

The study shall examine:

(1) how distinctions based on volume purchased or class of purchaser affect manufacturer, wholesale, and retail pricing;

(2) how manufacturer and wholesale pricing are affected by other industry practices, by federal and state law, and by other factors such as marketing, promotion, and research and development;

(3) how manufacturer and wholesale pricing affect retail pricing;

(4) other factors affecting retail pricing; and

(5) methods of reducing manufacturer, wholesale, and retail prices, including but not limited to:

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(i) mandatory prescription drug contracting programs operated by the state;

(ii) voluntary prescription drug contracting programs operated by the state;

(iii) legislation to facilitate the development of manufacturer and wholesale purchasing programs in the private sector;

(iv) most favored purchaser legislation;

(v) legislation limiting manufacturer and wholesale price increases;

(vi) legislation providing for preferential treatment for underserved or disadvantaged retail purchasers;

(vii) legislation providing for the use of a state formulary or other formularies;

(viii) legislation requiring pharmacists to substitute for prescribed drugs a less expensive therapeutic alternative in appropriate circumstances.

(ix) legislation providing for price disclosure; and

(x) limitations on drug promotion and marketing.

The study must include recommendations and draft legislation for reducing the cost of prescription drugs for wholesale purchasers, consumers, retail pharmacies, and third-party payors. The recommendations must ensure that parties benefiting from price savings at the manufacturer or wholesale level pass these savings on to consumers. The recommendations must not reduce costs through methods that would adversely affect access to prescription drugs, reduce the quality of prescription drugs, or cause a significant increase in manufacturer, wholesale, or retail prices for certain market segments.

Sec. 16. **REVIEW.**

The commissioner of commerce shall review the health care policies currently in use in the state, and prepare standardized health care policy forms to be used by all insurers, health service plans, or others subject to the jurisdiction of Minnesota Statutes, chapter 62A, 62C, 62E, or 62H. The commissioner shall recommend possible legislative changes necessary to adopt the policy forms to the chairs of the senate commerce and consumer protection committee and the house of representatives financial institutions and insurance committee by February 1, 1994.

Sec. 17. **LEAVE DONATION PROGRAM.**

Subdivision 1. **DONATION OF VACATION TIME.** A state employee may donate up to 12 hours of accrued vacation leave for the benefit of a state employee in Morrison county whose child was attacked by a dog in 1993. The number of hours donated must be credited to the sick leave account of the receiving state employee. If the receiving state employee uses all of the donated time, additional hours up to 50 hours per employee of accrued vacation leave time may be donated.

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Subd. 2. **PROCESS FOR CREDITING.** The donating employee must notify the employee's agency head of the amount of accrued vacation time the employee wishes to donate. The agency head shall transfer that amount to the sick leave account of the recipient. A donation of accrued vacation leave time is irrevocable once it has been transferred to the account.

Sec. 18. **INSTRUCTION TO REVISOR.**

The revisor of statutes shall change the words "centers of excellence" to "referral centers" wherever they appear in Minnesota Statutes, chapters 62D and 62J, in the next and subsequent editions of Minnesota Statutes and Minnesota Rules, parts 4685.0100 to 4685.3400.

Sec. 19. **EFFECTIVE DATE.**

Sections 1, 4, 5, 7, 8, 9, 13, 14, 15, and 16 are effective the day following final enactment.

Section 17 is effective the day following final enactment and applies retroactively to January 1, 1993.

Sections 3, 6, 10, 11, and 12 are effective January 1, 1994.

ARTICLE 6

COST CONTAINMENT AMENDMENTS

Section 1. Minnesota Statutes 1992, section 62J.03, subdivision 8, is amended to read:

Subd. 8. **PROVIDER OR HEALTH CARE PROVIDER.** "Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee~~, as further defined in rules adopted by the commissioner.~~ and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

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Sec. 2. Minnesota Statutes 1992, section 62J.04, subdivision 5, is amended to read:

Subd. 5. **APPEALS.** A person ~~or organization~~ aggrieved may appeal a decision ~~of the commissioner~~ under sections 62J.17 and 62J.23 through a contested case proceeding governed under chapter 14. The notice of appeal must be served on the commissioner within 30 days of receiving notice of the decision. The commissioner shall decide the contested case.

Sec. 3. Minnesota Statutes 1992, section 62J.04, subdivision 7, is amended to read:

Subd. 7. **PLAN FOR CONTROLLING GROWTH IN SPENDING.** (a) By January 15, 1993, the Minnesota health care commission shall submit to the legislature and the governor for approval a plan, with as much detail as possible, for slowing the growth in health care spending to the growth rate identified by the commission, beginning July 1, 1993. The goal of the plan shall be to reduce the growth rate of health care spending, adjusted for population changes, so that it declines by at least ten percent per year for each of the next five years. ~~The commission shall use the rate of spending growth in 1991 as the base year for developing its plan.~~ The plan may include tentative targets for reducing the growth in spending for consideration by the legislature.

(b) In developing the plan, the commission shall consider the advisability and feasibility of the following options, but is not obligated to incorporate them into the plan:

(1) data and methods that could be used to calculate regional and statewide spending limits and the various options for expressing spending limits, such as maximum percentage growth rates or actuarially adjusted average per capita rates that reflect the demographics of the state or a region of the state;

(2) methods of adjusting spending limits to account for patients who are not Minnesota residents, to reflect care provided to a person outside the person's region, and to adjust for demographic changes over time;

(3) methods that could be used to monitor compliance with the limits;

(4) criteria for exempting spending on research and experimentation on new technologies and medical practices when setting or enforcing spending limits;

(5) methods that could be used to help providers, purchasers, consumers, and communities control spending growth;

(6) methods of identifying activities of consumers, providers, or purchasers that contribute to excessive growth in spending;

(7) methods of encouraging voluntary activities that will help keep spending within the limits;

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(8) methods of consulting providers and obtaining their assistance and cooperation and safeguards that are necessary to protect providers from abrupt changes in revenues or practice requirements;

(9) methods of avoiding, preventing, or recovering spending in excess of the rate of growth identified by the commission;

(10) methods of depriving those who benefit financially from overspending of the benefit of overspending, including the option of recovering the amount of the excess spending from the greater provider community or from individual providers or groups of providers through targeted assessments;

(11) methods of reallocating health care resources among provider groups to correct existing inequities, reward desirable provider activities, discourage undesirable activities, or improve the quality, affordability, and accessibility of health care services;

(12) methods of imposing mandatory requirements relating to the delivery of health care, such as practice parameters, hospital admission protocols, 24-hour emergency care screening systems, or designated specialty providers;

(13) methods of preventing unfair health care practices that give a provider or group purchaser an unfair advantage or financial benefit or that significantly circumvent, subvert, or obstruct the goals of this chapter;

(14) methods of providing incentives through special spending allowances or other means to encourage and reward special projects to improve outcomes or quality of care; and

(15) the advisability or feasibility of a system of permanent, regional coordinating boards to ensure community involvement in activities to improve affordability, accessibility, and quality of health care in each region.

Sec. 4. Minnesota Statutes 1992, section 62J.05, is amended by adding a subdivision to read:

Subd. 9. **REPEALER.** This section is repealed effective July 1, 1996.

Sec. 5. Minnesota Statutes 1992, section 62J.09, subdivision 2, is amended to read:

Subd. 2. **MEMBERSHIP.** (a) **NUMBER OF MEMBERS.** Each regional ~~health care management~~ coordinating board consists of ~~16~~ 17 members as provided in this subdivision. A member may designate a representative to act as a member of the commission in the member's absence. The governor shall appoint the chair of each regional board from among its members. The appointing authorities under each paragraph for which there is to be chosen more than one member shall consult prior to appointments being made to ensure that, to the extent possible, the board includes a representative from each county within the region.

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(b) **PROVIDER REPRESENTATIVES.** Each regional board must include four members representing health care providers who practice in the region. One member is appointed by the Minnesota Medical Association. One member is appointed by the Minnesota Hospital Association. One member is appointed by the Minnesota Nurses' Association. The remaining member is appointed by the governor to represent providers other than physicians, hospitals, and nurses.

(c) **HEALTH PLAN COMPANY REPRESENTATIVES.** Each regional board includes ~~three~~ four members representing health plan companies who provide coverage for residents of the region, including one member representing health insurers who is elected by a vote of all health insurers providing coverage in the region, one member elected by a vote of all health maintenance organizations providing coverage in the region, and one member appointed by Blue Cross and Blue Shield of Minnesota. The fourth member is appointed by the governor.

(d) **EMPLOYER REPRESENTATIVES.** Regional boards include three members representing employers in the region. Employer representatives are elected by a vote of the employers who are members of chambers of commerce in the region. At least one member must represent self-insured employers.

(e) **EMPLOYEE UNIONS.** Regional boards include one member appointed by the AFL-CIO Minnesota who is a union member residing or working in the region or who is a representative of a union that is active in the region.

(f) **PUBLIC MEMBERS.** Regional boards include three consumer members. One consumer member is elected by the community health boards in the region, with each community health board having one vote. One consumer member is elected by the state legislators with districts in the region. One consumer member is appointed by the governor.

(g) **COUNTY COMMISSIONER.** Regional boards include one member who is a county board member. The county board member is elected by a vote of all of the county board members in the region, with each county board having one vote.

(h) **STATE AGENCY.** Regional boards include one state agency commissioner appointed by the governor to represent state health coverage programs.

Sec. 6. Minnesota Statutes 1992, section 62J.09, subdivision 5, is amended to read:

Subd. 5. **CONFLICTS OF INTEREST.** No member may ~~participate or~~ vote in regional coordinating board proceedings involving an individual provider, purchaser, or patient, or a specific activity or transaction, if the member has a direct financial interest in the outcome of the regional coordinating board's proceedings other than as an individual consumer of health care services. A member with a direct financial interest may participate in the proceedings, without voting, provided that the member discloses any direct financial interest to the regional coordinating board at the beginning of the proceedings.

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Sec. 7. Minnesota Statutes 1992, section 62J.09, is amended by adding a subdivision to read:

Subd. 6a. **CONTRACTING.** The commissioner, at the request of a regional coordinating board, may contract on behalf of the board with an appropriate regional organization to provide staff support to the board, in order to assist the board in carrying out the duties assigned in this section.

Sec. 8. Minnesota Statutes 1992, section 62J.09, subdivision 8, is amended to read:

Subd. 8. **REPEALER.** This section is repealed effective July 1, ~~1993~~ 1996.

Sec. 9. Minnesota Statutes 1992, section 62J.17, subdivision 2, is amended to read:

Subd. 2. **DEFINITIONS.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) **ACCESS.** "Access" has the meaning given in section 62J.2912, subdivision 2.

(b) **CAPITAL EXPENDITURE.** "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

(c) **COST.** "Cost" means the amount paid by consumers or third party payers for health care services or products.

(d) **DATE OF THE MAJOR SPENDING COMMITMENT.** "Date of the major spending commitment" means the date the provider formally obligated itself to the major spending commitment. The obligation may be incurred by entering into a contract, making a down payment, issuing bonds or entering a loan agreement to provide financing for the major spending commitment, or taking some other formal, tangible action evidencing the provider's intention to make the major spending commitment.

~~(b)~~ (e) **HEALTH CARE SERVICE.** "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

~~(c)~~ (f) **MAJOR SPENDING COMMITMENT.** "Major spending commitment" means an expenditure in excess of $500,000 for:

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(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

~~(d)~~ (g) **MEDICAL EQUIPMENT.** "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

~~(e)~~ (h) **NEW SPECIALIZED SERVICE.** "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

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~~(f) **PROVIDER.** "Provider" means an individual, corporation, association, firm, partnership, or other entity that is regularly engaged in providing health care services in Minnesota.~~

Sec. 10. Minnesota Statutes 1992, section 62J.17, is amended by adding a subdivision to read:

Subd. 4a. **EXPENDITURE REPORTING.** (a) **GENERAL REQUIREMENT.** A provider making a major spending commitment after April 1, 1992, shall submit notification of the expenditure to the commissioner and provide the commissioner with any relevant background information.

(b) **REPORT.** Notification must include a report, submitted within 60 days after the date of the major spending commitment, using terms conforming to the definitions in section 62J.03 and this section. Each report is subject to retrospective review and must contain:

(1) a detailed description of the major spending commitment and its purpose;

(2) the date of the major spending commitment;

(3) a statement of the expected impact that the major spending commitment will have on charges by the provider to patients and third party payors;

(4) a statement of the expected impact on the clinical effectiveness or quality of care received by the patients that the provider expects to serve;

(5) a statement of the extent to which equivalent services or technology are already available to the provider's actual and potential patient population;

(6) a statement of the distance from which the nearest equivalent services or technology are already available to the provider's actual and potential population;

(7) a statement describing the pursuit of any lawful collaborative arrangements; and

(8) a statement of assurance that the provider will not use, purchase, or perform health care technologies and procedures that are not clinically effective and cost-effective, unless the technology is used for experimental or research purposes to determine whether a technology or procedure is clinically effective and cost-effective.

The provider may submit any additional information that it deems relevant.

(c) **ADDITIONAL INFORMATION.** The commissioner may request additional information from a provider for the purpose of review of a report submitted by that provider, and may consider relevant information from other sources. A provider shall provide any information requested by the commissioner within the time period stated in the request, or within 30 days after the date of the request if the request does not state a time.

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(d) **FAILURE TO COMPLY.** If the provider fails to submit a complete and timely expenditure report, including any additional information requested by the commissioner, the commissioner may make the provider's subsequent major spending commitments subject to the procedures of prospective review and approval under subdivision 6a.

Sec. 11. Minnesota Statutes 1992, section 62J.17, is amended by adding a subdivision to read:

Subd. 5a. **RETROSPECTIVE REVIEW.** (a) The commissioner shall retrospectively review each major spending commitment and notify the provider of the results of the review. The commissioner shall determine whether the major spending commitment was appropriate. In making the determination, the commissioner may consider the following criteria: the major spending commitment's impact on the cost, access, and quality of health care; the clinical effectiveness and cost-effectiveness of the major spending commitment; and the alternatives available to the provider.

(b) The commissioner may not prevent or prohibit a major spending commitment subject to retrospective review. However, if the provider fails the retrospective review, any major spending commitments by that provider for the five-year period following the commissioner's decision are subject to prospective review under subdivision 6a.

Sec. 12. Minnesota Statutes 1992, section 62J.17, is amended by adding a subdivision to read:

Subd. 6a. **PROSPECTIVE REVIEW AND APPROVAL.** (a) **REQUIREMENT.** No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) **APPLICATION.** A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The application must address each item listed in subdivision 4a, paragraph (a), and must also include documentation to support the response to each item. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under paragraph (d). The submission may be made either in addition to or instead of the submission of information relating to the items listed in subdivision 4a, paragraph (a).

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(c) **REVIEW.** The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under paragraph (d). In making this determination, the commissioner may also consider relevant information from other sources. At the request of the commissioner, the Minnesota health care commission shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner. The commissioner shall make a decision on the application within 60 days after an application is received.

(d) **EXCEPTIONS.** The prospective review and approval process does not apply to:

(1) a major spending commitment to replace existing equipment with comparable equipment, if the old equipment will no longer be used in the state;

(2) a major spending commitment made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school or by a federal or foundation grant, or clinical trials;

(3) a major spending commitment to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided; and

(4) mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

(e) **NOTIFICATION REQUIRED FOR EXCEPTED MAJOR SPENDING COMMITMENT.** A provider making a major spending commitment covered by paragraph (d) shall provide notification of the major spending commitment as provided under subdivision 4a.

(f) **PENALTIES AND REMEDIES.** The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

Sec. 13. Minnesota Statutes 1992, section 62J.23, is amended by adding a subdivision to read:

Subd. 4. **INTEGRATED SERVICE NETWORKS.** (a) The legislature finds that the formation and operation of integrated service networks will accomplish the purpose of the federal Medicare antikickback statute, which is to reduce the overutilization and overcharging that may result from inappropriate provider

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incentives. Accordingly, it is the public policy of the state of Minnesota to support the development of integrated service networks. The legislature finds that the federal Medicare antikickback laws should not be interpreted to interfere with the development of integrated service networks or to impose liability for arrangements between an integrated service network and its participating entities.

(b) An arrangement between an integrated service network and any or all of its participating entities is not subject to liability under subdivisions 1 and 2.

Sec. 14. **[62J.2911] ANTITRUST EXCEPTIONS; PURPOSE.**

The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care services will be significantly enhanced by cooperative arrangements involving providers or purchasers that might be prohibited by state and federal antitrust laws if undertaken without governmental involvement. The purpose of sections 62J.2911 to 62J.2921 is to create an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result in lower costs, or greater access or quality, than would otherwise occur in the marketplace. The legislature intends that approval of arrangements be accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power, and that an arrangement approved by the commissioner and accompanied by such appropriate conditions, supervision, and regulation shall not be subject to state and federal antitrust liability.

Sec. 15. **[62J.2912] DEFINITIONS.**

Subdivision 1. **SCOPE.** For purposes of sections 62J.2911 to 62J.2921, the terms defined in this section have the meanings given them.

Subd. 2. **ACCESS.** "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.

Subd. 3. **APPLICANT.** "Applicant" means the party or parties to an agreement or business arrangement for which the commissioner's approval is sought under this section.

Subd. 4. **COMMISSIONER.** "Commissioner" means the commissioner of health.

Subd. 5. **CONTESTED CASE.** "Contested case" means a proceeding conducted by the office of administrative hearings under sections 14.57 to 14.62.

Subd. 6. **COST OR COST OF HEALTH CARE.** "Cost" or "cost of health care" means the amount paid by consumers or third party payers for health care services or products.

Subd. 7. **CRITERIA.** "Criteria" means the cost, access, and quality of health care.

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Subd. 8. **HEALTH CARE PRODUCTS.** "Health care products" means durable medical equipment and "medical equipment" as defined in section 62J.17, subdivision 2, paragraph (g).

Subd. 9. **HEALTH CARE SERVICE.** "Health care service" has the meaning given in section 62J.17, subdivision 2, paragraph (e).

Subd. 10. **PERSON.** "Person" means an individual or legal entity.

Sec. 16. **[62J.2913] SCOPE.**

Subdivision 1. **AVAILABILITY OF EXCEPTION.** Providers or purchasers wishing to engage in contracts, business or financial arrangements, or other activities, practices, or arrangements that might be construed to be violations of state or federal antitrust laws but which are in the best interests of the state and further the policies and goals of this chapter may apply to the commissioner for an exception.

