

## CHAPTER 625—S.F.No. 2192

*An act relating to health; MinnesotaCare; establishing and regulating community integrated service networks; defining terms; creating a reinsurance and risk adjustment association; classifying data; requiring reports; mandating studies; modifying provisions relating to the regulated all-payer option; modifying provisions relating to nursing facilities; requiring administrative rulemaking; setting timelines and requiring plans for implementation; designating essential community providers; establishing an expedited fact finding and dispute resolution process; requiring proposed legislation; establishing task forces; providing for demonstration models; mandating universal coverage; requiring insurance reforms; providing grant programs; establishing the Minnesota health care administrative simplification act; implementing electronic data interchange standards; creating the Minnesota center for health care electronic data interchange; providing standards for the Minnesota health care identification card; appropriating money; providing penalties; amending Minnesota Statutes 1992, sections 60A.02, subdivision 3; 60A.15, subdivision 1; 62A.303; 62A.48, subdivision 1; 62D.02, subdivision 4; 62D.04, by adding a subdivision; 62E.02, subdivisions 10, 18, 20, and 23; 62E.10, subdivisions 1, 2, and 3; 62E.141; 62E.16; 62J.03, by adding a subdivision; 62J.04, by adding a subdivision; 62J.05, subdivision 2; 62L.02, subdivisions 9, 13, 17, 24, and by adding subdivisions; 62L.03, subdivisions 1 and 6; 62L.05, subdivisions 1, 5, and 8; 62L.06; 62L.07, subdivision 2; 62L.08, subdivisions 2, 5, 6, 7, and by adding a subdivision; 62L.12; 62L.21, subdivision 2; 62M.02, subdivisions 5 and 21; 62M.03, subdivisions 1, 2, and 3; 62M.05, subdivision 3; 62M.06, subdivision 3; 72A.20, by adding a subdivision; 144.1485; 144.335, by adding a subdivision; 144.581, subdivision 2; 145.64, subdivision 1; 256.9355, by adding a subdivision; 256.9358, subdivision 4; 295.50, by adding subdivisions; 295.55, subdivisions 2 and 3; 308A.005, by adding a subdivision; 308A.635, by adding a subdivision; and 318.02, by adding a subdivision; Minnesota Statutes 1993 Supplement, sections 43A.317, by adding a subdivision; 60K.14, subdivision 7; 61B.20, subdivision 13; 62A.011, subdivision 3; 62A.31, subdivision 1h; 62A.36, subdivision 1; 62A.65, subdivisions 2, 3, 4, 5, and by adding a subdivision; 62D.12, subdivision 17; 62J.03, subdivision 6; 62J.04, subdivisions 1 and 1a; 62J.09, subdivisions 1a and 2; 62J.23, subdivision 4; 62J.2916, subdivision 2; 62J.32, subdivision 4; 62J.33, by adding subdivisions; 62J.35, subdivisions 2 and 3; 62J.38; 62J.41, subdivision 2; 62J.45, subdivision 11, and by adding subdivisions; 62L.02, subdivisions 8, 11, 15, 16, 19, and 26; 62L.03, subdivisions 3, 4, and 5; 62L.04, subdivision 1; 62L.08, subdivisions 4 and 8; 62N.01; 62N.02, subdivisions 1, 8, and by adding a subdivision; 62N.06, subdivision 1; 62N.065, subdivision 1; 62N.10, subdivisions 1 and 2; 62N.22; 62N.23; 62P.01; 62P.03; 62P.04; 62P.05; 144.1464; 144.1486; 144.335, subdivision 3a; 144.802, subdivision 3b; 144A.071, subdivision 4a, as amended; 151.21, subdivisions 7 and 8; 256.9352, subdivision 3; 256.9353, subdivisions 3 and 7; 256.9354, subdivisions 1, 4, 5, 6, and by adding a subdivision; 256.9356, subdivision 3; 256.9357, subdivision 2; 256.9362, subdivision 6; 256.9363, subdivisions 6, 7, and 9; 256.9657, subdivision 3; 256.9695, subdivision 3, as amended; 256B.0917, subdivision 2; 295.50, subdivisions 3, 4, and 12b; 295.52, subdivision 5; 295.53, subdivisions 1, 2, and 5; 295.54; 295.58; and 295.582; H.F. 3210, article 1, section 2, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 62A; 62J; 62N; 62P; 144; 308A; and 317A; proposing coding for new law as Minnesota Statutes, chapters 62Q and 62R; repealing Minnesota Statutes 1992, sections 62A.02, subdivision 5; 62E.51; 62E.52; 62E.53; 62E.531; 62E.54; 62E.55; and 256.362, subdivision 5; Minnesota Statutes 1993 Supplement, sections 62J.04, subdivision 8; 62N.07; 62N.075; 62N.08; 62N.085; and 62N.16; Laws 1992, chapter 549, article 9, section 22.*

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

ARTICLE 1

COMMUNITY INTEGRATED SERVICE NETWORKS

Section 1. [62J.016] GOALS OF RESTRUCTURING.

The state seeks to bring about changes in the health care delivery and financing system that will assure quality, affordable, and accessible health care for all Minnesotans. This goal will be accomplished by restructuring the delivery system, the financial incentives, and the regulatory environment in a way that will make health care providers and health plan companies more accountable to consumers, group purchasers, and communities for their costs and quality, their effectiveness in meeting the health care needs of all of their patients and enrollees, and their contributions to improving the health of the greater community.

Sec. 2. [62J.017] IMPLEMENTATION TIMETABLE.

The state seeks to complete the restructuring of the health care delivery and financing system by July 1, 1997. The restructured system will have two options: (1) integrated service networks, which will be accountable for meeting state cost containment, quality, and access standards; or (2) a uniform set of price and utilization controls for all health care services for Minnesota residents not provided through an integrated service network. Both systems will operate under the state's growth limits and will be structured to promote competition in the health care marketplace.

Beginning July 1, 1994, measures will be taken to increase the public accountability of existing health plan companies, to promote the development of small, community-based integrated service networks, and to reduce administrative costs by standardizing third-party billing forms and procedures and utilization review requirements. Voluntary formation of other integrated service networks will begin after rules have been adopted, but not before July 1, 1996. Statutes and rules for the entire restructured health care financing and delivery system must be enacted or adopted by January 1, 1996, and a phase-in of the all-payer reimbursement system must begin on that date. By July 1, 1997, all health coverage must be regulated under integrated service network or community integrated service network law pursuant to chapter 62N or all-payer law pursuant to chapter 62P.

Sec. 3. Minnesota Statutes 1993 Supplement, section 62N.02, is amended by adding a subdivision to read:

Subd. 4a. COMMUNITY INTEGRATED SERVICE NETWORK. (a) "Community integrated service network" or "community network" means a formal arrangement licensed by the commissioner under section 62N.25 for provid-

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ing prepaid health services to enrolled populations of 50,000 or fewer enrollees, including enrollees who are residents of other states.

(b) Notwithstanding paragraph (a), an organization licensed as a community network that accepts payments for health care services on a capitated basis, or under another similar risk sharing agreement, from a program of self-insurance as described in section 60A.02, subdivision 3, paragraph (b), shall not be regulated as a community network with respect to the receipt of the payments. The payments are not premium revenues for the purpose of calculating the community network's liability for otherwise applicable state taxes, assessments, or surcharges, with the exception of:

(1) the MinnesotaCare provider tax;

(2) the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d); and

(3) effective July 1, 1995, assessments by the Minnesota comprehensive health association.

This paragraph applies only where:

(1) the community network does not bear risk in excess of 110 percent of the self-insurance program's expected costs;

(2) the employer does not carry stop loss, excess loss, or similar coverage with an attachment point lower than 120 percent of the self-insurance program's expected costs;

(3) the community network and the employer comply with the data submission and administrative simplification provisions of chapter 62J;

(4) the community network and the employer comply with the provider tax pass-through provisions of section 295.582;

(5) the community network's required minimum reserves reflect the risk borne by the community network under this paragraph, with an appropriate adjustment for the 110 percent limit on risk borne by the community network;

(6) on or after July 1, 1994, but prior to January 1, 1995, the employer has at least 1,500 current employees, as defined in section 62L.02, or, on or after January 1, 1995, the employer has at least 750 current employees, as defined in section 62L.02;

(7) the employer does not exclude any eligible employees or their dependents, both as defined in section 62L.02, from coverage offered by the employer, under this paragraph or any other health coverage, insured or self-insured, offered by the employer, on the basis of the health status or health history of the person.

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This paragraph expires December 31, 1997.

Sec. 4. Minnesota Statutes 1993 Supplement, section 62N.02, subdivision 8, is amended to read:

Subd. 8. **INTEGRATED SERVICE NETWORK.** (a) "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. Integrated service network does not include a community integrated service network.