Subd. 2. **ABSOLUTE DEFENSE.** Approval by the commissioner is an absolute defense against any action under state and federal antitrust laws, except as provided under section 62J.2921, subdivision 5.

Subd. 3. **APPLICATION CANNOT BE USED TO IMPOSE LIABILITY.** The commissioner may ask the attorney general to comment on an application. The application and any information obtained by the commissioner under sections 62J.2914 to 62J.2916 that is not otherwise available is not admissible in any civil or criminal proceeding brought by the attorney general or any other person based on an antitrust claim, except:

(1) a proceeding brought under section 62J.2921, subdivision 5, based on an applicant's failure to substantially comply with the terms of the application; or

(2) a proceeding based on actions taken by the applicant prior to submitting the application, where such actions are admitted to in the application.

Subd. 4. **OUT-OF-STATE APPLICANTS.** Providers or purchasers not physically located in Minnesota are eligible to seek an exception for arrangements in which they transact business in Minnesota as defined in section 295.51.

Sec. 17. **[62J.2914] APPLICATION.**

Subdivision 1. **DISCLOSURE.** An application for approval must include, to the extent applicable, disclosure of the following:

(1) a descriptive title;

(2) a table of contents;

(3) exact names of each party to the application and the address of the principal business office of each party;

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(4) the name, address, and telephone number of the persons authorized to receive notices and communications with respect to the application;

(5) a verified statement by a responsible officer of each party to the application attesting to the accuracy and completeness of the enclosed information;

(6) background information relating to the proposed arrangement, including:

(i) a description of the proposed arrangement, including a list of any services or products that are the subject of the proposed arrangement;

(ii) an identification of any tangential services or products associated with the services or products that are the subject of the proposed arrangement;

(iii) a description of the geographic territory involved in the proposed arrangement;

(iv) if the geographic territory described in item (iii), is different from the territory in which the applicants have engaged in the type of business at issue over the last five years, a description of how and why the geographic territory differs;

(v) identification of all products or services that a substantial share of consumers would consider substitutes for any service or product that is the subject of the proposed arrangement;

(vi) identification of whether any services or products of the proposed arrangement are currently being offered, capable of being offered, utilized, or capable of being utilized by other providers or purchasers in the geographic territory described in item (iii);

(vii) identification of the steps necessary, under current market and regulatory conditions, for other parties to enter the territory described in item (iii) and compete with the applicant;

(viii) a description of the previous history of dealings between the parties to the application;

(ix) a detailed explanation of the projected effects, including expected volume, change in price, and increased revenue, of the arrangement on each party's current businesses, both generally as well as the aspects of the business directly involved in the proposed arrangement;

(x) the present market share of the parties to the application and of others affected by the proposed arrangement, and projected market shares after implementation of the proposed arrangement;

(xi) a statement of why the projected levels of cost, access, or quality could not be achieved in the existing market without the proposed arrangement; and

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(xii) an explanation of how the arrangement relates to any Minnesota health care commission or applicable regional coordinating board plans for delivery of health care; and

(7) a detailed explanation of how the transaction will affect cost, access, and quality. The explanation must address the factors in section 62J.2917, subdivision 2, paragraphs (b) to (d), to the extent applicable.

Subd. 2. **STATE REGISTER NOTICE.** In addition to the disclosures required in subdivision 1, the application must contain a written description of the proposed arrangement for purposes of publication in the State Register. The notice must include sufficient information to advise the public of the nature of the proposed arrangement and to enable the public to provide meaningful comments concerning the expected results of the arrangement. The notice must also state that any person may provide written comments to the commissioner, with a copy to the applicant, within 20 days of the notice's publication. The commissioner shall approve the notice before publication. If the commissioner determines that the submitted notice does not provide sufficient information, the commissioner may amend the notice before publication and may consult with the applicant in preparing the amended notice. The commissioner shall not publish an amended notice without the applicant's approval.

Subd. 3. **MULTIPLE PARTIES TO A PROPOSED ARRANGEMENT.** For a proposed arrangement involving multiple parties, one joint application must be submitted on behalf of all parties to the arrangement.

Subd. 4. **FILING FEE.** An application must be accompanied by a filing fee, which must be deposited in the health care access fund. The total of the deposited application fees is appropriated annually to the commissioner to administer the antitrust exceptions program. The filing fee is $1,000 for any application submitted by parties whose combined gross revenues exceeded $20 million in the most recent calendar or fiscal year for which such figures are available. The filing fee for all other applications is $250.

Subd. 5. **TRADE SECRET INFORMATION; PROTECTION.** Trade secret information, as defined in section 13.37, subdivision 1, paragraph (b), must be protected to the extent required under chapter 13.

Subd. 6. **COMMISSIONER'S AUTHORITY TO REFUSE TO REVIEW.** (a) If the commissioner determines that an application is unclear, incomplete, or provides an insufficient basis on which to base a decision, the commissioner may return the application. The applicant may complete or revise the application and resubmit it.

(b) If, upon review of the application and upon advice from the attorney general, the commissioner concludes that the proposed arrangement does not present any potential for liability under the state or federal antitrust laws, the commissioner may decline to review the application and so notify the applicant.

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(c) The commissioner may decline to review any application relating to arrangements already in effect before the submission of the application. However, the commissioner shall review any application if the review is expressly provided for in a settlement agreement entered into before the enactment of this section by the applicant and the attorney general.

Subd. 7. **COMMISSIONER'S AUTHORITY TO EXTEND TIME LIMIT.** Upon the showing of good cause, the commissioner may extend any of the time limits stated in sections 62J.2915 and 62J.2916 at the request of the applicant or another person.

Sec. 18. **[62J.2915] NOTICE AND COMMENT.**

Subdivision 1. **NOTICE.** The commissioner shall cause the notice described in section 62J.2914, subdivision 2, to be published in the State Register and sent to the Minnesota health care commission, the regional coordinating boards for any regions that include all or part of the territory covered by the proposed arrangement, and any person who has requested to be placed on a list to receive notice of applications. The commissioner may maintain separate notice lists for different regions of the state. The commissioner may also send a copy of the notice to any person together with a request that the person comment as provided under subdivision 2. Copies of the request must be provided to the applicant.

Subd. 2. **COMMENTS.** Within 20 days after the notice is published, any person may mail to the commissioner written comments with respect to the application. Within 30 days after the notice is published, the Minnesota health care commission or any regional coordinating board may mail to the commissioner comments with respect to the application. Persons submitting comments shall provide a copy of the comments to the applicant. The applicant may mail to the commissioner written responses to any comments within ten days after the deadline for mailing such comments. The applicant shall send a copy of the response to the person submitting the comment.

Sec. 19. **[62J.2916] PROCEDURE FOR REVIEW OF APPLICATIONS.**

Subdivision 1. **CHOICE OF PROCEDURES.** After the conclusion of the period provided in section 62J.2915, subdivision 2, for the applicant to respond to comments, the commissioner shall select one of the three procedures provided in subdivision 2. In determining which procedure to use, the commissioner shall consider the following criteria:

(1) the size of the proposed arrangement, in terms of number of parties and amount of money involved;

(2) the complexity of the proposed arrangement;

(3) the novelty of the proposed arrangement;

(4) the substance and quantity of the comments received;

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(5) any comments received from the Minnesota health care commission or regional coordinating boards; and

(6) the presence or absence of any significant gaps in the factual record.

If the applicant demands a contested case hearing no later than the conclusion of the period provided in section 62J.2915, subdivision 2, for the applicant to respond to comments, the commissioner shall not select a procedure. Instead, the applicant shall be given a contested case proceeding as a matter of right.

Subd. 2. **PROCEDURES AVAILABLE.** (a) **DECISION ON THE WRITTEN RECORD.** The commissioner may issue a decision based on the application, the comments, and the applicant's responses to the comments, to the extent each is relevant. In making the decision, the commissioner may consult with staff of the department of health and may rely on department of health data.

(b) **LIMITED HEARING.** (1) The commissioner may order a limited hearing. A copy of the order must be mailed to the applicant and to all persons who have submitted comments or requested to be kept informed of the proceedings involving the application. The order must state the date, time, and location of the limited hearing and must identify specific issues to be addressed at the limited hearing. The issues may include the feasibility and desirability of one or more alternatives to the proposed arrangement. The order must require the applicant to submit written evidence, in the form of affidavits and supporting documents, addressing the issues identified, within 20 days after the date of the order. The order shall also state that any person may arrange to receive a copy of the written evidence from the commissioner, at the person's expense, and may provide written comments on the evidence within 40 days after the date of the order. A person providing written comments shall provide a copy of the comments to the applicant.

(2) The limited hearing must be held before the commissioner or department of health staff member designated by the commissioner. The commissioner or the commissioner's designee shall question the applicant about the evidence submitted by the applicant. The questions may address relevant issues identified in the comments submitted in response to the written evidence or identified by department of health staff or brought to light by department of health data. At the conclusion of the applicant's responses to the questions, any person who submitted comments about the applicant's written evidence may make a statement addressing the applicant's responses to the questions. The commissioner or the commissioner's designee may ask questions of any person making a statement. At the conclusion of all statements, the applicant may make a closing statement.

(3) The commissioner's decision after a limited hearing must be based upon the application, the comments, the applicant's response to the comments, the applicant's written evidence, the comments in response to the written evidence, and the information presented at the limited hearing, to the extent each is relevant. In making the decision, the commissioner may consult with staff of the department of health and may rely on department of health data.

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(c) **CONTESTED CASE HEARING.** The commissioner may order a contested case hearing. A contested case hearing shall be tried before an administrative law judge who shall issue a written recommendation to the commissioner and shall follow the procedures in sections 14.57 to 14.62. All factual issues relevant to a decision must be presented in the contested case. The attorney general may appear as a party. Additional parties may appear to the extent permitted under sections 14.57 to 14.62. The record in the contested case includes the application, the comments, the applicant's response to the comments, and any other evidence that is part of the record under sections 14.57 to 14.62.

Sec. 20. **[62J.2917] CRITERIA FOR DECISION.**

Subdivision 1. **CRITERIA.** The commissioner shall not approve an application unless the commissioner determines that the arrangement is more likely to result in lower costs, increased access, or increased quality of health care, than would otherwise occur under existing market conditions or conditions likely to develop without an exemption from state and federal antitrust law. In the event that a proposed arrangement appears likely to improve one or two of the criteria at the expense of another one or two of the criteria, the commissioner shall not approve the application unless the commissioner determines that the proposed arrangement, taken as a whole, is likely to substantially further the purpose of this chapter. In making such a determination, the commissioner may employ a cost/benefit analysis.

Subd. 2. **FACTORS.** (a) **GENERALLY APPLICABLE FACTORS.** In making a determination about cost, access, and quality, the commissioner may consider the following factors, to the extent relevant:

(1) whether the proposal is compatible with the cost containment plan or other plan of the Minnesota health care commission or the applicable regional plans of the regional coordinating boards;

(2) market structure:

(i) actual and potential sellers and buyers, or providers and purchasers;

(ii) actual and potential consumers;

(iii) geographic market area; and

(iv) entry conditions;

(3) current market conditions;

(4) the historical behavior of the market;

(5) performance of other, similar arrangements;

(6) whether the proposal unnecessarily restrains competition or restrains competition in ways not reasonably related to the purposes of this chapter; and

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(7) the financial condition of the applicant.

(b) **COST.** The commissioner's analysis of cost must focus on the individual consumer of health care. Cost savings to be realized by providers, health carriers, group purchasers, or other participants in the health care system are relevant only to the extent that the savings are likely to be passed on to the consumer. However, where an application is submitted by providers or purchasers who are paid primarily by third party payers unaffiliated with the applicant, it is sufficient for the applicant to show that cost savings are likely to be passed on to the unaffiliated third party payers; the applicants do not have the burden of proving that third party payers with whom the applicants are not affiliated will pass on cost savings to individuals receiving coverage through the third party payers. In making determinations as to costs, the commissioner may consider:

(1) the cost savings likely to result to the applicant;

(2) the extent to which the cost savings are likely to be passed on to the consumer and in what form;

(3) the extent to which the proposed arrangement is likely to result in cost shifting by the applicant onto other payers or purchasers of other products or services;

(4) the extent to which the cost shifting by the applicant is likely to be followed by other persons in the market;

(5) the current and anticipated supply and demand for any products or services at issue;

(6) the representations and guarantees of the applicant and their enforceability;

(7) likely effectiveness of regulation by the commissioner;

(8) inferences to be drawn from market structure;

(9) the cost of regulation, both for the state and for the applicant; and

(10) any other factors tending to show that the proposed arrangement is or is not likely to reduce cost.

(c) **ACCESS.** In making determinations as to access, the commissioner may consider:

(1) the extent to which the utilization of needed health care services or products by the intended targeted population is likely to increase or decrease. When a proposed arrangement is likely to increase access in one geographic area, by lowering prices or otherwise expanding supply, but limits access in another geographic area by removing service capabilities from that second area, the commissioner shall articulate the criteria employed to balance these effects;

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(2) the extent to which the proposed arrangement is likely to make available a new and needed service or product to a certain geographic area; and

(3) the extent to which the proposed arrangement is likely to otherwise make health care services or products more financially or geographically available to persons who need them.

If the commissioner determines that the proposed arrangement is likely to increase access and bases that determination on a projected increase in utilization, the commissioner shall also determine and make a specific finding that the increased utilization does not reflect overutilization.

(d) **QUALITY.** In making determinations as to quality, the commissioner may consider the extent to which the proposed arrangement is likely to:

(1) decrease morbidity and mortality;

(2) result in faster convalescence;

(3) result in fewer hospital days;

(4) permit providers to attain needed experience or frequency of treatment, likely to lead to better outcomes;

(5) increase patient satisfaction; and

(6) have any other features likely to improve or reduce the quality of health care.

Sec. 21. **[62J.2918] DECISION.**

Subdivision 1. **APPROVAL OR DISAPPROVAL.** The commissioner shall issue a written decision approving or disapproving the application. The commissioner may condition approval on a modification of all or part of the proposed arrangement to eliminate any restriction on competition that is not reasonably related to the goals of reducing cost or improving access or quality. The commissioner may also establish conditions for approval that are reasonably necessary to protect against abuses of private economic power and to ensure that the arrangement is appropriately supervised and regulated by the state.

Subd. 2. **FINDINGS OF FACT.** The commissioner's decision shall make specific findings of fact concerning the cost, access, and quality criteria, and identify one or more of those criteria as the basis for the decision.

Subd. 3. **DATA FOR SUPERVISION.** A decision approving an application must require the periodic submission of specific data relating to cost, access, and quality, and to the extent feasible, identify objective standards of cost, access, and quality by which the success of the arrangement will be measured. However, if the commissioner determines that the scope of a particular proposed arrangement is such that the arrangement is certain to have neither a positive or nega-

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tive impact on one or two of the criteria, the commissioner's decision need not require the submission of data or establish an objective standard relating to those criteria.

Sec. 22. **[62J.2919] APPEAL.**

After the commissioner has rendered a decision, the applicant or any other person aggrieved may appeal the decision to the Minnesota court of appeals within 30 days after receipt of the commissioner's decision. The appeal is governed by sections 14.63 to 14.69. The appellate process does not include a contested case under sections 14.57 to 14.62. The commissioner's determination, under section 62J.2916, subdivision 1, of which procedure to use may not be raised as an issue on appeal.

Sec. 23. **[62J.2920] SUPERVISION AFTER APPROVAL.**

Subdivision 1. **APPROPRIATE SUPERVISION.** The commissioner shall appropriately supervise, monitor, and regulate approved arrangements.

Subd. 2. **PROCEDURES.** The commissioner shall review data submitted periodically by the applicant. The commissioner's order shall set forth the time schedule for the submission of data, which shall be at least once a year. The commissioner's order must identify the data that must be submitted, although the commissioner may subsequently require the submission of additional data or alter the time schedule. Upon review of the data submitted, the commissioner shall notify the applicant of whether the arrangement is in compliance with the commissioner's order. If the arrangement is not in compliance with the commissioner's order, the commissioner shall identify those respects in which the arrangement does not conform to the commissioner's order.

An applicant receiving notification that an arrangement is not in compliance has 30 days in which to respond with additional data. The response may include a proposal and a time schedule by which the applicant will bring the arrangement into compliance with the commissioner's order. If the arrangement is not in compliance and the commissioner and the applicant cannot agree to the terms of bringing the arrangement into compliance, the matter shall be set for a contested case hearing.

The commissioner shall publish notice in the State Register two years after the date of an order approving an application, and at two-year intervals thereafter, soliciting comments from the public concerning the impact that the arrangement has had on cost, access, and quality. The commissioner may request additional oral or written information from the applicant or from any other source.

Subd. 3. **STUDY.** The commissioner shall study and make recommendations by January 15, 1995, on the appropriate length and scope of supervision of arrangements approved for exemption from the antitrust laws.

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Sec. 24. **[62J.2921] REVOCATION.**

Subdivision 1. **CONDITIONS.** The commissioner may revoke approval of a cooperative arrangement only if:

(1) the arrangement is not in substantial compliance with the terms of the application;

(2) the arrangement is not in substantial compliance with the conditions of approval;

(3) the arrangement has not and is not likely to substantially achieve the improvements in cost, access, or quality identified in the approval order as the basis for the commissioner's approval of the arrangement; or

(4) the conditions in the marketplace have changed to such an extent that competition would promote reductions in cost and improvements in access and quality better than does the arrangement at issue. In order to revoke on the basis that conditions in the marketplace have changed, the commissioner's order must identify specific changes in the marketplace and articulate why those changes warrant revocation.

Subd. 2. **NOTICE.** The commissioner shall begin a proceeding to revoke approval by providing written notice to the applicant describing in detail the basis for the proposed revocation. Notice of the proceeding must be published in the State Register and submitted to the Minnesota health care commission and the applicable regional coordinating boards. The notice must invite the submission of comments to the commissioner.

Subd. 3. **PROCEDURE.** A proceeding to revoke an approval must be conducted as a contested case proceeding upon the written request of the applicant. Decisions of the commissioner in a proceeding to revoke approval are subject to judicial review under sections 14.63 to 14.69.