(b) Notwithstanding paragraph (a), an organization licensed as an integrated service network that accepts payments for health care services on a capitated basis, or under another similar risk sharing agreement, from a program of self-insurance as described in section 60A.02, subdivision 3, paragraph (b), shall not be regulated as an integrated service network with respect to the receipt of the payments. The payments are not premium revenues for the purpose of calculating the integrated service network's liability for otherwise applicable state taxes, assessments, or surcharges, with the exception of:

(1) the MinnesotaCare provider tax;

(2) the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d); and

(3) effective July 1, 1995, assessments by the Minnesota comprehensive health association.

This paragraph applies only where:

(1) the integrated service network does not bear risk in excess of 110 percent of the self-insurance program's expected costs;

(2) the employer does not carry stop loss, excess loss, or similar coverage with an attachment point lower than 120 percent of the self-insurance program's expected costs;

(3) the integrated service network and the employer comply with the data submission and administrative simplification provisions of chapter 62J;

(4) the integrated service network and the employer comply with the provider tax pass-through provisions of section 295.582;

(5) the integrated service network's required minimum reserves reflect the risk borne by the integrated service network under this paragraph, with an appropriate adjustment for the 110 percent limit on risk borne by the integrated service network;

(6) on or after July 1, 1994, but prior to January 1, 1995, the employer has at least 1,500 current employees, as defined in section 62L.02, or, on or after

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January 1, 1995, the employer has at least 750 current employees, as defined in section 62L.02;

(7) the employer does not exclude any eligible employees or their dependents, both as defined in section 62L.02, from coverage offered by the employer, under this paragraph or any other health coverage, insured or self-insured, offered by the employer, on the basis of the health status or health history of the person.

This paragraph expires December 31, 1997.

**Sec. 5. [62N.25] COMMUNITY INTEGRATED SERVICE NETWORKS.**

Subdivision 1. SCOPE OF LICENSURE. Beginning July 1, 1994, the commissioner shall accept applications for licensure as a community integrated service network under this section. Licensed community integrated service networks may begin providing health coverage to enrollees no earlier than January 1, 1995, and may begin marketing coverage to prospective enrollees upon licensure.

Subd. 2. LICENSURE REQUIREMENTS GENERALLY. To be licensed and to operate as a community integrated service network, an applicant must satisfy the requirements of chapter 62D, and all other legal requirements that apply to entities licensed under chapter 62D, except as exempted or modified in this section. Community networks must, as a condition of licensure, comply with rules adopted under section 256B.0644 that apply to entities governed by chapter 62D.

Subd. 3. REGULATION; APPLICABLE LAW. Community integrated service networks are regulated and licensed by the commissioner under the same authority that applies to entities licensed under chapter 62D, except as exempted or modified under this section. All statutes or rules that apply to health maintenance organizations apply to community networks, unless otherwise specified. A cooperative organized under chapter 308A may establish a community integrated service network.

Subd. 4. GOVERNING BODY. In addition to the requirements of section 62D.06, at least 51 percent of the members of the governing body of the community integrated service network must be residents of the community integrated service network's service area. Service area, for purposes of this subdivision, may include contiguous geographic areas outside the state of Minnesota.

Subd. 5. BENEFITS. Community integrated service networks must offer the health maintenance organization benefit set, as defined in chapter 62D, and other laws applicable to entities regulated under chapter 62D, except that the community integrated service network may impose a deductible, not to exceed \$1,000 per person per year, provided that out-of-pocket expenses on covered services do not exceed \$3,000 per person or \$5,000 per family per year. The

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deductible must not apply to preventive health services as described in Minnesota Rules, part 4685.0801, subpart 8. Community networks and chemical dependency facilities under contract with a community network shall use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660, when assessing enrollees for chemical dependency treatment.

Subd. 6. SOLVENCY. A community integrated service network is exempt from the deposit, reserve, and solvency requirements specified in sections 62D.041, 62D.042, 62D.043, and 62D.044 and shall comply instead with sections 62N.27 to 62N.32. In applying sections 62N.27 to 62N.32, the commissioner is exempt from the rulemaking requirements of chapter 14. However, to the extent that there are analogous definitions or procedures in chapter 62D or in rules promulgated thereunder, the commissioner shall follow those existing provisions rather than adopting a contrary approach or interpretation. This rulemaking exemption shall expire on June 1, 1995.