Subd. 4. **ALTERNATIVES TO REVOCATION PREFERRED.** In deciding whether to revoke an approval, the commissioner shall take into account the hardship that the revocation may impose on the applicant and any potential disruption of the market as a whole. The commissioner shall not revoke an approval if the arrangement can be modified, restructured, or regulated so as to remedy the problem upon which the revocation proceeding is based. The applicant may submit proposals for alternatives to revocation. Before approving an alternative to revocation that involves modifying or restructuring an arrangement, the commissioner shall publish notice in the State Register that any person may comment on the proposed modification or restructuring within 20 days after publication of the notice. The commissioner shall not approve the modification or restructuring until the comment period has concluded. An approved modified or restructured arrangement is subject to appropriate supervision under section 62J.2920.

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Subd. 5. **IMPACT OF REVOCATION.** An applicant that has had its approval revoked is not required to terminate the arrangement. The applicant cannot be held liable under state or federal antitrust law for acts that occurred while the approval was in effect, except to the extent that the applicant failed to substantially comply with the terms of its application or failed to substantially comply with the terms of the approval. The applicant is fully subject to state and federal antitrust law after the revocation becomes effective and may be held liable for acts that occur after the revocation.

Sec. 25. **UNIVERSAL COVERAGE PLAN.**

The health care commission shall develop and submit to the legislature and the governor by December 15, 1993, a comprehensive plan that will lead to universal health coverage for all Minnesotans by January 1, 1997. The plan must include an implementation plan and time schedule for the coordinated phasing in of health insurance reforms, including the expansion of community rating and the phasing out of underwriting restrictions, changes or expansions in government programs, and other actions recommended by the commission. The plan must also include annual targets for expanding coverage to uninsured persons and populations and periodic evaluations of the progress being made toward achieving annual targets and universal coverage.

Sec. 26. **REPEALER.**

Minnesota Statutes 1992, sections 62J.17, subdivisions 4, 5, and 6; and 62J.29, are repealed.

Sec. 27. **EFFECTIVE DATE.**

Sections 1 to 24 are effective the day following final enactment. Sections 9 to 12 apply retroactively to any major spending commitment entered into after April 1, 1992, except that the requirements of section 62J.17, subdivision 4a, paragraph (a), that a report be submitted within 60 days after a major spending commitment and that a report include the items specifically listed are not retroactive.

ARTICLE 7

SMALL EMPLOYER INSURANCE REFORM

Section 1. Minnesota Statutes 1992, section 62L.02, subdivision 19, is amended to read:

Subd. 19. **LATE ENTRANT.** "Late entrant" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period applicable to the employee or dependent under the terms of the health benefit plan, provided that the initial enrollment

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period must be a period of at least 30 days. However, an eligible employee or dependent must not be considered a late entrant if:

(1) the individual was covered under qualifying existing coverage at the time the individual was eligible to enroll in the health benefit plan, declined enrollment on that basis, and presents to the carrier a certificate of termination of the qualifying prior coverage, due to loss of eligibility for that coverage, provided that the individual maintains continuous coverage. For purposes of this clause, eligibility for prior coverage does not include eligibility for continuation coverage required under state or federal law;

(2) the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law Number 99-272, as amended, and any state continuation laws applicable to the employer or carrier, provided that the individual maintains continuous coverage;

(3) the individual is a new spouse of an eligible employee, provided that enrollment is requested within 30 days of becoming legally married;

(4) the individual is a new dependent child of an eligible employee, provided that enrollment is requested within 30 days of becoming a dependent;

(5) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(6) a court has ordered that coverage be provided for a dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

Sec. 2. Minnesota Statutes 1992, section 62L.02, subdivision 26, is amended to read:

Subd. 26. **SMALL EMPLOYER.** "Small employer" means a person, firm, corporation, partnership, association, or other entity actively engaged in business who, on at least 50 percent of its working days during the preceding calendar year, employed no fewer than two nor more than 29 eligible employees, the majority of whom were employed in this state. ~~If a small employer has only two eligible employees, one employee must not be the spouse, child, sibling, parent, or grandparent of the other, except that~~ If an employer has only two eligible employees and one is the spouse, child, sibling, parent, or grandparent of the other, the employer must be a Minnesota domiciled employer and have paid social security or self-employment tax on behalf of both eligible employees. A small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than two employees ~~or the employees are family members~~. Entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single

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employer for purposes of determining the number of eligible employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan. Where an association, described in section 62A.10, subdivision 1, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association ~~may elect to~~ shall be considered to be a small employer, with respect to those employers in the association that employ no fewer than two nor more than 29 eligible employees, even though the association provides coverage to ~~more than 29 employees of its members, so long as each employer that is provided coverage through the association qualifies as a small employer. An association's election to be considered a small employer under this section is not effective unless filed with the commissioner of commerce. The association may revoke its election at any time by filing notice of revocation with the commissioner.~~ its members that do not qualify as small employers. An association in existence prior to July 1, 1993, is exempt from this chapter with respect to small employers that are members as of that date. However, in providing coverage to new groups after July 1, 1993, the existing association must comply with all requirements of chapter 62L. Existing associations must register with the commissioner of commerce prior to July 1, 1993. If an employer has employees covered under a trust established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq., as amended, those employees are excluded in determining whether the employer qualifies as a small employer.

Sec. 3. Minnesota Statutes 1992, section 62L.02, subdivision 27, is amended to read:

Subd. 27. **SMALL EMPLOYER MARKET.** (a) "Small employer market" means the market for health benefit plans for small employers.

(b) A health carrier is considered to be participating in the small employer market if the carrier offers, sells, issues, or renews a health benefit plan to: (1) any small employer; or (2) the eligible employees of a small employer offering a health benefit plan if, with the knowledge of the health carrier, ~~both~~ either of the following conditions ~~are~~ is met:

(i) any portion of the premium or benefits is paid for or reimbursed by a small employer; ~~and~~ or

(ii) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of the Internal Revenue Code, section 106, 125, or 162.

Sec. 4. Minnesota Statutes 1992, section 62L.03, subdivision 3, is amended to read:

Subd. 3. **MINIMUM PARTICIPATION AND CONTRIBUTION.** (a) A

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small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan and that contributes at least 50 percent toward the cost of coverage of eligible employees must be guaranteed coverage from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier may not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to coverage under another group health plan.

~~(b) A health carrier may require that small employers contribute a specified minimum percentage toward the cost of the coverage of eligible employees, so long as the requirement is uniformly applied for all small employers~~

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual coverage or a health benefit plan which, except for guaranteed issue, must fully comply with this chapter. A health carrier that provides group coverage to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer individual coverage, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers coverage, on a guaranteed issue basis, to all other employees of the same employer.

~~For the small employer plans, a health carrier must require that small employers contribute at least 50 percent of the cost of the coverage of eligible employees. The health carrier must impose this requirement on a uniform basis for both small employer plans and for all small employers.~~

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer.

Sec. 5. Minnesota Statutes 1992, section 62L.03, subdivision 4, is amended to read:

Subd. 4. **UNDERWRITING RESTRICTIONS.** Health carriers may apply underwriting restrictions to coverage for health benefit plans for small employers, including any preexisting condition limitations, only as expressly permitted under this chapter. For purposes of this subdivision, "underwriting restrictions" means any refusal of the health carrier to issue or renew coverage, any premium rate higher than the lowest rate charged by the health carrier for the same coverage, or any preexisting condition limitation or exclusion. Health carriers may collect information relating to the case characteristics and demographic composition of small employers, as well as health status and health history information

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about employees of small employers. Except as otherwise authorized for late entrants, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the effective date of coverage of an eligible employee or dependent. When calculating a preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying prior coverage, provided that the individual maintains continuous coverage. Late entrants may be subject to a preexisting condition limitation not to exceed 18 months from the effective date of coverage of the late entrant. Late entrants may also be excluded from coverage for a period not to exceed 18 months, provided that if a health carrier imposes an exclusion from coverage and a preexisting condition limitation, the combined time period for both the coverage exclusion and preexisting condition limitation must not exceed 18 months. A health carrier shall, at the time of first issuance or renewal of a health benefit plan on or after July 1, 1993, credit against any preexisting condition limitation or exclusion permitted under this section, the time period prior to July 1, 1993, during which an eligible employee or dependent was covered by qualifying existing coverage or qualifying prior coverage, if the person has maintained continuous coverage.

Sec. 6. Minnesota Statutes 1992, section 62L.04, subdivision 1, is amended to read:

Subdivision 1. **APPLICABILITY OF CHAPTER REQUIREMENTS.** Beginning July 1, 1993, health carriers participating in the small employer market must offer and make available any health benefit plan that they offer, including both of the small employer plans provided in section 62L.05, to all small employers who satisfy the small employer participation and contribution requirements specified in this chapter. Compliance with these requirements is required as of the first renewal date of any small employer group occurring after July 1, 1993. For new small employer business, compliance is required as of the first date of offering occurring after July 1, 1993.

Compliance with these requirements is required as of the first renewal date occurring after July 1, 1994, with respect to employees of a small employer who had been issued individual coverage prior to July 1, 1993, administered by the health carrier on a group basis. Notwithstanding any other law to the contrary, the health carrier shall offer to terminate any individual coverage for employees of small employers who satisfy the small employer participation requirements specified in section 62L.03 and offer to replace it with a health benefit plan. If the employer elects not to purchase a health benefit plan, the health carrier must offer all covered employees and dependents the option of maintaining their current coverage, administered on an individual basis, or replacement individual coverage. Small employer and replacement individual coverage provided under this subdivision must be without application of underwriting restrictions, provided continuous coverage is maintained.

Sec. 7. Minnesota Statutes 1992, section 62L.05, subdivision 2, is amended to read:

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Subd. 2. **DEDUCTIBLE-TYPE SMALL EMPLOYER PLAN.** The benefits of the deductible-type small employer plan offered by a health carrier must be equal to 80 percent of the ~~eligible~~ charges, as specified in subdivision 10, for health care services, supplies, or other articles covered under the small employer plan, in excess of an annual deductible which must be $500 per individual and $1,000 per family.

Sec. 8. Minnesota Statutes 1992, section 62L.05, subdivision 3, is amended to read:

Subd. 3. **COPAYMENT-TYPE SMALL EMPLOYER PLAN.** The benefits of the copayment-type small employer plan offered by a health carrier must be equal to 80 percent of the ~~eligible~~ charges, as specified in subdivision 10, for health care services, supplies, or other articles covered under the small employer plan, in excess of the following copayments:

(1) $15 per outpatient visit, ~~other than~~ including visits to an urgent care center but not including visits to a hospital outpatient department or emergency room, ~~urgent care center,~~ or similar facility;

(2) $15 per ~~day~~ visit for the services of a home health agency or private duty registered nurse;

(3) $50 per outpatient visit to a hospital outpatient department or emergency room, ~~urgent care center,~~ or similar facility; and

(4) $300 per inpatient admission to a hospital.

Sec. 9. Minnesota Statutes 1992, section 62L.05, subdivision 4, is amended to read:

Subd. 4. **BENEFITS.** The medical services and supplies listed in this subdivision are the benefits that must be covered by the small employer plans described in subdivisions 2 and 3~~:~~. Benefits under this subdivision may be provided through the managed care procedures practiced by health carriers.

(1) inpatient and outpatient hospital services, excluding services provided for the diagnosis, care, or treatment of chemical dependency or a mental illness or condition, other than those conditions specified in clauses (10), (11), and (12). The health care services required to be covered under this clause must also be covered if rendered in a nonhospital environment, on the same basis as coverage provided for those same treatments or services if rendered in a hospital, provided, however, that this sentence must not be interpreted as expanding the types or extent of services covered;

(2) physician, chiropractor, and nurse practitioner services for the diagnosis or treatment of illnesses, injuries, or conditions;

(3) diagnostic X-rays and laboratory tests;

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(4) ground transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, or as otherwise required by the health carrier;

(5) services of a home health agency if the services qualify as reimbursable services under Medicare ~~and are directed by a physician or qualify as reimbursable under the health carrier's most commonly sold health plan for insured group coverage~~;

(6) services of a private duty registered nurse if medically necessary, as determined by the health carrier;

(7) the rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

(8) child health supervision services up to age 18, as defined in section 62A.047;

(9) maternity and prenatal care services, as defined in sections 62A.041 and 62A.047;

(10) inpatient hospital and outpatient services for the diagnosis and treatment of certain mental illnesses or conditions, as defined by the International Classification of Diseases-Clinical Modification (ICD-9-CM), seventh edition (1990) and as classified as ICD-9 codes 295 to 299;

(11) ten hours per year of outpatient mental health diagnosis or treatment for illnesses or conditions not described in clause (10);

(12) 60 hours per year of outpatient treatment of chemical dependency; and

(13) 50 percent of eligible charges for prescription drugs, up to a separate annual maximum out-of-pocket expense of $1,000 per individual for prescription drugs, and 100 percent of eligible charges thereafter.

Sec. 10. Minnesota Statutes 1992, section 62L.05, subdivision 6, is amended to read:

Subd. 6. **CHOICE PRODUCTS EXCEPTION.** Nothing in subdivision 1 prohibits a health carrier from offering a small employer plan which provides for different benefit coverages based on whether the benefit is provided through a primary network of providers or through a secondary network of providers so long as the benefits provided in the primary network equal the benefit requirements of the small employer plan as described in this section. For purposes of products issued under this subdivision, out-of-pocket costs in the secondary network may exceed the out-of-pocket limits described in subdivision 1. A secondary network must not be used to provide "benefits in addition" as defined in subdivision 5, except in compliance with that subdivision.

Sec. 11. Minnesota Statutes 1992, section 62L.08, subdivision 4, is amended to read:

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Subd. 4. **GEOGRAPHIC PREMIUM VARIATIONS.** A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. A health carrier may also request approval to establish one additional geographic region and a separate index rate for premiums for employees residing outside of Minnesota, and that index rate must not be more than 30 percent higher than the next highest index rate. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) if one geographic region is rural, the index rate for the rural region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area;

(4) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

Sec. 12. Minnesota Statutes 1992, section 62L.08, subdivision 8, is amended to read:

Subd. 8. **FILING REQUIREMENT.** No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates. The rates shall not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. For premium rates proposed to go into effect between July 1, 1993, and December 31, 1993, the pertinent growth rate is the growth rate applied under section 62J.04, subdivision 1, paragraph (b), to calendar year 1994. As provided in section 62A.65, subdivision 3, this subdivision applies to the individual market, as well as to the small employer market.

Sec. 13. Minnesota Statutes 1992, section 62L.09, subdivision 1, is amended to read:

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Subdivision 1. **NOTICE TO COMMISSIONER.** A health carrier electing to cease doing business in the small employer market shall notify the commissioner 180 days prior to the effective date of the cessation. ~~The cessation of business does not include the failure of a health carrier to offer or issue new business in the small employer market or continue an existing product line, provided that a health carrier does not terminate, cancel, or fail to renew its current small employer business or other product lines.~~ The health carrier shall simultaneously provide a copy of the notice to each small employer covered by a health benefit plan issued by the health carrier.

Upon making the notification, the health carrier shall not offer or issue new business in the small employer market. The health carrier shall renew its current small employer business due for renewal within 120 days after the date of the notification but shall not renew any small employer business more than 120 days after the date of the notification.

A health carrier that elects to cease doing business in the small employer market shall continue to be governed by this chapter with respect to any continuing small employer business conducted by the health carrier.

Sec. 14. Minnesota Statutes 1992, section 62L.11, subdivision 1, is amended to read:

Subdivision 1. **DISCIPLINARY PROCEEDINGS.** The commissioner may, by order, suspend or revoke a health carrier's license or certificate of authority and impose a monetary penalty not to exceed $25,000 for each violation of this chapter~~, including~~. Violations include the failure to pay an assessment required by section 62L.22, and knowingly and willfully encouraging a small employer to not meet the contribution or participation requirements of section 62L.03, subdivision 3, in order to avoid the requirements of this chapter. The notice, hearing, and appeal procedures specified in section 60A.051 or 62D.16, as appropriate, apply to the order. The order is subject to judicial review as provided under chapter 14.

Sec. 15. **[62L.081] PHASE-IN.**

Subdivision 1. **COMPLIANCE.** No health carrier, as defined in Minnesota Statutes, section 62L.02, shall renew any health benefit plan, as defined in Minnesota Statutes, section 62L.02, except in compliance with this section.

Subd. 2. **PREMIUM ADJUSTMENTS.** (a) Any increase or decrease in premiums by a health carrier that is caused by Minnesota Statutes, section 62L.08, and that is greater than 30 percent, is subject to this subdivision. A health carrier shall determine renewal premiums only as follows:

(1) one-half of that premium increase or decrease may be charged upon the first renewal of the coverage on or after July 1, 1993; and

(2) the remaining one-half of that premium increase or decrease may be

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charged upon the renewal of the coverage one year after the date of the renewal under clause (1).

(b) For purposes of this subdivision, the premium increase or decrease is the total premium increase or decrease caused by section 62L.08 and not just the portion that exceeds 30 percent. This subdivision does not apply to any portion of a premium increase or decrease that is not caused by section 62L.08.

Sec. 16. **REPEALER.**

Minnesota Statutes 1992, section 62L.09, subdivision 2, is repealed.

Sec. 17. **EFFECTIVE DATE.**

Sections 1 to 16 are effective July 1, 1993.

ARTICLE 8

INDIVIDUAL MARKET REFORM; MISCELLANEOUS

Section 1. Minnesota Statutes 1992, section 43A.317, subdivision 5, is amended to read:

Subd. 5. **EMPLOYER ELIGIBILITY.** (a) **PROCEDURES.** All employers are eligible for coverage through the program subject to the terms of this subdivision. The commissioner shall establish procedures for an employer to apply for coverage through the program.

(b) **TERM.** The initial term of an employer's coverage will be two years from the effective date of the employer's application. After that, coverage will be automatically renewed for additional two-year terms unless the employer gives notice of withdrawal from the program according to procedures established by the commissioner or the commissioner gives notice to the employer of the discontinuance of the program. The commissioner may establish conditions under which an employer may withdraw from the program prior to the expiration of a two-year term, including by reason of a midyear increase in health coverage premiums of 50 percent or more. An employer that withdraws from the program may not reapply for coverage for a period of two years from its date of withdrawal.

(c) **MINNESOTA WORK FORCE.** An employer is not eligible for coverage through the program if five percent or more of its eligible employees work primarily outside Minnesota, except that an employer may apply to the program on behalf of only those employees who work primarily in Minnesota.

(d) **EMPLOYEE PARTICIPATION; AGGREGATION OF GROUPS.** An employer is not eligible for coverage through the program unless its application includes all eligible employees who work primarily in Minnesota, except employ-

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ees who waive coverage as permitted by subdivision 6. Private entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer, except as otherwise approved by the commissioner.

(e) **PRIVATE EMPLOYER.** A private employer is not eligible for coverage unless it has two or more eligible employees in the state of Minnesota. ~~If an employer has only two eligible employees, one employee must not be the spouse, child, sibling, parent, or grandparent of the other.~~ If an employer has only two eligible employees and one is the spouse, child, sibling, parent, or grandparent of the other, the employer must be a Minnesota domiciled employer and have paid social security or self-employment tax on behalf of both eligible employees.

(f) **MINIMUM PARTICIPATION.** The commissioner must require as a condition of employer eligibility that at least 75 percent of its eligible employees who have not waived coverage participate in the program. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. For purposes of this section, waiver of coverage includes only waivers due to coverage under another group health benefit plan.

(g) **EMPLOYER CONTRIBUTION.** The commissioner must require as a condition of employer eligibility that the employer contribute at least 50 percent toward the cost of the premium of the employee and may require that the contribution toward the cost of coverage is structured in a way that promotes price competition among the coverage options available through the program.

(h) **ENROLLMENT CAP.** The commissioner may limit employer enrollment in the program if necessary to avoid exceeding the program's reserve capacity.

Sec. 2. Minnesota Statutes 1992, section 62A.021, subdivision 1, is amended to read:

Subdivision 1. **LOSS RATIO STANDARDS.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, ~~a~~ health care ~~policy form or certificate form~~ policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the ~~policy form or certificate form~~ policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the ~~policy form or certificate form~~ policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of ~~policies~~ each policy form or certificate form issued in the individual market~~;~~, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. ~~A health~~

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~~carrier shall demonstrate that the third-year loss ratio is greater than or equal to the applicable percentage.~~ Assessments by the reinsurance association created in chapter 62L and any types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for ~~policy forms~~ policies and ~~certificate forms~~ certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an ~~80~~ 82 percent loss ratio is reached on July 1, ~~1998~~ 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a ~~70~~ 72 percent loss ratio is reached on July 1, ~~1998~~ 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

Notwithstanding section 645.26, any act enacted at the 1992 regular legislative session that amends or repeals section 62A.135 or that otherwise changes the loss ratios provided in that section is void.

All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. ~~An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policy forms or certificate forms in force less than three years.~~ If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner

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shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

For purposes of this section, (1) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (2) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

Sec. 3. **[62A.61] DISCLOSURE OF METHODS USED BY HEALTH CARRIERS TO DETERMINE USUAL AND CUSTOMARY FEES.**

(a) A health carrier that bases reimbursement to health care providers upon a usual and customary fee must maintain in its office a copy of a description of the methodology used to calculate fees including at least the following:

(1) the frequency of the determination of usual and customary fees;

(2) a general description of the methodology used to determine usual and customary fees; and

(3) the percentile of usual and customary fees that determines the maximum allowable reimbursement.

(b) A health carrier must provide a copy of the information described in paragraph (a) to the Minnesota health care commission, the commissioner of health, or the commissioner of commerce, upon request.

(c) The commissioner of health or the commissioner of commerce, as appropriate, may use to enforce this section any enforcement powers otherwise available to the commissioner with respect to the health carrier. The appropriate commissioner shall enforce compliance with a request made under this section by the Minnesota health care commission, at the request of the commissioner. The commissioner of health or commerce, as appropriate, may require health

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carriers to provide the information required under this section and may use any powers granted under other laws relating to the regulation of health carriers to enforce compliance.

(d) For purposes of this section, "health carrier" has the meaning given in section 62A.011.

Sec. 4. Minnesota Statutes 1992, section 62A.65, is amended to read:

62A.65 **INDIVIDUAL MARKET REGULATION.**

Subdivision 1. **APPLICABILITY.** No health carrier, as defined in ~~chapter 62L~~ section 62A.011, shall offer, sell, issue, or renew any individual ~~policy of accident and sickness coverage, as defined in section 62A.01, subdivision 1, any individual subscriber contract regulated under chapter 62C, any individual health maintenance contract regulated under chapter 62D, any individual health benefit certificate regulated under chapter 64B, or any individual health coverage provided by a multiple employer welfare arrangement,~~ health plan, as defined in section 62A.011, to a Minnesota resident except in compliance with this section. ~~For purposes of this section, "health benefit plan" has the meaning given in chapter 62L, except that the term means individual coverage, including family coverage, rather than employer group coverage.~~ This section does not apply to the comprehensive health association established in section 62E.10 ~~or to coverage described in section 62A.31, subdivision 1, paragraph (h), or to long-term care policies as defined in section 62A.46, subdivision 2~~.

Subd. 2. **GUARANTEED RENEWAL.** No individual health ~~benefit~~ plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health ~~benefit~~ plan provides that the plan is guaranteed renewable at a premium rate that does not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the health ~~benefit~~ plan to the person. The premium rate upon renewal must also otherwise comply with this section. ~~A~~ An individual health ~~benefit~~ plan may be subject to refusal to renew only under the conditions provided in chapter 62L for health benefit plans.

Subd. 3. **PREMIUM RATE RESTRICTIONS.** No individual health ~~benefit~~ plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the rating and premium restrictions provided under chapter 62L, except that the minimum loss ratio applicable to an individual ~~coverage~~ health plan is as provided in section 62A.021. All ~~provisions~~ rating and premium restrictions of chapter 62L apply to ~~rating and premium restrictions in~~ the individual market, unless clearly inapplicable to the individual market.

Subd. 4. **GENDER RATING PROHIBITED.** No individual health ~~benefit~~ plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, on the gender of any person covered or to be covered under the health ~~benefit~~ plan.

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Subd. 5. **PORTABILITY OF COVERAGE.** (a) No individual health ~~benefit~~ plan may be offered, sold, issued, or with respect to children age 18 or under renewed, to a Minnesota resident that contains a preexisting condition limitation or exclusion, unless the limitation or exclusion would be permitted under chapter 62L, provided that, except for children age 18 or under, underwriting restrictions may be retained on individual contracts that are issued without evidence of insurability as a replacement for prior individual coverage that was sold before May 17, 1993. The individual may be treated as a late entrant, as defined in chapter 62L, unless the individual has maintained continuous coverage as defined in chapter 62L. An individual who has maintained continuous coverage may be subjected to a one-time preexisting condition limitation as permitted under chapter 62L for persons who are not late entrants, at the time that the individual first is covered ~~by~~ under an individual ~~coverage~~ health plan by any health carrier. Thereafter, the person must not be subject to any preexisting condition limitation under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage.

(b) A health carrier must offer an individual ~~coverage~~ health plan to any individual previously covered under a group health benefit plan issued by that health carrier, so long as the individual maintained continuous coverage as defined in chapter 62L. ~~Coverage~~ A health plan issued under this paragraph must be a qualified plan and must not contain any preexisting condition limitation or exclusion, except for any unexpired limitation or exclusion under the previous coverage. The initial premium rate for the individual ~~coverage~~ health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed 90 percent of the premium charged for comparable individual coverage by the Minnesota comprehensive health association.

Subd. 6. **GUARANTEED ISSUE NOT REQUIRED.** Nothing in this section requires a health carrier to initially issue a health ~~benefit~~ plan to a Minnesota resident, except as otherwise expressly provided in subdivision 4 or 5.

Sec. 5. Minnesota Statutes 1992, section 62E.11, subdivision 12, is amended to read:

Subd. 12. **FUNDING.** Notwithstanding subdivision 5, the claims expenses and operating and administrative expenses of the association incurred on or after January 1, 1994, to the extent that they exceed the premiums received, shall be paid from the health care access account established in section 16A.724, to the extent appropriated for that purpose by the legislature. Any such expenses not paid from that account shall be paid as otherwise provided in this section. All contributing members shall adjust their premium rates to fully reflect funding provided under this subdivision. The commissioner of commerce or the commissioner of health, as appropriate, shall require contributing members to prove compliance with this rate adjustment requirement.

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Sec. 6. **[62A.651] PHASE-IN.**

Subdivision 1. **COMPLIANCE.** No health carrier, as defined in Minnesota Statutes, section 62A.011, shall renew any individual health plan, as defined in Minnesota Statutes, section 62A.011, except in compliance with this section.

Subd. 2. **PREMIUM ADJUSTMENTS.** Any increase or decrease in premiums by a health carrier that is caused by Minnesota Statutes, section 62A.65, is subject to the premium adjustments in this subdivision. A health carrier shall determine renewal premiums for any coverage under subdivision 1 as follows:

(1) one-half of the premium increase or decrease may be charged upon the first renewal of the coverage on or after July 1, 1993; and

(2) the remaining half of the premium increase or decrease may be charged upon the first renewal of the coverage one year after the date of the renewal under clause (1).

Sec. 7. **EFFECTIVE DATE.**

Sections 1, 2, and 4 to 6 are effective July 1, 1993.

ARTICLE 9

MINNESOTACARE PROGRAM

Section 1. Minnesota Statutes 1992, section 256.9351, subdivision 3, is amended to read:

Subd. 3. **ELIGIBLE PROVIDERS.** "Eligible providers" means those health care providers who provide covered health services to medical assistance recipients under rules established by the commissioner for that program. ~~Reimbursement under this section shall be at the same rates and conditions established for medical assistance.~~

Sec. 2. Minnesota Statutes 1992, section 256.9352, subdivision 3, is amended to read:

Subd. 3. **FINANCIAL MANAGEMENT.** The commissioner shall manage spending for the health right plan in a manner that maintains a minimum reserve equal to five percent of the expected cost of state premium subsidies. The commissioner must make a quarterly assessment of the expected expenditures for the covered services for the remainder of the current fiscal year and for the following two fiscal years. The estimated expenditure shall be compared to an estimate of the revenues that will be deposited in the health care access fund. Based on this comparison, and after consulting with the chairs of the house appropriations committee and the senate finance committee, and the legislative commission on health care access, the commissioner shall make adjustments as

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necessary to ensure that expenditures remain within the limits of available revenues. The adjustments the commissioner may use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the health right plan; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the health right plan. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner may further limit enrollment or decrease premium subsidies.

~~If the commissioner determines that, despite adjustments made as authorized under this subdivision, estimated costs will exceed the forecasted amount of available revenues other than the reserve, the commissioner may, with the approval of the commissioner of finance, use all or part of the reserve to cover the costs of the program.~~ The reserve referred to in this subdivision is appropriated to the commissioner but may only be used upon approval of the commissioner of finance, if estimated costs will exceed the forecasted amount of available revenues after all adjustments authorized under this subdivision have been made.

By February 1, 1994, the department of human services and the department of health shall develop a plan to adjust benefit levels, eligibility guidelines, or other steps necessary to ensure that expenditures for the MinnesotaCare program are contained within the two percent provider tax and the one percent HMO gross premiums tax for the 1996-1997 biennium. Notwithstanding any law to the contrary, no further enrollment in MinnesotaCare, and no additional hiring of staff for the departments shall take place after June 1, 1994, unless a plan to balance the MinnesotaCare budget for the 1996-1997 biennium has been passed by the 1994 legislature.

Sec. 3. Minnesota Statutes 1992, section 256.9353, is amended to read:

Subdivision 1. **COVERED HEALTH SERVICES.** "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than preventive services, orthodontic services, medical transportation services, personal care assistant and case management services, hospice care services, nursing home or intermediate care facilities services, inpatient mental health services, ~~outpatient mental health services in excess of $1,000 per adult enrollee and $2,500 per child enrollee per 12-month eligibility period,~~ and chemical dependency services. Outpatient mental health services covered under the health right plan are limited to diagnostic assessments, psychological testing, explanation of findings, day treatment, partial hospitalization, and individual, family, and group psychotherapy. ~~Medication~~

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~~management by a physician is not subject to the $1,000 and $2,500 limitations on outpatient mental health services.~~ Covered health services shall be expanded as provided in this section.

Subd. 2. **ALCOHOL AND DRUG DEPENDENCY.** Beginning ~~October~~ July 1, ~~1992~~ 1993, covered health services shall include ~~up to ten hours per year of~~ individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program. ~~Two hours of group treatment count as one hour of individual treatment.~~

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the department of human services must place a person in need of chemical dependency services as provided in Minnesota Rules, parts 9530.6600 to 9530.6660. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Subd. 3. **INPATIENT HOSPITAL SERVICES.** (a) Beginning July 1, 1993, covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spend-down. The inpatient hospital benefit for adult enrollees ~~not eligible for medical assistance~~ is subject to an annual benefit limit of $10,000. The commissioner shall provide enrollees with at least 60 days' notice of coverage for inpatient hospital services and any premium increase associated with the inclusion of this benefit.

(b) Enrollees shall apply for and cooperate with the requirements of medical assistance by the last day of the third month following admission to an inpatient hospital. If an enrollee fails to apply for medical assistance within this time period, the enrollee and the enrollee's family shall be disenrolled from the plan within one calendar month. Enrollees and enrollees' families disenrolled for not applying for or not cooperating with medical assistance may not reenroll.

Subd. 4. **HOSPICE.** Beginning July 1, 1993, covered health services shall include hospice care services.

Subd. ~~4~~ 5. **EMERGENCY MEDICAL TRANSPORTATION SERVICES.**

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Beginning July 1, 1993, covered health services shall include emergency medical transportation services.

Subd. ~~5~~ 6. ~~**FEDERAL WAIVERS AND APPROVALS**~~ **COORDINATION WITH MEDICAL ASSISTANCE.** The commissioner shall coordinate the provision of hospital inpatient services under the health right plan with enrollee eligibility under the medical assistance spend-down, and shall apply to the secretary of health and human services for any necessary federal waivers or approvals.

Subd. ~~6~~ 7. **COPAYMENTS AND COINSURANCE.** The health right benefit plan shall include the following copayments and coinsurance requirements:

(1) ten percent of the charges submitted for inpatient hospital services for adult enrollees not eligible for medical assistance, subject to an annual out-of-pocket maximum of ~~$2,000~~ $1,000 per individual and $3,000 per family;

~~(2) 50 percent for adult dental services, except for preventive services;~~

~~(3)~~ (2) $3 per prescription for adult enrollees; and

~~(4)~~ (3) $25 for eyeglasses for adult enrollees.

Enrollees who would be eligible for medical assistance with a spend-down shall be financially responsible for the coinsurance amount up to the spend-down limit or the coinsurance amount, whichever is less, in order to become eligible for the medical assistance program.

Sec. 4. Minnesota Statutes 1992, section 256.9354, subdivision 1, is amended to read:

Subdivision 1. **CHILDREN.** "Eligible persons" means children who are one year of age or older but less than 18 years of age who have gross family incomes that are equal to or less than ~~185~~ 150 percent of the federal poverty guidelines and who are not eligible for medical assistance under chapter 256B and who are not otherwise insured for the covered services. The period of eligibility extends from the first day of the month in which the child's first birthday occurs to the last day of the month in which the child becomes 18 years old. Eligibility for ~~the health right plan~~ MinnesotaCare shall be expanded as provided in subdivisions 2 to 5, except children who meet the criteria in this subdivision shall continue to be enrolled pursuant to this subdivision. Under subdivisions ~~2~~ 1 to 5, parents who enroll in the health right plan must also enroll their children and dependent siblings, if the children and their dependent siblings are eligible. Children and dependent siblings may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. Families cannot choose to enroll only certain uninsured members. For purposes of this section, a "dependent sibling" means an unmarried child who is a full-time student under the age

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of 25 years who is financially dependent upon a parent. Proof of school enrollment will be required.

Sec. 5. Minnesota Statutes 1992, section 256.9354, subdivision 4, is amended to read:

Subd. 4. **FAMILIES WITH CHILDREN; ELIGIBILITY BASED ON PERCENTAGE OF INCOME PAID FOR HEALTH COVERAGE.** Beginning January 1, 1993, "eligible persons" means children, parents, and dependent siblings residing in the same household who are not eligible for medical assistance under chapter 256B. ~~These persons are eligible for coverage through the health right plan but~~ Children who meet the criteria in subdivision 1 shall continue to be enrolled pursuant to subdivision 1. Persons who are eligible under this subdivision or subdivision 2, 3, or 5 must pay a premium as determined under sections 256.9357 and 256.9358, and children eligible under subdivision 1 must pay the premium required under section 256.9356, subdivision 1. Individuals and families whose income is greater than the limits established under section 256.9358 may not enroll in ~~the health right plan~~ MinnesotaCare. Individuals who initially enroll in ~~the health right plan~~ MinnesotaCare under the eligibility criteria in this subdivision remain eligible for ~~the health right plan~~ MinnesotaCare, regardless of age, place of residence within Minnesota, or the presence or absence of children in the same household, as long as all other eligibility requirements are met and continuous enrollment in ~~the health right plan~~ MinnesotaCare or medical assistance is maintained.

Sec. 6. Minnesota Statutes 1992, section 256.9354, is amended by adding a subdivision to read:

Subd. 6. **APPLICANTS POTENTIALLY ELIGIBLE FOR MEDICAL ASSISTANCE.** Individuals who apply for MinnesotaCare, but who are potentially eligible for medical assistance shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer such individuals to their county social service agency. The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60-day enrollment period. Enrollees who do not apply for and cooperate with medical assistance within the 60-day enrollment period, and their other family members, shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination for the family member or members who were referred to the county agency. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination. The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

Sec. 7. Minnesota Statutes 1992, section 256.9356, is amended to read:

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256.9356 ~~ENROLLMENT AND~~ PREMIUM ~~FEE~~ FEES AND PAYMENTS.

Subdivision 1. ~~ENROLLMENT FEE~~ PREMIUM FEES. ~~Until October 1, 1992,~~ An annual ~~enrollment~~ premium fee of ~~$25, not to exceed $150 per family,~~ $48 is required from ~~eligible persons for covered health services~~ all MinnesotaCare enrollees eligible under section 256.9354, subdivision 1.