Subd. 7. EXEMPTIONS FROM EXISTING REQUIREMENTS. Community integrated service networks are exempt from the following requirements applicable to health maintenance organizations:

- (1) conducting focused studies under Minnesota Rules, part 4685.1125;
- (2) preparing and filing, as a condition of licensure, a written quality assurance plan, and annually filing such a plan and a work plan, under Minnesota Rules, parts 4685.1110 and 4685.1130;
- (3) maintaining statistics under Minnesota Rules, part 4685.1200;
- (4) filing provider contract forms under sections 62D.03, subdivision 4, and 62D.08, subdivision 1;
- (5) reporting any changes in the address of a network provider or length of a provider contract or additions to the provider network to the commissioner within ten days under section 62D.08, subdivision 5. Community networks must report such information to the commissioner on a quarterly basis. Community networks that fail to make the required quarterly filing are subject to the penalties set forth in section 62D.08, subdivision 5; and
- (6) preparing and filing, as a condition of licensure, a marketing plan, and annually filing a marketing plan, under sections 62D.03, subdivision 4, paragraph (1), and 62D.08, subdivision 1.

Subd. 8. PROVIDER CONTRACTS. The provisions of section 62D.123 are implied in every provider contract or agreement between a community integrated service network and a provider, regardless of whether those provisions are expressly included in the contract. No participating provider, agent, trustee, or assignee of a participating provider has or may maintain any cause of action against a subscriber or enrollee to collect sums owed by the community network.

Subd. 9. EXCEPTIONS TO ENROLLMENT LIMIT. A community integrated service network may enroll enrollees in excess of 50,000 if necessary to comply with guaranteed issue or guaranteed renewal requirements of chapter 62L or section 62A.65.

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## Sec. 6. [62N.255] EXPANDED PROVIDER NETWORKS.

Subdivision 1. PROVIDER ACCEPTANCE REQUIRED. Each health plan company, with the exception of any health plan company with 50,000 or fewer enrollees and health plan companies that are exempt under subdivision 6, shall establish an expanded network of allied independent health providers, in addition to a preferred network. A health plan company shall accept as a provider in the expanded network any allied independent health provider who: (1) meets the health plan company's credentialing standards; (2) agrees to the terms of the health plan company's provider contract; and (3) agrees to comply with all managed care protocols of the health plan company. A preferred network shall be considered an expanded network if all allied independent health providers who meet the requirements of clauses (1), (2), and (3), are accepted into the preferred network. A community integrated service network may offer to its enrollees an expanded network of allied independent health providers as described under this section.

Subd. 2. MANAGED CARE. The managed care protocols used by the health plan company may include: (1) a requirement that an enrollee obtain a referral from the health plan company before obtaining services from an allied independent health provider in the expanded network; (2) limits on the number and length of visits to allied independent health providers in the expanded network allowed by each referral, as long as the number and length of visits allowed is not less than the number and length allowed for comparable referrals to allied independent health providers in the preferred network; and (3) ongoing management and review by the health plan company of the care provided by an allied independent health provider in the expanded network after a referral is made.

Subd. 3. MANDATORY OFFERING TO ENROLLEES. Each health plan company shall offer to enrollees the option of receiving covered services through the expanded network of allied independent health providers established under subdivisions 1 and 2. This expanded network option may be offered as a separate health plan. The network may establish separate premium rates and cost-sharing requirements for this expanded network plan, as long as these premium rates and cost-sharing requirements are actuarially justified and approved by the commissioner. This subdivision does not apply to Medicare, medical assistance, general assistance medical care, and MinnesotaCare. This subdivision is effective January 1, 1995, and applies to health plans issued or renewed, or offers of health plans to be issued or renewed, on or after January 1, 1995, except that this subdivision is effective January 1, 1996, for collective bargaining agreements of the department of employee relations and the University of Minnesota.

Subd. 4. PROVIDER REIMBURSEMENT. A health plan company shall pay each allied independent health provider in the expanded network the same rate per unit of service as paid to allied independent health providers in the preferred network.

Subd. 5. DEFINITIONS. (a) For purposes of this section, the following definitions apply.

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(b) "Allied independent health provider" means an independently enrolled audiologist, chiropractor, dietitian, home health care provider, licensed marriage and family therapist, nurse practitioner or advanced practice nurse, occupational therapist, optometrist, optician, outpatient chemical dependency counselor, pharmacist who is not employed by and based on the premises of a health plan company, physical therapist, podiatrist, licensed psychologist, psychological practitioner, licensed social worker, or speech therapist.

(c) "Home health care provider" means a provider of personal care assistance, home health aide, homemaker, respite care, adult day care, or home therapies and home health nursing services.