Subd. 2. PREMIUM PAYMENTS. ~~Beginning October 1, 1992,~~ The commissioner shall require ~~health right plan~~ MinnesotaCare enrollees eligible under section 256.9354, subdivisions 2 to 5, to pay a premium based on a sliding scale, as established under section ~~256.9357~~ 256.9358. ~~Applicants who are eligible under section 256.9354, subdivision 1, are exempt from this requirement until July 1, 1993, if the application is received by the health right plan staff on or before September 30, 1992. Before July 1, 1993, these individuals shall continue to pay the annual enrollment fee required by subdivision 1.~~

Subd. 3. ADMINISTRATION AND COMMISSIONER'S DUTIES. ~~Enrollment and premium fees~~ Premiums are dedicated to the commissioner for ~~the health right plan~~ MinnesotaCare. The commissioner shall make an annual redetermination of continued eligibility and identify people who may become eligible for medical assistance. The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon changes in enrollee income; and (3) disenroll enrollees from ~~the health right plan~~ MinnesotaCare for failure to pay required premiums. Premiums are calculated on a calendar month basis and may be paid on a monthly ~~or~~, quarterly, or annual basis, with the first payment due upon notice from the commissioner of the premium amount required. Premium payment is required before enrollment is complete and to maintain eligibility in ~~the health right plan~~ MinnesotaCare. Nonpayment of the premium will result in disenrollment from the plan within one calendar month after the due date. Persons disenrolled for nonpayment may not reenroll until four calendar months have elapsed.

Sec. 8. Minnesota Statutes 1992, section 256.9357, subdivision 1, is amended to read:

Subdivision 1. GENERAL REQUIREMENTS. Families and individuals ~~who enroll on or after October 1, 1992,~~ are eligible for subsidized premium payments based on a sliding scale under section 256.9358 only if the family or individual meets the requirements in subdivisions 2 and 3. ~~Children already enrolled in the health right plan as of September 30, 1992, are eligible for subsidized premium payments without meeting these requirements, as long as they maintain continuous coverage in the health right plan or medical assistance.~~

Families and individuals who initially enrolled in ~~the health right~~ MinnesotaCare plan under section 256.9354, and whose income increases above the limits established in section 256.9358, may continue enrollment and pay the full cost of coverage.

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Sec. 9. **[256.9362] PROVIDER PAYMENT.**

Subdivision 1. **MEDICAL ASSISTANCE RATE TO BE USED.** Payment to providers under sections 256.9351 to 256.9362 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to 6.

Subd. 2. **PAYMENT OF CERTAIN PROVIDERS.** Services provided by federally qualified health centers, rural health clinics, and facilities of the Indian health service shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, or facilities of the Indian health service.

Subd. 3. **INPATIENT HOSPITAL SERVICES.** Inpatient hospital services provided under section 256.9353, subdivision 3, shall be paid for as provided in subdivisions 4 to 6.

Subd. 4. **DEFINITION OF MEDICAL ASSISTANCE RATE FOR INPATIENT HOSPITAL SERVICES.** The "medical assistance rate," as used in this section to apply to rates for providing inpatient hospital services, means the rates established under sections 256.9685 to 256.9695 for providing inpatient hospital services to medical assistance recipients who receive aid to families with dependent children.

Subd. 5. **ENROLLEES YOUNGER THAN 18.** Payment for inpatient hospital services provided to MinnesotaCare enrollees who are younger than 18 years old on the date of admission to the inpatient hospital shall be at the medical assistance rate.

Subd. 6. **ENROLLEES 18 OR OLDER.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b).

(a) If the medical assistance rate minus any copayment required under section 256.9353, subdivision 6, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256.9353, subdivision 3, payment must be the medical assistance rate minus any copayment required under section 256.9353, subdivision 6. The hospital must not seek payment from the enrollee in addition to the copayment. The MinnesotaCare payment plus the copayment must be treated as payment in full.

(b) If the medical assistance rate minus any copayment required under section 256.9353, subdivision 6, is greater than the amount remaining in the enrollee's benefit limit under section 256.9353, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any copayment established under section 256.9353, subdivision 6.

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The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph.

Sec. 10. **[256.9363] MANAGED CARE.**

Subdivision 1. **SELECTION OF VENDORS.** In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Managed care plans may include integrated service networks as defined in section 62N.02.

Subd. 2. **GEOGRAPHIC AREA.** The commissioner shall designate the geographic areas in which eligible individuals must receive services through managed care plans.

Subd. 3. **LIMITATION OF CHOICE.** Persons enrolled in the MinnesotaCare program who reside in the designated geographic areas must enroll in a managed care plan to receive their health care services. Enrollees must receive their health care services from health care providers who are part of the managed care plan provider network, unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract.

If only one managed care option is available in a geographic area, the managed care plan may require that enrollees designate a primary care provider from which to receive their health care. Enrollees will be permitted to change their designated primary care provider upon request to the managed care plan. Requests to change primary care providers may be limited to once annually. If more than one managed care plan is offered in a geographic area, enrollees will be enrolled in a managed care plan for up to one year from the date of enrollment, but shall have the right to change to another managed care plan once within the first year of initial enrollment. Enrollees may also change to another managed care plan during an annual 30 day open enrollment period. Enrollees shall be notified of the opportunity to change to another managed care plan before the start of each annual open enrollment period.

Enrollees may change managed care plans or primary care providers at other than the above designated times for cause as determined through an appeal pursuant to section 256.045.

Subd. 4. **EXEMPTIONS TO LIMITATIONS ON CHOICE.** All contracts between the department of human services and prepaid health plans or integrated service networks to serve medical assistance, general assistance medical care, and MinnesotaCare recipients must comply with the requirements of United States Code, title 42, section 1396a (a) (23) (B), notwithstanding any

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waivers authorized by the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1315.

Subd. 5. **ELIGIBILITY FOR OTHER STATE PROGRAMS.** MinnesotaCare enrollees who become eligible for medical assistance or general assistance medical care will remain in the same managed care plan if the managed care plan has a contract for that population. Contracts between the department of human services and managed care plans must include MinnesotaCare, and medical assistance and may also include general assistance medical care.

Subd. 6. **COPAYMENTS AND BENEFIT LIMITS.** Enrollees are responsible for all copayments in section 256.9353, subdivision 6, and shall pay copayments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit to the managed care plan or its participating providers.

Subd. 7. **MANAGED CARE PLAN VENDOR REQUIREMENTS.** The following requirements apply to all counties or vendors who contract with the department of human services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256.9353 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee copayments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D;

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services; and

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(9) shall submit to the commissioner claims in the format specified by the commissioner of human services for all hospital services provided to enrollees for the purpose of determining whether enrollees meet medical assistance spend-down requirements and shall provide to the enrollee, upon the enrollee's request, information on the cost of services provided to the enrollee by the managed care plan for the purpose of establishing whether the enrollee has met medical assistance spenddown requirements.

Subd. 8. **CHEMICAL DEPENDENCY ASSESSMENTS.** The managed care plan shall be responsible for assessing the need and placement for chemical dependency services according to criteria set forth in Minnesota Rules, parts 9530.6600 to 9530.6660.

Subd. 9. **RATE SETTING.** Rates will be prospective, per capita, where possible. The commissioner shall consult with an independent actuary to determine appropriate rates.

Subd. 10. **CHILDHOOD IMMUNIZATION.** Each managed care plan contracting with the department of human services under this section shall collaborate with the local public health agencies to ensure childhood immunization to all enrolled families with children. As part of this collaboration the plan must provide the families with a recommended immunization schedule.

Sec. 11. Minnesota Statutes 1992, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. **PREGNANT WOMEN AND INFANTS.** An infant less than one year of age or a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, is eligible for medical assistance if countable family income is equal to or less than ~~185~~ 275 percent of the federal poverty guideline for the same family size. For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program, except for the earned income disregard and employment deductions. An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions of the AFDC program will be deducted for pregnant women and infants less than one year of age. Eligibility for a pregnant woman or infant less than one year of age under this subdivision must be determined without regard to asset standards established in section 256B.056, subdivision 3.

An infant born on or after January 1, 1991, to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday, as long as the child remains in the woman's household.

Sec. 12. Minnesota Statutes 1992, section 256B.057, is amended by adding a subdivision to read:

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Subd. 1a. **PREMIUMS.** Women and infants who are eligible under subdivision 1 and whose countable family income is equal to or greater than 185 percent of the federal poverty guideline for the same family size shall be required to pay a premium for medical assistance coverage based on a sliding scale as established under section 256.9358.

Sec. 13. Minnesota Statutes 1992, section 256B.057, subdivision 2a, is amended to read:

Subd. 2a. **NO ASSET TEST FOR CHILDREN AND THEIR PARENTS.** Eligibility for medical assistance for a person under age 21, and the person's parents who are eligible under section 256B.055, subdivision 3, and who live in the same household as the person eligible under age 21, must be determined without regard to asset standards established in section 256B.056.

Sec. 14. Minnesota Statutes 1992, section 256B.0644, is amended to read:

256B.0644 **PARTICIPATION REQUIRED FOR REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.**

A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and ~~the health right plan~~ MinnesotaCare as a condition of participating as a provider in health insurance plans or contractor for state employees established under section 43A.18, the public employees insurance plan under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.17. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the department of human services. For providers other than health maintenance organizations, participation in the medical assistance program means that (1) the provider accepts new medical assistance patients or (2) at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, or ~~the health right plan~~ MinnesotaCare as their primary source of coverage. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program.

Sec. 15. Minnesota Statutes 1992, section 256D.03, subdivision 3, is amended to read:

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Subd. 3. **GENERAL ASSISTANCE MEDICAL CARE; ELIGIBILITY.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spend-down of excess income according to section 256B.056, subdivision 5, and:

(1) who is receiving assistance under section 256D.05 or 256D.051; or

(2)(i) who is a resident of Minnesota; and whose equity in assets is not in excess of $1,000 per assistance unit. No asset test shall be applied to children and their parents living in the same household. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in chapter 256B, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; and

(ii) who has countable income not in excess of the assistance standards established in section 256B.056, subdivision 4, or whose excess income is spent down pursuant to section 256B.056, subdivision 5, using a six-month budget period, except that a one-month budget period must be used for recipients residing in a long-term care facility. The method for calculating earned income disregards and deductions for a person who resides with a dependent child under age 21 shall be as specified in section 256.74, subdivision 1. However, if a disregard of $30 and one-third of the remainder described in section 256.74, subdivision 1, clause (4), has been applied to the wage earner's income, the disregard shall not be applied again until the wage earner's income has not been considered in an eligibility determination for general assistance, general assistance medical care, medical assistance, or aid to families with dependent children for 12 consecutive months. The earned income and work expense deductions for a person who does not reside with a dependent child under age 21 shall be the same as the method used to determine eligibility for a person under section 256D.06, subdivision 1, except the disregard of the first $50 of earned income is not allowed; or

(3) who would be eligible for medical assistance except that the person resides in a facility that is determined by the commissioner or the federal health care financing administration to be an institution for mental diseases.

(b) Eligibility is available for the month of application, and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

(c) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person

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is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(d) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(e) In determining the amount of assets of an individual, there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 30 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

Sec. 16. **DEMONSTRATION WAIVER.**

The commissioner of human services shall seek a demonstration waiver or otherwise obtain federal approval to: (1) allow the state to charge premiums as described in section 12; (2) increase the income standard to 275 percent of the federal poverty guideline; and (3) continue eligibility without redetermination for infants 13 to 24 months of age.

Sec. 17. **MINNESOTACARE PROGRAM STUDY.**

The commissioner of human services shall examine the impact the MinnesotaCare program is having on the increase in medical assistance enrollment and costs. As part of this study, the commissioner shall determine whether other factors unrelated to the MinnesotaCare program may be contributing to the increase in medical assistance enrollment. The commissioner shall also make recommendations on necessary adjustments in revenues or expenditures to ensure that the health care access fund remains solvent for the 1996-1997 biennium. The commissioner shall present findings and recommendations to the legislative oversight commission by November 15, 1993.

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Sec. 18. **EFFECTIVE DATE.**

Section 12 is effective July 1, 1993, or after the effective date of the waiver referred to in section 16, whichever is later. Sections 10 and 16 are effective the day following final enactment. Section 10, subdivision 4, is effective for all contracts entered into or renewed on or after the day following final enactment. Section 14 is effective for health insurance contracts negotiated after November 1, 1993.

ARTICLE 10

RURAL HEALTH INITIATIVE

Section 1. Minnesota Statutes 1992, section 144.147, subdivision 4, is amended to read:

Subd. 4. **ALLOCATION OF GRANTS.** (a) Eligible hospitals must apply to the commissioner no later than September 1 of each fiscal year for grants awarded for ~~the~~ that fiscal year ~~beginning the following July 1~~. A grant may be awarded upon signing of a grant contract.

(b) The commissioner must make a final decision on the funding of each application within 60 days of the deadline for receiving applications.

(c) Each relevant community health board has 30 days in which to review and comment to the commissioner on grant applications from hospitals in their community health service area.

(d) In determining which hospitals will receive grants under this section, the commissioner shall consider the following factors:

(1) Description of the problem, description of the project, and the likelihood of successful outcome of the project. The applicant must explain clearly the nature of the health services problems in their service area, how the grant funds will be used, what will be accomplished, and the results expected. The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations.

(2) The extent of community support for the hospital and this proposed project. The applicant should demonstrate support for the hospital and for the proposed project from other local health service providers and from local community and government leaders. Evidence of such support may include past commitments of financial support from local individuals, organizations, or government entities; and commitment of financial support, in-kind services or cash, for this project.

(3) The comments, if any, resulting from a review of the application by the

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community health board in whose community health service area the hospital is located.

(e) In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning the maximum of 70 points for an applicant's understanding of the problem, description of the project, and likelihood of successful outcome of the project; and a maximum of 30 points for the extent of community support for the hospital and this project. The commissioner may also take into account other relevant factors.

(f) A grant to a hospital, including hospitals that submit applications as consortia, may not exceed ~~$50,000~~ $37,500 a year and may not exceed a term of two years. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one-half of the amount, which may include in-kind services, is available for the same purposes from nonstate sources. A hospital receiving a grant under this section may use the grant for any expenses incurred in the development of strategic plans or the implementation of transition projects with respect to which the grant is made. Project grants may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

(g) The commissioner may adopt rules to implement this section.

Sec. 2. Minnesota Statutes 1992, section 144.1484, subdivision 1, is amended to read:

Subdivision 1. **SOLE COMMUNITY HOSPITAL FINANCIAL ASSISTANCE GRANTS.** The commissioner of health shall award financial assistance grants to rural hospitals in isolated areas of the state. To qualify for a grant, a hospital must: (1) be eligible to be classified as a sole community hospital according to the criteria in Code of Federal Regulations, title 42, section 412.92 or be located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services; (2) have experienced net income losses in the two most recent consecutive hospital fiscal years for which audited financial information is available; (3) consist of ~~30~~ 40 or fewer licensed beds; and (4) ~~have exhausted local sources of support. Before applying for a grant, the hospital must have developed a strategic plan. The commissioner shall award grants in equal amounts.~~ demonstrate to the commissioner that it has obtained local support for the hospital and that any state support awarded under this program will not be used to supplant local support for the hospital. The commissioner shall review audited financial statements of the hospital to assess the extent of local support. Evidence of local support may include bonds issued by a local government entity such as a city, county, or hospital district for the purpose of financing hospital projects; and loans, grants, or donations to the hospital from local government entities, private organizations, or individuals. The commissioner shall determine the amount of the award to be given to each eligible hospital based on the hospital's financial need and the total amount of funding available.

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Sec. 3. Minnesota Statutes 1992, section 144.1484, subdivision 2, is amended to read:

Subd. 2. **GRANTS TO AT-RISK RURAL HOSPITALS TO OFFSET THE IMPACT OF THE HOSPITAL TAX.** (a) The commissioner of health shall award financial assistance grants to rural hospitals that would otherwise close as a direct result of the hospital tax in section 295.52. To be eligible for a grant, a hospital must have 50 or fewer beds and must not be located in a city of the first class. To receive a grant, the hospital must demonstrate to the satisfaction of the commissioner of health that the hospital will close in the absence of state assistance under this subdivision and that the hospital tax is the principal reason for the closure.

(b) At a minimum the hospital must demonstrate that:

(1) it has had a net margin of minus ten percent or below in at least one of the last two years or a net margin of less than zero percent in at least three of the last four years. For purposes of this subdivision, "net margin" means the ratio of net income from all hospital sources to total revenues generated by the hospital;

(2) it has had a negative cash flow in at least three of the last four years. For purposes of this subdivision, "cash flow" means the total of net income plus depreciation; and

(3) its fund balance has declined by at least 25 percent over the last two years, and its fund balance at the end of its last fiscal year was equal to or less than its accumulated net loss during the last two years. For purposes of this subdivision, "fund balance" means the excess of assets of the hospital's fund over its liabilities and reserves.

(c) A hospital seeking a grant shall submit the following with its application:

(1) a statement of the projected dollar amount of tax liability for the current fiscal year, projected monthly disbursements, and projected net patient revenue base for the current fiscal year, broken down by payer categories including Medicare, medical assistance, MinnesotaCare, general assistance medical care, and others. The figures must be certified by the hospital administrator;

(2) a statement of all rate increases, listing the date and percentage of each increase during the last three years and the date and percentage of any increases for the current fiscal year. The statement must be certified by the hospital administrator and must include a narrative explaining whether or not the rate increase incorporates a pass-through of the hospital tax;

(3) a statement certified by the chair or equivalent of the hospital board, and by an independent auditor, that the hospital will close within the next 12 months as a result of the hospital tax unless it receives a grant; and

(4) a statement certified by the chair or equivalent of the hospital board that the hospital will not close for financial reasons within the next 12 months if it receives a grant.

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The amount of the grant must not exceed the amount of the tax the hospital would pay under section 295.52, based on the previous year's hospital revenues. A hospital that closes within 12 months after receiving a grant under this subdivision must refund the amount of the grant to the commissioner of health.

ARTICLE 11

HEALTH PROFESSIONAL EDUCATION

Section 1. Minnesota Statutes 1992, section 124C.62, is amended to read:

124C.62 **SUMMER HEALTH CARE INTERNS.**

Subdivision 1. **SUMMER INTERNSHIPS.** The commissioner of education, through a contract with a nonprofit organization as required by subdivision 4, shall award grants to hospitals and clinics to establish a summer health care intern program ~~for pupils who intend to complete high school graduation requirements and who are between their junior and senior year of high school~~. The purpose of the program is to expose interested high school pupils to various careers within the health care profession.