(d) "Independently enrolled" means that a provider can bill, and receive direct payment for services from, a third-party payer or patient.

Subd. 6. EXEMPTION. A health plan company, to the extent that it operates as a staff model health plan company as defined in section 295.50, subdivision 12b, by employing allied independent health care providers to deliver health care services to enrollees, is exempt from this section.

#### Sec. 7. [62N.26] SHARED SERVICES COOPERATIVE.

The commissioner of health shall establish, or assist in establishing, a shared services cooperative organized under chapter 308A to make available administrative and legal services, technical assistance, provider contracting and billing services, and other services to those community integrated service networks and integrated service networks that choose to participate in the cooperative. The commissioner shall provide, to the extent funds are appropriated, start-up loans sufficient to maintain the shared services cooperative until its operations can be maintained by fees and contributions. The cooperative must not be staffed, administered, or supervised by the commissioner of health. The cooperative shall make use of existing resources that are already available in the community, to the extent possible.

#### Sec. 8. [62N.27] DEFINITIONS.

Subdivision 1. APPLICABILITY. For purposes of sections 62N.27 to 62N.32, the terms defined in this section have the meanings given. Other terms used in those sections have the meanings given in sections 62D.041, 62D.042, 62D.043, and 62D.044.

Subd. 2. NET WORTH. "Net worth" means admitted assets as defined in subdivision 3, minus liabilities. Liabilities do not include those obligations that are subordinated in the same manner as preferred ownership claims under section 60B.44, subdivision 10. For purposes of this subdivision, preferred ownership claims under section 60B.44, subdivision 10, include promissory notes subordinated to all other liabilities of the community integrated service network.

Subd. 3. ADMITTED ASSETS. "Admitted assets" means admitted assets as defined in section 62D.044, except that real estate investments allowed by section 62D.045 are not admitted assets. Admitted assets include the deposit required under section 62N.32.

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**Subd. 4. ACCREDITED CAPITATED PROVIDER.** “Accredited capitated provider” means a health care providing entity that:

(1) receives capitated payments from a community network under a contract to provide health services to the network’s enrollees. For purposes of this section, a health care providing entity is “capitated” when its compensation arrangement with a network involves the provider’s acceptance of material financial risk for the delivery of a predetermined set of services for a specified period of time;

(2) is licensed to provide and provides the contracted services, either directly or through an affiliate. For purposes of this section, an “affiliate” is any person that directly or indirectly controls, is controlled by, or is under common control with the health care providing entity, and “control” exists when any person, directly or indirectly, owns, controls, or holds the power to vote or holds proxies representing no less than 80 percent of the voting securities or governance rights of any other person;

(3) agrees to serve as an accredited capitated provider of a community network or for the purpose of reducing the network’s net worth and deposit requirements under section 62N.28; and

(4) is approved by the commissioner as an accredited capitated provider for a community network in accordance with section 62N.31.

**Subd. 5. PERCENTAGE OF RISK CEDED.** “Percentage of risk ceded” means the ratio, expressed as a percentage, between capitated payments made or, in the case of a new entity, expected to be made by a community network to all accredited capitated providers during any contract year and the total premium revenue, adjusted to eliminate expected administrative costs, received for the same time period by the community network.

**Subd. 6. PROVIDER AMOUNT AT RISK.** “Provider amount at risk” means a dollar amount certified by a qualified actuary to represent the expected direct costs to an accredited capitated provider for providing the contracted, covered health care services to the enrollees of the network to which it is accredited for a period of 120 days.

#### Sec. 9. [62N.28] NET WORTH REQUIREMENT.

**Subdivision 1. REQUIREMENT.** Except as otherwise permitted by this chapter, each community network must maintain a minimum net worth equal to the greater of:

(1) \$1,000,000;

(2) two percent of the first \$150,000,000 of annual premium revenue plus one percent of annual premium revenue in excess of \$150,000,000;

(3) eight percent of the annual health services costs, except those paid on a capitated or managed hospital payment basis, plus four percent of the annual capitation and managed hospital payment costs; or

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(4) four months uncovered health services costs.

Subd. 2. DEFINITIONS. For purposes of this section, the following terms have the meanings given:

(1) "capitated basis" means fixed per member per month payment or percentage of premium paid to a provider that assumes the full risk of the cost of contracted services without regard to the type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities;

(2) "managed hospital payment basis" means agreements in which the financial risk is primarily related to the degree of utilization rather than to the cost of services; and

(3) "uncovered health services costs" means the cost to the community network of health services covered by the community network for which the enrollee would also be liable in the event of the community network's insolvency, and that are not guaranteed, insured, or assumed by a person other than the community network.