Subd. 2. **CRITERIA.** (a) The commissioner~~, with the advice of the Minnesota Medical Association and the Minnesota Hospital Association~~, through the organization under contract, shall ~~establish criteria for awarding~~ award grants to hospitals and clinics~~.~~ that agree to:

~~(b) The criteria must include, among other things:~~

(1) ~~the kinds of~~ provide summer health care interns with formal exposure to the health care profession ~~a hospital or clinic can provide to a pupil~~;

(2) ~~the need for health care professionals in a particular area; and~~ provide an orientation for summer health care interns;

(3) ~~the willingness of a hospital or clinic to~~ pay one-half the costs of employing a ~~pupil~~ summer health care intern, based on an overall hourly wage that is at least the minimum wage but does not exceed $6 an hour; and

(4) interview and hire pupils for a minimum of six weeks and a maximum of 12 weeks.

(b) In order to be eligible to be hired as a summer health intern by a hospital or clinic, a pupil must:

(1) intend to complete high school graduation requirements and be between the junior and senior year of high school;

(2) be from a school district in proximity to the facility; and

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(3) provide the facility with a letter of recommendation from a health occupations or science educator.

(c) Hospitals and clinics awarded grants may employ pupils as summer health care interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period before disbursement of state grant money, with money designated as the facility's 50 percent contribution towards internship costs.

~~(c) The Minnesota Medical Association and the Minnesota Hospital Association must provide the commissioner, by January 31, 1993, with a list of hospitals and clinics willing to participate in the program and what provisions those hospitals or clinics will make to ensure a pupil's adequate exposure to the health care profession, and indicate whether a hospital or clinic is willing to pay one-half the costs of employing a pupil.~~

Subd. 3. **GRANTS.** The commissioner, through the organization under contract, shall award grants to hospitals and clinics meeting the requirements of subdivision 2. The grants must be used to pay one-half of the costs of employing a pupil in a hospital or clinic during the course of the program. No more than five pupils may be selected from any one high school to participate in the program and no more than one-half of the number of pupils selected may be from the seven-county metropolitan area.

Subd. 4. **CONTRACT.** The commissioner shall contract with a statewide, nonprofit organization representing facilities at which summer health care interns will serve, to administer the grant program established by this section. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program, in the form and at the times specified by the commissioner.

Sec. 2. Minnesota Statutes 1992, section 136A.1355, subdivision 1, is amended to read:

Subdivision 1. **CREATION OF ACCOUNT.** A rural physician education account is established in the health care access fund. The higher education coordinating board shall use money from the account to establish a loan forgiveness program for medical students agreeing to practice in designated rural areas, as defined by the board.

Sec. 3. Minnesota Statutes 1992, section 136A.1355, subdivision 3, is amended to read:

Subd. 3. **LOAN FORGIVENESS.** ~~Prior to June 30, 1992, the higher education coordinating board may accept up to eight applicants who are fourth year medical students, up to eight applicants who are first year residents, and up to eight applicants who are second year residents for participation in the loan forgiveness program.~~ For the period July 1, ~~1992~~ 1993 through June 30, 1995, the higher education coordinating board may accept up to ~~eight~~ four applicants who are fourth year medical students, three applicants who are pediatric residents,

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and four applicants who are family practice residents, and one applicant who is an internal medicine resident, per fiscal year for participation in the loan forgiveness program. If the higher education coordinating board does not receive enough applicants per fiscal year to fill the number of residents in the specific areas of practice, the resident applicants may be from any area of practice. The eight resident applicants can be in any year of training. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed $10,000, as a qualified loan. For each year that a participant serves as a physician in a designated rural area, up to a maximum of four years, the higher education coordinating board shall annually pay an amount equal to one year of qualified loans. Participants who move their practice from one designated rural area to another remain eligible for loan repayment. In addition, if a resident participating in the loan forgiveness program serves at least four weeks during a year of residency substituting for a rural physician to temporarily relieve the rural physician of rural practice commitments to enable the rural physician to take a vacation, engage in activities outside the practice area, or otherwise be relieved of rural practice commitments, the participating resident may designate up to an additional $2,000, above the $10,000 maximum, for each year of residency during which the resident substitutes for a rural physician for four or more weeks.

Sec. 4. Minnesota Statutes 1992, section 136A.1355, subdivision 4, is amended to read:

Subd. 4. **PENALTY FOR NONFULFILLMENT.** If a participant does not fulfill the required three-year minimum commitment of service in a designated rural area, the higher education coordinating board shall collect from the participant the amount paid by the board under the loan forgiveness program. The higher education coordinating board shall deposit the money collected in the rural physician education account established in subdivision 1. The board shall allow waivers of all or part of the money owed the board if emergency circumstances prevented fulfillment of the three-year service commitment.

Sec. 5. Minnesota Statutes 1992, section 136A.1355, is amended by adding a subdivision to read:

Subd. 5. **LOAN FORGIVENESS; UNDERSERVED URBAN COMMUNITIES.** For the period July 1, 1993 to June 30, 1995, the higher education coordinating board may accept up to four applicants who are either fourth year medical students, or residents in family practice, pediatrics, or internal medicine per fiscal year for participation in the urban primary care physician loan forgiveness program. The resident applicants may be in any year of residency training. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed $10,000, as a qualified loan. For each year that a participant serves as a physician in a designated underserved urban area, up to a maximum of four years,

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the higher education coordinating board shall annually pay an amount equal to one year of qualified loans. Participants who move their practice from one designated underserved urban community to another remain eligible for loan repayment.

Sec. 6. Minnesota Statutes 1992, section 136A.1356, subdivision 2, is amended to read:

Subd. 2. **CREATION OF ACCOUNT.** A midlevel practitioner education account is established in the health care access fund. The higher education coordinating board shall use money from the account to establish a loan forgiveness program for midlevel practitioners agreeing to practice in designated rural areas.

Sec. 7. Minnesota Statutes 1992, section 136A.1356, subdivision 5, is amended to read:

Subd. 5. **PENALTY FOR NONFULFILLMENT.** If a participant does not fulfill the service commitment required under subdivision 4 for full repayment of all qualified loans, the higher education coordinating board shall collect from the participant 100 percent of any payments made for qualified loans and interest at a rate established according to section 270.75. The higher education coordinating board shall deposit the money collected in the midlevel practitioner education account established in subdivision 2. The board shall allow waivers of all or part of the money owed the board if emergency circumstances prevented fulfillment of the required service commitment.

Sec. 8. Minnesota Statutes 1992, section 136A.1357, is amended to read:

136A.1357 **EDUCATION ACCOUNT FOR NURSES WHO AGREE TO PRACTICE IN A NURSING HOME OR INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.**

Subdivision 1. **CREATION OF THE ACCOUNT.** An education account in the general health care access fund is established for a loan forgiveness program for nurses who agree to practice nursing in a nursing home or intermediate care facility for persons with mental retardation or related conditions. The account consists of money appropriated by the legislature and repayments and penalties collected under subdivision 4. Money from the account must be used for a loan forgiveness program.

Subd. 2. **ELIGIBILITY.** To be eligible to participate in the loan forgiveness program, a person planning to enroll or enrolled in a program of study designed to prepare the person to become a registered nurse or licensed practical nurse must submit a letter of interest to the board before completing the first year of study completion of a nursing education program. Before completing the first year of study completion of the program, the applicant must sign a contract in which the applicant agrees to practice nursing for at least one of the first two years following completion of the nursing education program providing nursing

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services in a licensed nursing home or intermediate care facility for persons with mental retardation or related conditions.

Subd. 3. **LOAN FORGIVENESS.** The board may accept up to ten applicants a year. Applicants are responsible for securing their own loans. For each year of nursing education, for up to two years, applicants accepted into the loan forgiveness program may designate an agreed amount, not to exceed $3,000, as a qualified loan. For each year that a participant practices nursing in a nursing home or intermediate care facility for persons with mental retardation or related conditions, up to a maximum of two years, the board shall annually repay an amount equal to one year of qualified loans. Participants who move from one nursing home or intermediate care facility for persons with mental retardation or related conditions to another remain eligible for loan repayment.

Subd. 4. **PENALTY FOR NONFULFILLMENT.** If a participant does not fulfill the service commitment required under subdivision 3 for full repayment of all qualified loans, the ~~commissioner~~ higher education coordinating board shall collect from the participant 100 percent of any payments made for qualified loans and interest at a rate established according to section 270.75. The board shall deposit the collections in the ~~general~~ health care access fund to be credited to the account established in subdivision 1. The board may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

Subd. 5. **RULES.** The board shall adopt rules to implement this section.

Sec. 9. **[136A.1358] RURAL CLINICAL SITES FOR NURSE PRACTITIONER EDUCATION.**

Subdivision 1. **DEFINITION.** For purposes of this section, "rural" means any area of the state outside of the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

Subd. 2. **ESTABLISHMENT.** A grant program is established under the authority of the higher education coordinating board to provide grants to colleges or schools of nursing located in Minnesota that operate programs of study designed to prepare registered nurses for advanced practice as nurse practitioners.

Subd. 3. **PROGRAM GOALS.** Colleges and schools of nursing shall use grants received to provide rural students with increased access to programs of study for nurse practitioners, by:

(1) developing rural clinical sites;

(2) allowing students to remain in their rural communities for clinical rotations; and

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(3) providing faculty to supervise students at rural clinical sites.

The overall goal of the grant program is to increase the number of graduates of nurse practitioner programs who work in rural areas of the state.

Subd. 4. **RESPONSIBILITY OF NURSING PROGRAMS.** (a) Colleges or schools of nursing interested in participating in the grant program must apply to the higher education coordinating board, according to the policies established by the board. Applications submitted by colleges or schools of nursing must include a detailed proposal for achieving the goals listed in subdivision 3, a plan for encouraging sufficient applications from rural applicants to meet the requirements of paragraph (b), and any additional information required by the board.

(b) Each college or school of nursing, as a condition of accepting a grant, shall make at least 25 percent of the openings in each nurse practitioner entering class available to applicants who live in rural areas and desire to practice as a nurse practitioner in rural areas. This requirement is effective beginning with the fall 1994 entering class and remains in effect for each biennium thereafter for which a college or school of nursing is awarded a grant renewal. The board may exempt colleges or schools of nursing from this requirement if the college or school can demonstrate, to the satisfaction of the board, that the nurse practitioner program did not receive enough applications or acceptance letters from qualified rural applicants to meet the requirement.

(c) Colleges or schools of nursing participating in the grant program shall report to the higher education coordinating board on their program activity as requested by the board.

Subd. 5. **RESPONSIBILITIES OF THE HIGHER EDUCATION COORDINATING BOARD.** (a) The board shall establish an application process for interested colleges and schools of nursing, and shall require colleges and schools of nursing to submit grant applications to the board by November 1, 1993. The board may award up to two grants for the biennium ending June 30, 1995.

(b) In selecting grant recipients, the board shall consider:

(1) the likelihood that an applicant's grant proposal will be successful in achieving the program goals listed in subdivision 3;

(2) the potential effectiveness of the college's or school's plan to encourage applications from rural applicants; and

(3) the academic quality of the college's or school's program of education for nurse practitioners.

(c) The board shall notify grant recipients of an award by December 1, 1993, and shall disburse the grants by January 1, 1994. The board may renew grants if a college or school of nursing demonstrates that satisfactory progress has been made during the past biennium toward achieving the goals listed in subdivision 3.

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Sec. 10. Minnesota Statutes 1992, section 137.38, subdivision 2, is amended to read:

Subd. 2. **PRIMARY CARE.** For purposes of sections 137.38 to 137.40, "primary care" means a type of medical care delivery that assumes ongoing responsibility for the patient in both health maintenance and illness treatment. It is personal care involving a unique interaction and communication between the patient and the physician. It is comprehensive in scope, and includes all the overall coordination of the care of the patient's health care problems including biological, behavioral, and social problems. The appropriate use of consultants and community resources is an important aspect of effective primary care. Primary care physicians include family practitioners, general pediatricians, and general internists.

Sec. 11. Minnesota Statutes 1992, section 137.38, subdivision 3, is amended to read:

Subd. 3. **GOALS.** The board of regents of the University of Minnesota, through the University of Minnesota medical school, is requested to implement the initiatives required by sections 137.38 to 137.40 in order to increase the number of graduates of residency programs of the medical school who practice primary care by 20 percent over an eight-year period. The initiatives must be designed to encourage newly graduated primary care physicians to establish practices in areas of rural and urban Minnesota that are medically underserved.

Sec. 12. Minnesota Statutes 1992, section 137.38, subdivision 4, is amended to read:

Subd. 4. **GRANTS.** The board of regents is requested to seek grants from private foundations and other nonstate sources, including community provider organizations, for the medical school initiatives outlined in sections 137.38 to 137.40.

Sec. 13. Minnesota Statutes 1992, section 137.39, subdivision 2, is amended to read:

Subd. 2. **DESIGN OF CURRICULUM.** The medical school is requested to ensure that its curriculum provides students with early exposure to primary care physicians and primary care practice, and to address other primary care curriculum issues such as public health, preventive medicine, and health care delivery. The medical school is requested to also support premedical school educational initiatives that provide students with greater exposure to primary care physicians and practices.

Sec. 14. Minnesota Statutes 1992, section 137.39, subdivision 3, is amended to read:

Subd. 3. **CLINICAL EXPERIENCES IN PRIMARY CARE.** The medical school~~; in consultation with medical school faculty at the University of Minne-~~

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~~sota, Duluth,~~ is requested to develop a program to provide students with clinical experiences in primary care settings in internal medicine and pediatrics. The program must provide training experiences in medical clinics in rural Minnesota communities, as well as in community clinics and health maintenance organizations in the Twin Cities metropolitan area.

Sec. 15. Minnesota Statutes 1992, section 137.40, subdivision 3, is amended to read:

Subd. 3. **CONTINUING MEDICAL EDUCATION.** The medical school is requested to develop continuing medical education programs for primary care physicians that are comprehensive, community-based, ~~and~~ accessible to primary care physicians in all areas of the state, and which enhance primary care skills.

Sec. 16. **[144.1487] LOAN REPAYMENT PROGRAM FOR HEALTH PROFESSIONALS.**

Subdivision 1. **DEFINITIONS.** (a) For purposes of sections 144.1487 to 144.1492, the following definitions apply.

(b) "Board" means the higher education coordinating board.

(c) "Health professional shortage area" means an area designated as such by the federal secretary of health and human services, as provided under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E.

Subd. 2. **ESTABLISHMENT AND PURPOSE.** The commissioner shall establish a National Health Services Corps state loan repayment program authorized by section 388I of the Public Health Service Act, United States Code, title 42, section 254q-1, as amended by Public Law Number 101-597. The purpose of the program is to assist communities with the recruitment and retention of health professionals in federally designated health professional shortage areas.

Sec. 17. **[144.1488] PROGRAM ADMINISTRATION AND ELIGIBILITY.**

Subdivision 1. **DUTIES OF THE COMMISSIONER OF HEALTH.** The commissioner shall administer the state loan repayment program. The commissioner shall:

(1) ensure that federal funds are used in accordance with program requirements established by the federal National Health Services Corps;

(2) notify potentially eligible loan repayment sites about the program;

(3) develop and disseminate application materials to sites;

(4) review and rank applications using the scoring criteria approved by the federal department of health and human services as part of the Minnesota department of health's National Health Services Corps state loan repayment program application;

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(5) select sites that qualify for loan repayment based upon the availability of federal and state funding;

(6) provide the higher education coordinating board with a list of qualifying sites; and

(7) carry out other activities necessary to implement and administer sections 144.1487 to 144.1492.

The commissioner shall enter into an interagency agreement with the higher education coordinating board to carry out the duties assigned to the board under sections 144.1487 to 144.1492.

Subd. 2. **DUTIES OF THE HIGHER EDUCATION COORDINATING BOARD.** The higher education coordinating board, through an interagency agreement with the commissioner of health, shall:

(1) verify the eligibility of program participants;

(2) sign a contract with each participant that specifies the obligations of the participant and the state;

(3) arrange for the payment of qualifying educational loans for program participants;

(4) monitor the obligated service of program participants;

(5) waive or suspend service or payment obligations of participants in appropriate situations;

(6) place participants who fail to meet their obligations in default;

(7) enforce penalties for default; and

(8) report regularly to the commissioner.

Subd. 3. **ELIGIBLE LOAN REPAYMENT SITES.** Private, nonprofit, and public entities located in and providing health care services in federally designated primary care health professional shortage areas are eligible to apply for the program. The commissioner shall develop a list of Minnesota health professional shortage areas in greatest need of health care professionals and shall select loan repayment sites from that list. The commissioner shall ensure, to the greatest extent possible, that the geographic distribution of sites within the state reflects the percentage of the population living in rural and urban health professional shortage areas.

Subd. 4. **ELIGIBLE HEALTH PROFESSIONALS.** (a) To be eligible to apply to the higher education coordinating board for the loan repayment program, health professionals must be citizens or nationals of the United States, must not have any unserved obligations for service to a federal, state, or local government, or other entity, and must be ready to begin full-time clinical practice upon signing a contract for obligated service.

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(b) In selecting physicians for participation, the board shall give priority to physicians who are board certified or have completed a residency in family practice, osteopathic general practice, obstetrics and gynecology, internal medicine, or pediatrics. A physician selected for participation is not eligible for loan repayment until the physician has an employment agreement or contract with an eligible loan repayment site and has signed a contract for obligated service with the higher education coordinating board.

Sec. 18. **[144.1489] OBLIGATIONS OF PARTICIPANTS.**

Subdivision 1. **CONTRACT REQUIRED.** Before starting the period of obligated service, a participant must sign a contract with the higher education coordinating board that specifies the obligations of the participant and the board.

Subd. 2. **OBLIGATED SERVICE.** A participant shall agree in the contract to fulfill the period of obligated service by providing primary health care services in full-time clinical practice. The service must be provided in a private, nonprofit, or public entity that is located in and providing services to a federally designated health professional shortage area and that has been designated as an eligible site by the commissioner under the state loan repayment program.

Subd. 3. **LENGTH OF SERVICE.** Participants must agree to provide obligated service for a minimum of two years. A participant may extend a contract to provide obligated service for a third year, subject to board approval and the availability of federal and state funding.

Subd. 4. **AFFIDAVIT OF SERVICE REQUIRED.** Within 30 days of the start of obligated service, and by February 1 of each succeeding calendar year, a participant shall submit an affidavit to the board stating that the participant is providing the obligated service and which is signed by a representative of the organizational entity in which the service is provided. Participants must provide written notice to the board within 30 days of: a change in name or address, a decision not to fulfill a service obligation, or cessation of clinical practice.

Subd. 5. **TAX RESPONSIBILITY.** The participant is responsible for reporting on federal income tax returns any amount paid by the state on designated loans, if required to do so under federal law.

Subd. 6. **NONDISCRIMINATION REQUIREMENTS.** Participants are prohibited from charging a higher rate for professional services than the usual and customary rate prevailing in the area where the services are provided. If a patient is unable to pay this charge, a participant shall charge the patient a reduced rate or not charge the patient. Participants must agree not to discriminate on the basis of ability to pay or status as a Medicare or medical assistance enrollee. Participants must agree to accept assignment under the Medicare program and to serve as an enrolled provider under medical assistance.

Sec. 19. **[144.1490] RESPONSIBILITIES OF THE LOAN REPAYMENT PROGRAM.**

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Subdivision 1. **LOAN REPAYMENT.** Subject to the availability of federal and state funds for the loan repayment program, the higher education coordinating board shall pay all or part of the qualifying education loans up to $20,000 annually for each primary care physician participant that fulfills the required service obligation. For purposes of this provision, "qualifying educational loans" are government and commercial loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

Subd. 2. **PROCEDURE FOR LOAN REPAYMENT.** Program participants, at the time of signing a contract, shall designate the qualifying loan or loans for which the higher education coordinating board is to make payments. The participant shall submit to the board all payment books for the designated loan or loans or all monthly billings for the designated loan or loans within five days of receipt. The board shall make payments in accordance with the terms and conditions of the designated loans, in an amount not to exceed $20,000 when annualized. If the amount paid by the board is less than $20,000 during a 12-month period, the board shall pay during the 12th month an additional amount towards a loan or loans designated by the participant, to bring the total paid to $20,000. The total amount paid by the board must not exceed the amount of principal and accrued interest of the designated loans.

Sec. 20. **[144.1491] FAILURE TO COMPLETE OBLIGATED SERVICE.**

Subdivision 1. **PENALTIES FOR BREACH OF CONTRACT.** A program participant who fails to complete two years of obligated service shall repay the amount paid, as well as a financial penalty based upon the length of the service obligation not fulfilled. If the participant has served at least one year, the financial penalty is the number of unserved months multiplied by $1,000. If the participant has served less than one year, the financial penalty is the total number of obligated months multiplied by $1,000.

Subd. 2. **SUSPENSION OR WAIVER OF OBLIGATION.** Payment or service obligations cancel in the event of a participant's death. The board may waive or suspend payment or service obligations in case of total and permanent disability or long-term temporary disability lasting for more than two years. The board shall evaluate all other requests for suspension or waivers on a case-by-case basis.

Sec. 21. **NURSE PRACTITIONER PROMOTION TEAMS.**

The commissioner of health, through the office of rural health, shall establish nurse practitioner promotion teams, consisting of one nurse practitioner and one physician who are practicing jointly. The promotion teams shall travel to rural communities and provide physicians, medical clinic administrators, and other interested parties with information on: the benefits of joint practices between nurse practitioners and physicians and methods of establishing and maintaining joint practices. The office of rural health shall contract with promotion teams to visit up to 20 rural communities during the biennium ending June

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30, 1995. The office of rural health shall provide members of promotion teams with stipends for their time and travel expenses not to exceed the amount specified in Minnesota Statutes, section 15.059, subdivision 3.

Sec. 22. **EFFECTIVE DATE.**

Section 1, relating to summer internships, is effective the day following final enactment. Sections 16 to 20 related to the National Health Services Corps loan repayment program are effective the day following final enactment.

ARTICLE 12

DATA RESEARCH INITIATIVES

Section 1. Minnesota Statutes 1992, section 62J.30, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** For purposes of sections 62J.30 to 62J.34, the following definitions apply:

(a) "Practice parameter" means a statement intended to guide the clinical decision making of health care providers and patients that is supported by the results of appropriately designed outcomes research studies~~,~~ ~~including those studies sponsored~~ or that has been approved by the federal agency for health care policy and research~~,~~ or ~~has been~~ adopted for use by ~~a national medical society~~ the American Medical Association, the National Medical Association, a member board of the American Board of Medical Specialties, a board approved by the American Osteopathic Association, a college or board approved by the Royal College of Physicians and Surgeons of Canada, a national health professional board or association, or a board approved by the American Dental Association.

(b) "Outcomes research" means research designed to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition, in order to determine the most appropriate and cost-effective means to prevent, diagnose, treat, or manage the condition, or in order to develop and test methods for reducing inappropriate or unnecessary variations in the type and frequency of interventions.

Sec. 2. Minnesota Statutes 1992, section 62J.30, subdivision 6, is amended to read:

Subd. 6. **DATA COLLECTION PROCEDURES.** The health care analysis unit shall collect data from health care providers, health carriers, and individuals in the most cost-effective manner, which does not unduly burden ~~providers~~ them. The unit may require health care providers and health carriers to collect and provide all patient health records and claim files, ~~provide mailing lists of~~

~~patients who have consented to release of data,~~ and cooperate in other ways with the data collection process. ~~For purposes of this chapter, the health care analysis unit shall assign, or require health care providers and health carriers to assign, a unique identification number to each patient to safeguard patient identity.~~ The unit may also require health care providers and health carriers to provide mailing lists of patients who have consented to release of data. The commissioner shall require all health care providers, group purchasers, and state agencies to use a standard patient identifier and a standard identifier for providers and health plans when reporting data under this chapter. The data analysis unit must code patient identifiers to prevent identification and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consistent with chapter 13 and section 144.335.

Sec. 3. Minnesota Statutes 1992, section 62J.30, subdivision 7, is amended to read:

Subd. 7. **DATA CLASSIFICATION.** (a) Data collected through the large-scale data base initiatives of the health care analysis unit required by section 62J.31 that identify individuals are private data on individuals. Data not on individuals are nonpublic data. The commissioner may release private data on individuals and nonpublic data to researchers affiliated with university research centers or departments who are conducting research on health outcomes, practice parameters, and medical practice style; researchers working under contract with the commissioner; and individuals purchasing health care services for health carriers and groups. ~~Prior to releasing any nonpublic or private data under this paragraph that identify or relate to a specific health carrier, medical provider, or health care facility, the commissioner shall provide at least 30 days' notice to the subject of the data, including a copy of the relevant data, and allow the subject of the data to provide a brief explanation or comment on the data which must be released with the data.~~ The commissioner shall require any person or organization receiving under this subdivision either private data on individuals or nonpublic data to sign an agreement to maintain the data that it receives according to the statutory provisions applicable to the data. The agreement shall not limit the preparation and dissemination of summary data as permitted under section 13.05, subdivision 7. To the extent reasonably possible, release of private or confidential data under this chapter shall be made without releasing data that could reveal the identity of individuals and should instead be released using the identification numbers required by subdivision 6.

(b) Summary data derived from data collected through the large-scale data base initiatives of the health care analysis unit may be provided under section 13.05, subdivision 7, and may be released in studies produced by the commissioner.

(c) The commissioner shall adopt rules to establish criteria and procedures to govern access to and the use of data collected through the initiatives of the health care analysis unit.

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Sec. 4. Minnesota Statutes 1992, section 62J.30, subdivision 8, is amended to read:

Subd. 8. **DATA COLLECTION ADVISORY COMMITTEE.** (a) The commissioner shall convene a 15-member data collection advisory committee consisting of health service researchers, health care providers, health carrier representatives, representatives of businesses that purchase health coverage, and consumers. Six members of this committee must be health care providers. The advisory committee shall evaluate methods of data collection and shall recommend to the commissioner methods of data collection that minimize administrative burdens, address data privacy concerns, and meet the needs of health service researchers. The advisory committee is governed by section 15.059.

(b) The data collection advisory committee shall develop a timeline to complete all responsibilities and transfer any ongoing responsibilities to the data institute. The timeline must specify the data on which ongoing responsibilities will be transferred. This transfer must be completed by July 1, 1994.

Sec. 5. Minnesota Statutes 1992, section 62J.32, subdivision 4, is amended to read:

Subd. 4. **PRACTICE PARAMETER ADVISORY COMMITTEE.** (a) The commissioner shall convene a 15-member practice parameter advisory committee comprised of eight health care professionals, and representatives of the research community and the medical technology industry. The committee shall present recommendations on the adoption of practice parameters to the commissioner and the Minnesota health care commission and provide technical assistance as needed to the commissioner and the commission. The advisory committee is governed by section 15.059, but does not expire.

(b) The commissioner, upon the advice and recommendation of the practice parameter advisory committee, may convene expert review panels to assess practice parameters and outcome research associated with practice parameters.

Sec. 6. Minnesota Statutes 1992, section 62J.34, subdivision 2, is amended to read:

Subd. 2. **APPROVAL.** The commissioner of health, after receiving the advice and recommendations of the Minnesota health care commission, may approve practice parameters that are endorsed, developed, or revised by the health care analysis unit. The commissioner is exempt from the rulemaking requirements of chapter 14 when approving practice parameters approved by the federal agency for health care policy and research, practice parameters adopted for use by ~~a national medical society, or national medical specialty society~~ the American Medical Association, the National Medical Association, a member board of the American Board of Medical Specialties, a board approved by the American Osteopathic Association, a college or board approved by the Royal College of Physicians and Surgeons of Canada, a national health professional board or association, a board approved by the American Dental Associa-

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tion. The commissioner shall use rulemaking to approve practice parameters that are newly developed or substantially revised by the health care analysis unit. Practice parameters adopted without rulemaking must be published in the State Register.

Sec. 7. Minnesota Statutes 1992, section 144.335, is amended by adding a subdivision to read:

Subd. 3b. **RELEASE OF RECORDS TO COMMISSIONER OF HEALTH OR DATA INSTITUTE.** Subdivision 3a does not apply to the release of health records to the commissioner of health or the data institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Sec. 8. Minnesota Statutes 1992, section 214.16, subdivision 3, is amended to read:

Subd. 3. **GROUNDS FOR DISCIPLINARY ACTION.** The board shall take disciplinary action, which may include license revocation, against a regulated person for:

(1) intentional failure to provide the commissioner of health or the health care analysis unit established under section 62J.30 with the data ~~on gross patient revenue as~~ required under ~~section 62J.04~~ chapter 62J;

(2) ~~failure to provide the health care analysis unit with data as required under Laws 1992, chapter 549, article 7;~~

~~(3)~~ intentional failure to provide the commissioner of revenue with data on gross revenue and other information required for the commissioner to implement sections 295.50 to 295.58; and

~~(4)~~ (3) intentional failure to pay the health care provider tax required under section 295.52.

ARTICLE 13

FINANCING

Section 1. Minnesota Statutes 1992, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **DRUGS.** (a) Medical assistance covers drugs if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, or by a physician enrolled in the medical assistance program as a dispensing physician. The commissioner, after receiving recommendations from the Minnesota Medical Association and the Minnesota Pharmacists Association, shall designate a formulary committee to advise the commissioner on the names of drugs for which payment

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is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The commissioner shall appoint the formulary committee members no later than 30 days following July 1, 1981. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve two-year terms and shall serve without compensation. The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the administrative procedure act, but the formulary committee shall review and comment on the formulary contents. The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; and

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include: drugs or products for which there is no federal funding; over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, and vitamins for children under the age of seven and pregnant or nursing women; or any other over-the-counter drug identified by the commissioner, in consultation with the drug formulary committee as necessary, appropriate and cost effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14, the administrative procedure act; nutritional products, except for those products needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as

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requiring a similarly necessary nutritional product; anorectics; and drugs for which medical value has not been established. Nutritional products needed for the treatment of a combined allergy to human milk, cow's milk, and soy formula require prior authorization. Separate payment shall not be made for nutritional products for residents of long-term care facilities; payment for dietary requirements is a component of the per diem rate paid to these facilities. Payment to drug vendors shall not be modified before the formulary is established except that the commissioner shall not permit payment for any drugs which may not by law be included in the formulary, and the commissioner's determination shall not be subject to chapter 14, the administrative procedure act. The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

(b) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee established by the commissioner, the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee or the usual and customary price charged to the public. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug ~~may~~ shall be estimated by the commissioner, at average wholesale price minus 7.6 percent effective January 1, 1994. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the administrative procedure act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written - brand necessary" on the prescription as required by section 151.21, subdivision 2. Implementation of any change in the fixed dispensing fee that has not been subject to the administrative procedure act is limited to not more than 180 days, unless, during that time, the commissioner initiates rulemaking through the administrative procedure act.

(c) Until January 4, 1993, or the date the Medicaid Management Informa-

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tion System (MMIS) upgrade is implemented, whichever occurs last, a pharmacy provider may require individuals who seek to become eligible for medical assistance under a one-month spend-down, as provided in section 256B.056, subdivision 5, to pay for services to the extent of the spend-down amount at the time the services are provided. A pharmacy provider choosing this option shall file a medical assistance claim for the pharmacy services provided. If medical assistance reimbursement is received for this claim, the pharmacy provider shall return to the individual the total amount paid by the individual for the pharmacy services reimbursed by the medical assistance program. If the claim is not eligible for medical assistance reimbursement because of the provider's failure to comply with the provisions of the medical assistance program, the pharmacy provider shall refund to the individual the total amount paid by the individual. Pharmacy providers may choose this option only if they apply similar credit restrictions to private pay or privately insured individuals. A pharmacy provider choosing this option must inform individuals who seek to become eligible for medical assistance under a one-month spend-down of (1) their right to appeal the denial of services on the grounds that they have satisfied the spend-down requirement, and (2) their potential eligibility for the health right program or the children's health plan.

Sec. 2. Minnesota Statutes 1992, section 270B.01, subdivision 8, is amended to read:

Subd. 8. **MINNESOTA TAX LAWS.** For purposes of this chapter only, "Minnesota tax laws" means the taxes administered by or paid to the commissioner under chapters 289A, 290, 290A, 291, and 297A and sections 295.50 to 295.59, and includes any laws for the assessment, collection, and enforcement of those taxes.

Sec. 3. Minnesota Statutes 1992, section 295.50, subdivision 3, is amended to read:

Subd. 3. **GROSS REVENUES.** ~~(a)~~ "Gross revenues" are total amounts received in money or otherwise by:

(1) a resident hospital for ~~inpatient or outpatient~~ patient services ~~as defined in Minnesota Rules, part 4650.0102, subparts 21 and 29~~;

(2) a resident surgical center for patient services;

(3) a nonresident hospital for ~~inpatient or outpatient~~ patient services ~~as defined in Minnesota Rules, part 4650.0102, subparts 21 and 29,~~ provided to patients domiciled in Minnesota;

(4) a nonresident surgical center for patient services provided to patients domiciled in Minnesota;

~~(3)~~ (5) a resident health care provider, other than a ~~health maintenance organization~~ staff model health carrier, for ~~covered~~ patient services ~~listed in section 256B.0625~~;

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~~(4)~~ (6) a nonresident health care provider for ~~covered~~ patient services ~~listed in section 256B.0625~~ provided to an individual domiciled in Minnesota;

~~(5)~~ (7) a wholesale drug distributor for sale or distribution of prescription drugs that are delivered ~~in Minnesota by the distributor or a common carrier~~: (i) to a Minnesota resident by a wholesale drug distributor who is a nonresident pharmacy directly, by common carrier, or by mail; or (ii) in Minnesota by the wholesale drug distributor, by common carrier, or by mail, unless the prescription drugs are delivered to another wholesale drug distributor. Prescription drugs do not include nutritional products as defined in Minnesota Rules, part 9505.0325; and

~~(6)~~ (8) a ~~health maintenance organization~~ staff model health carrier as gross premiums for enrollees, ~~carrier~~ copayments, deductibles, coinsurance, and fees for ~~covered~~ patient services ~~listed in section 256B.0625~~ covered under its contracts with groups and enrollees.

~~(b) Gross revenues do not include governmental, foundation, or other grants or donations to a hospital or health care provider for operating or other costs.~~

Sec. 4. Minnesota Statutes 1992, section 295.50, subdivision 4, is amended to read:

Subd. 4. **HEALTH CARE PROVIDER.** (a) "Health care provider" ~~is a vendor of medical care qualifying for reimbursement under the medical assistance program provided under chapter 256B, and includes health maintenance organizations but excludes hospitals and pharmacies~~ means:

(1) a person furnishing any or all of the following goods or services directly to a patient or consumer: medical, surgical, optical, visual, dental, hearing, nursing services, drugs, medical supplies, medical appliances, laboratory, diagnostic or therapeutic services, or any goods and services not listed above that qualifies for reimbursement under the medical assistance program provided under chapter 256B;

(2) a staff model health carrier;

(3) a licensed ambulance service; or

(4) a pharmacy as defined in section 151.01.

(b) Health care provider does not include hospitals, nursing homes licensed under chapter 144A, and surgical centers.

Sec. 5. Minnesota Statutes 1992, section 295.50, subdivision 7, is amended to read:

Subd. 7. **HOSPITAL.** "Hospital" ~~is~~ means a hospital licensed under chapter 144, or a hospital ~~providing inpatient or outpatient services~~ licensed by any other state or province or territory of Canada ~~or a surgical center~~.

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Sec. 6. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

Subd. 9b. **PATIENT SERVICES.** "Patient services" means inpatient and outpatient services and other goods and services provided by hospitals, surgical centers, or health care providers. They include the following health care goods and services provided to a patient or consumer:

(1) bed and board;

(2) nursing services and other related services;

(3) use of hospitals, surgical centers, or health care provider facilities;

(4) medical social services;

(5) drugs, biologicals, supplies, appliances, and equipment;

(6) other diagnostic or therapeutic items or services;

(7) medical or surgical services;

(8) items and services furnished to ambulatory patients not requiring emergency care;

(9) emergency services; and

(10) covered services listed in section 256B.0625 and in Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 7. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

Subd. 9c. **PERSON.** "Person" means an individual, partnership, limited liability company, corporation, association, governmental unit or agency, or public or private organization of any kind.

Sec. 8. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

Subd. 10b. **REGIONAL TREATMENT CENTER.** "Regional treatment center" means a regional center as defined in section 253B.02, subdivision 18, and named in sections 252.025, subdivision 1; 253.015, subdivision 1; 253.201; and 254.05.

Sec. 9. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

Subd. 12b. **STAFF MODEL HEALTH CARRIER.** "Staff model health carrier" means a health carrier as defined in section 62L.02, subdivision 16, which employs one or more types of health care provider to deliver health care services to the health carrier's enrollees.

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Sec. 10. Minnesota Statutes 1992, section 295.50, subdivision 14, is amended to read:

Subd. 14. **WHOLESALE DRUG DISTRIBUTOR.** "Wholesale drug distributor" means a wholesale drug distributor required to be licensed under sections 151.42 to 151.51 or a nonresident pharmacy required to be registered under section 151.19.

Sec. 11. Minnesota Statutes 1992, section 295.51, subdivision 1, is amended to read:

Subdivision 1. **BUSINESS TRANSACTIONS IN MINNESOTA.** A hospital, surgical center, or health care provider is subject to tax under sections 295.50 to 295.58 if it is "transacting business in Minnesota." A hospital, surgical center, or health care provider is transacting business in Minnesota only if it:

(1) maintains an office in Minnesota used in the trade or business of providing patient services;

(2) has employees, representatives, or independent contractors conducting business in Minnesota related to the trade or business of providing patient services;

(3) regularly ~~sells covered~~ provides patient services to customers that receive the ~~covered~~ services in Minnesota;

(4) regularly solicits business from potential customers in Minnesota. A hospital, surgical center, or health care provider is presumed to regularly solicit business within Minnesota if it receives gross receipts for patient services from 20 or more patients domiciled in Minnesota in a calendar year;

(5) regularly performs services outside Minnesota the benefits of which are consumed in Minnesota;

(6) owns or leases tangible personal or real property physically located in Minnesota and used in the trade or business of providing patient services; or

(7) receives medical assistance payments from the state of Minnesota.

Sec. 12. Minnesota Statutes 1992, section 295.52, is amended by adding a subdivision to read:

Subd. 1a. **SURGICAL CENTER TAX.** A tax is imposed on each surgical center equal to two percent of its gross revenues.

Sec. 13. Minnesota Statutes 1992, section 295.52, is amended by adding a subdivision to read:

Subd. 5. **VOLUNTEER AMBULANCE SERVICES.** Licensed ambulance services for which all the ambulance attendants are "volunteer ambulance attendants" as defined in section 144.8091, subdivision 2, are not subject to the tax under this section.

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Sec. 14. Minnesota Statutes 1992, section 295.53, subdivision 1, is amended to read:

Subdivision 1. **EXEMPTIONS.** The following payments are excluded from the gross revenues subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.57:

(1) payments received ~~from the federal government~~ for services provided under the Medicare program, including payments received from the government, and organizations governed by sections 1833 and 1876 of title XVIII the federal Social Security Act, United States Code, title 42, section 1395, ~~excluding~~ and enrollee ~~deductible~~ deductibles, coinsurance, and ~~coinsurance payments~~ copayments, whether paid by the individual or by insurer or other third party. Payments for services not covered by Medicare are taxable;

(2) medical assistance payments including payments received directly from the government or from a prepaid plan;

(3) payments received for ~~services performed by nursing homes licensed under chapter 144A, services provided in supervised living facilities and~~ home health care services;

(4) payments received from hospitals or surgical centers for goods and services ~~that are subject to tax~~ on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), (2), (7), (8), or (10);

(5) payments received from health care providers for goods and services ~~that are subject to tax~~ on which liability for tax is imposed under ~~section~~ sections 295.52 to 295.57 or the source of funds for the payment is exempt under clause (1), (2), (7), (8), or (10);

(6) amounts paid for prescription drugs, other than nutritional products, to a wholesale drug distributor reduced by reimbursements received for prescription drugs under clauses (1), (2), (7), and (8);

(7) payments received under the general assistance medical care program including payments received directly from the government or from a prepaid plan;

(8) payments received for providing services under the ~~health right~~ MinnesotaCare program ~~under Laws 1992, chapter 549, article~~ 4 including payments received directly from the government or from a prepaid plan and enrollee deductibles, coinsurance, and copayments; ~~and~~

(9) payments received by a resident health care provider or the wholly owned subsidiary of a resident health care provider for care provided outside Minnesota to a patient who is not domiciled in Minnesota~~.~~;

(10) payments received from the chemical dependency fund under chapter 254B;

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(11) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

(12) payments received for providing patient services if the services are incidental to conducting medical research;

(13) payments received from any governmental agency for services benefiting the public, not including payments made by the government in its capacity as an employer or insurer;

(14) payments received for services provided by community residential mental health facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690, community support programs and family community support programs approved under Minnesota Rules, parts 9535.1700 to 9535.1760, and community mental health centers as defined in section 245.62, subdivision 2; and

(15) government payments received by a regional treatment center.

Sec. 15. Minnesota Statutes 1992, section 295.53, subdivision 2, is amended to read:

Subd. 2. **DEDUCTIONS FOR ~~HEALTH MAINTENANCE ORGANIZATIONS~~ STAFF MODEL HEALTH CARRIERS.** ~~(a)~~ In addition to the exemptions allowed under subdivision 1, ~~a health maintenance organization~~ staff model health carrier may deduct from its gross revenues for the year:

(1) amounts paid to hospitals, surgical centers, and health care providers that are not employees of the staff model health carrier for services on which liability for the tax is imposed under section 295.52;

~~(1)~~ (2) amounts added to reserves, if total reserves do not exceed ~~25 percent of gross revenues for the prior year~~ 200 percent of the statutory net worth requirement, the calculation of which may be determined on a consolidated basis, taking into account the amounts held in reserve by affiliated staff model health carriers;

~~(2)~~ (3) assessments for the comprehensive health insurance plan under section 62E.11 ~~paid during the year~~; and

~~(3) an allowance~~ (4) amounts spent for administration ~~and underwriting~~ as reported as total administration to the department of health in the statement of revenues, expenses, and net worth pursuant to section 62D.08, subdivision 3, clause (a).

~~(b) The commissioner of health, in consultation with the commissioners of commerce and revenue, shall establish by rule under chapter 14 the percentage of health maintenance revenue that will be allowed as a deduction for administrative and underwriting expenses. The commissioner of health shall determine the percentage allowance based on the average expenses of health maintenance~~

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~~organizations that are equivalent to the claims administration and other underwriting services of third party payors. These expenses do not include the portion of health maintenance organization costs that are similar to the administrative costs of direct health care providers, rather than third party payors, and do not include costs deductible under paragraph (a), clauses (1) and (2). The commissioner of health may adopt emergency rules.~~

Sec. 16. Minnesota Statutes 1992, section 295.53, subdivision 3, is amended to read:

Subd. 3. **RESTRICTION ON ITEMIZATION.** A hospital, surgical center, or health care provider must not separately state the tax obligation under section 295.52 on bills provided to individual patients.

Sec. 17. Minnesota Statutes 1992, section 295.53, is amended by adding a subdivision to read:

Subd. 4. **DEDUCTION FOR RESEARCH.** (a) In addition to the exemptions allowed under subdivision 1, a hospital or health care provider which is exempt under section 501(c)(3) of the Internal Revenue Code of 1986 or is owned and operated under authority of a governmental unit, may deduct from its gross revenues subject to the hospital or health care provider taxes under sections 295.50 to 295.57 revenues equal to expenditures for allowable research programs.

(b) For purposes of this subdivision, expenditures for allowable research programs are the direct and general program costs for activities which are part of a formal program of medical and health care research approved by the governing body of the hospital or health care provider which also includes active solicitation of research funds from government and private sources. Any allowable research on humans or animals must be subject to review by appropriate regulatory committees operating in conformity with federal regulations such as an institutional review board or an institutional animal care and use committee. Costs of clinical research activities paid directly for the benefit of an individual patient are excluded from this exemption. Basic research in fields including biochemistry, molecular biology, and physiology are also included if such programs are subject to a peer review process.

(c) No deduction shall be allowed under this subdivision for any revenue received by the hospital or health care provider in the form of a grant, gift, or otherwise, whether from a government or nongovernment source, on which the tax liability under section 295.52 is not imposed or for which the tax liability under section 295.52 has been received from a third party as provided for in section 295.582.

(d) Effective beginning with calendar year 1995, the taxpayer shall not take the deduction under this section into account in determining estimated tax payments or the payment made with the annual return under section 295.55. The total deduction allowable to all taxpayers under this section for calendar years

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beginning after December 31, 1994, may not exceed $65,000,000. To implement this limit, each qualifying hospital and qualifying health care provider shall submit to the commissioner by March 15 its total expenditures qualifying for the deduction under this section for the previous calendar year. The commissioner shall sum the total expenditures of all taxpayers qualifying under this section for the calendar year. If the resulting amount exceeds $65,000,000, the commissioner shall allocate a part of the $65,000,000 deduction limit to each qualifying hospital and health care provider in proportion to its share of the total deductions. The commissioner shall pay a refund to each qualifying hospital or provider equal to its share of the deduction limit multiplied by two percent. The commissioner shall pay the refund no later than May 15 of the calendar year.

Sec. 18. Minnesota Statutes 1992, section 295.54, is amended to read:

295.54 **CREDIT FOR TAXES PAID TO ANOTHER STATE.**

A resident hospital, resident surgical center, or resident health care provider who is liable for taxes payable to another state or province or territory of Canada measured by gross receipts and is subject to tax under section 295.52 is entitled to a credit for the tax paid to another state or province or territory of Canada to the extent of the lesser of (1) the tax actually paid to the other state or province or territory of Canada, or (2) the amount of tax imposed by Minnesota on the gross receipts subject to tax in the other taxing jurisdictions.

Sec. 19. Minnesota Statutes 1992, section 295.55, subdivision 4, is amended to read:

Subd. 4. **ELECTRONIC FUNDS TRANSFER PAYMENTS.** A taxpayer with an aggregate tax liability of ~~$60,000~~ $30,000 or more during a calendar quarter ending the last day of March, June, September, or December of the first year the taxpayer is subject to the tax must ~~thereafter~~ remit all liabilities by means of a funds transfer as defined in section 336.4A-104, paragraph (a), for the remainder of the year. A taxpayer with an aggregate tax liability of $120,000 or more during a calendar year, must remit all liabilities by means of a funds transfer as defined in section 336.4A-104, paragraph (a), in the subsequent calendar year. The funds transfer payment date, as defined in section 336.4A-401, is on or before the date the tax is due. If the date the tax is due is not a funds-transfer business day, as defined in section 336.4A-105, paragraph (a), clause (4), the payment date is on or before the first funds-transfer business day after the date the tax is due.

Sec. 20. Minnesota Statutes 1992, section 295.57, is amended to read:

295.57 **COLLECTION AND ENFORCEMENT; REFUNDS; RULEMAKING; APPLICATION OF OTHER CHAPTERS.**

Unless specifically provided otherwise by sections 295.50 to 295.58, the enforcement, interest, and penalty provisions under chapter 294, appeal ~~and~~ provisions in sections 289A.43 and 289A.65, criminal ~~penalty~~ penalties in sec-

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tion 289A.63, and refunds provisions ~~under chapter 289A~~ in section 289A.50, and collection and rulemaking provisions under chapter 270, apply to a liability for the taxes imposed under sections 295.50 to 295.58.

Sec. 21. Minnesota Statutes 1992, section 295.58, is amended to read:

295.58 **DEPOSIT OF REVENUES AND PAYMENT OF REFUNDS.**

The commissioner shall deposit all revenues, including penalties and interest, derived from the taxes imposed by sections 295.50 to 295.57 and from the insurance premiums tax on health maintenance organizations and nonprofit health service corporations in the health care access fund in the state treasury. Refunds of overpayments must be paid from the health care access fund in the state treasury.

Sec. 22. Laws 1992, chapter 549, article 9, section 19, is amended to read as follows:

Sec. 19. **[295.582] ~~PASSTHROUGH~~ AUTHORITY.**

~~Subdivision 1. AUTHORITY.~~ A hospital, surgical center, or health care provider that is subject to a tax under section ~~7~~ 295.52 may transfer additional expense generated by section ~~7~~ 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. The expense must not exceed two percent of the gross revenues received under the third-party contract, including copayments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section ~~8~~ 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapters 60A, 62A, 62C, 62D, 64B, or 62H, must pay the transferred expense in addition to any payments due under existing or future contracts with the hospital, surgical center, or health care provider, to the extent allowed under federal law. Nothing in this subdivision limits the ability of a hospital, surgical center, or health care provider to recover all or part of the section ~~7~~ 295.52 obligation by other methods, including increasing fees or charges.

~~Subd. 2. EXPIRATION. This section expires January 1, 1994.~~

Sec. 23. Minnesota Statutes 1992, section 295.59, is amended to read:

295.59 **SEVERABILITY.**

If any section, subdivision, clause, or phrase of sections 295.50 to ~~295.58~~ 295.582 is for any reason held to be unconstitutional or in violation of federal law, the decision shall not affect the validity of the remaining portions of sections 295.50 to ~~295.58~~ 295.582. The legislature declares that it would have passed sections 295.50 to ~~295.58~~ 295.582 and each section, subdivision, sentence, clause, and phrase thereof, irrespective of the fact that any one or more sections, subdivisions, sentences, clauses, or phrases is declared unconstitutional.

New language is indicated by underline, deletions by ~~strikeout~~.

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Sec. 24. **REPEALER.**

Minnesota Statutes 1992, section 295.50, subdivisions 5 and 10, are repealed.

Minnesota Statutes 1992, section 295.51, subdivision 2, is repealed.

Sec. 25. **EFFECTIVE DATE.**

Sections 1, 2, 4, 5, 7, and 21 are effective the day following final enactment.

Sections 3, 6, clauses (1) to (9), 8, 11, 12, 14, 16, and 18 are effective retroactively to gross revenues generated by services performed and goods sold after December 31, 1992.

Section 6, clause (10), 9, 10, 13, and 15 are effective for services performed and goods sold after December 31, 1993.

For hospitals, section 17 is effective for gross revenues generated after December 31, 1992. For health care providers, section 17 is effective for gross revenues generated after December 31, 1993.

Section 19 is effective for payments due in calendar year 1994, and thereafter, based on the payments made in fiscal year ending June 30, 1993.

Sections 20, 22, and 23 are effective January 1, 1993.

ARTICLE 14

APPROPRIATIONS

Section 1. APPROPRIATIONS

The sums shown in the columns marked "APPROPRIATIONS" are appropriated from the health care access fund, or any other fund named, to the agencies and for the purposes specified in the following sections of this article, to be available for the fiscal years indicated for each purpose. The figures "1994" and "1995" where used in this article, mean that the appropriation or appropriations listed under them are available for the year ending June 30, 1994, or June 30, 1995, respectively.

	APPROPRIATIONS Available for the Year Ending June 30	
	1994	1995
Sec. 2. DEPARTMENT OF HUMAN SERVICES		
Health Care Access Fund	$44,475,000	$96,040,000
General Fund	2,919,000	6,704,000

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The general fund appropriation is for costs in the medical assistance and general assistance medical care programs.

Of the health care access fund appropriation, $7,790,000 the first year and $10,897,000 the second year is for administration of the MinnesotaCare program and $36,685,000 the first year and $85,143,000 the second year is for the MinnesotaCare subsidized health care plan.

Sec. 3. DEPARTMENT OF HEALTH	5,137,000	5,962,000
Sec. 4. UNIVERSITY OF MINNESOTA	2,277,000	2,357,000
Sec. 5. HIGHER EDUCATION COORDINATING BOARD	578,000	707,000
Sec. 6. LEGISLATIVE COORDINATING COMMISSION	175,000	175,000
Sec. 7. DEPARTMENT OF COMMERCE GENERAL FUND	175,000	162,000
Sec. 8. DEPARTMENT OF REVENUE	1,037,000	1,367,000
Sec. 9. DEPARTMENT OF EMPLOYEE RELATIONS	3,554,000	7,125,000

Sec. 10. **TRANSFERS.**

The commissioner of finance shall transfer $10,907,000 in fiscal year 1994 and $25,842,000 in fiscal year 1995 from the health care access fund to the general fund.

The commissioner of finance shall transfer $189,000 in fiscal year 1994 and $239,000 in fiscal year 1995 from the health care access fund to the special revenue fund for MAXIS.

Sec. 11. **CARRY FORWARD.**

Subdivision 1. $250,000 of the appropriation in Laws 1992, chapter 549, article 10, section 1, subdivision 3, is available until June 30, 1994, to develop and implement a program to establish community health centers in rural areas of the state as authorized in Minnesota Statutes, section 144.1486.

Subd. 2. $250,000 of the appropriation in Laws 1992, chapter 549, article 10, section 1, subdivision 3, is available until June 30, 1994, to award transition grants to rural hospitals as authorized in Minnesota Statutes, section 144.147.

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Subd. 3. $200,000 of the appropriation in Laws 1992, chapter 549, article 10, section 1, subdivision 3, is available until June 30, 1994, to award sole community hospital financial assistance grants as authorized by Minnesota Statutes, section 144.1484.

Subd. 4. The entire appropriation in Laws 1992, chapter 549, article 10, section 1, subdivision 3, is available until June 30, 1994.

Subd. 5. Notwithstanding Laws 1992, chapter 549, article 10, section 1, subdivision 1, $569,000 of the amount appropriated to the commissioner of revenue in Laws 1992, chapter 549, article 10, section 1, subdivision 8, is available until June 30, 1994.

Subd. 6. Up to $600,000 of the appropriation for systems modification and start-up costs for MinnesotaCare contained in Laws 1992, chapter 549, article 10, section 1, subdivision 4, shall not cancel, but may be transferred to the state systems account established in Minnesota Statutes, section 256.014, to complete the work of integrating MinnesotaCare into the Medicaid management information system.

Presented to the governor May 20, 1993

Signed by the governor May 24, 1993, 12:15 p.m.

CHAPTER 346—H.F.No. 373

VETOED

CHAPTER 347—S.F.No. 694

An act relating to alcohol and chemical use; increasing penalties for driving while intoxicated with a child under 16 in the vehicle and providing for vehicle forfeiture for multiple offenses; requiring driver's license revocation for persons convicted of a controlled substance offense if the court finds that the person committed the offense while driving a motor vehicle; providing pretrial release conditions for habitual DWI violators; increasing the penalty for certain persons who drive while under license cancellation; allowing the use of preliminary screening tests in certain proceedings; providing one-year program for funds from sale of certain forfeited vehicles to be used for DWI-related enforcement, training, and education; making technical changes to apply DWI-related provisions to commercial motor vehicle operators; requiring information related to the risks and effects of alcohol to be printed in driver's manual; clarifying administrative revocation penalties; extending ignition interlock pilot program for one year; defining "consumption" in the underage drinking law; expanding prosecutorial jurisdiction over underage drinking offenses; requiring driver's license suspen-

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