Subd. 3. REINSURANCE CREDIT. A community network may use the subtraction for premiums paid for insurance permitted under section 62D.042, subdivision 4.

Subd. 4. PHASE-IN FOR NET WORTH REQUIREMENT. A community network may choose to comply with the net worth requirement on a phase-in basis according to the following schedule:

(1) 50 percent of the amount required under subdivisions 1 to 3 at the time that the community network begins enrolling enrollees;

(2) 75 percent of the amount required under subdivisions 1 to 3 at the end of the first full calendar year of operation;

(3) 87.5 percent of the amount required under subdivisions 1 to 3 at the end of the second full calendar year of operation; and

(4) 100 percent of the amount required under subdivisions 1 to 3 at the end of the third full calendar year of operation.

Subd. 5. NET WORTH CORRIDOR. A community network shall not maintain net worth that exceeds two and one-half times the amount required of the community network under subdivision 1. Subdivision 4 is not relevant for purposes of this subdivision.

Subd. 6. NET WORTH REDUCTION. If a community network has contracts with accredited capitated providers, and only for so long as those contracts or successor contracts remain in force, the net worth requirement of subdivision 1 shall be reduced by the percentage of risk ceded, but in no event shall the net worth requirements be reduced by this subdivision to less than

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\$1,000,000. The phase-in requirements of subdivision 4 shall not be affected by this reduction.

**Sec. 10. [62N.29] GUARANTEEING ORGANIZATION.**

A community network may satisfy its net worth and deposit requirements, in whole or in part, through the use of one or more guaranteeing organizations, with the approval of the commissioner, under the conditions permitted in chapter 62D. Governmental entities, such as counties, may serve as guaranteeing organizations subject to the requirements of chapter 62D.

**Sec. 11. [62N.31] STANDARDS FOR ACCREDITED CAPITATED PROVIDER ACCREDITATION.**

Subdivision 1. GENERAL. Each health care providing entity seeking initial accreditation as an accredited capitated provider shall submit to the commissioner of health sufficient information to establish that the applicant has operational capacity, facilities, personnel, and financial capability to provide the contracted covered services to the enrollees of the network for which it seeks accreditation (1) on an ongoing basis; and (2) for a period of 120 days following the insolvency of the network without receiving payment from the network. Accreditation shall continue until abandoned by the accredited capitated provider or revoked by the commissioner in accordance with subdivision 4. The applicant may establish financial capability by demonstrating that the provider amount at risk can be covered by or through any of allocated or restricted funds, a letter of credit, the taxing authority of the applicant or governmental sponsor of the applicant, an unrestricted fund balance at least two times the provider amount at risk, reinsurance, either purchased directly by the applicant or by the community network to which it will be accredited, or any other method accepted by the commissioner. Accreditation of a health care providing entity shall not in itself limit the right of the accredited capitated provider to seek payment of unpaid capitated amounts from a community network, whether the community network is solvent or insolvent; provided that, if the community network is subject to any liquidation, rehabilitation, or conservation proceedings, the accredited capitated provider shall have the status accorded creditors under chapter 60B.44, subdivision 10.

Subd. 2. ANNUAL REPORTING PERIOD. Each accredited capitated provider shall submit to the commissioner annually, no later than April 15, the following information for each network to which it is accredited: the provider amount at risk for that year, the number of enrollees for the network, both for the prior year and estimated for the current year, any material change in the provider's operational or financial capacity since its last report, and any other information reasonably requested by the commissioner.

Subd. 3. ADDITIONAL REPORTING. Each accredited capitated provider shall provide the commissioner with 60 days' advance written notice of termination of the accredited capitated provider relationship with a network.

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Subd. 4. REVOCATION OF ACCREDITATION. The commissioner may revoke the accreditation of an accredited capitated provider if the accredited capitated provider's ongoing operational or financial capabilities fail to meet the requirements of this section. The revocation shall be handled in the same fashion as placing a health maintenance organization under administrative supervision.

**Sec. 12. [62N.32] DEPOSIT REQUIREMENT.**

A community network must satisfy the deposit requirement provided in section 62D.041. The deposit counts as an admitted asset and as part of the required net worth. The deposit requirement cannot be reduced by the alternative means that may be used to reduce the net worth requirement, other than through the use of a guaranteeing organization.

**Sec. 13. [62N.33] COVERAGE FOR ENROLLEES OF INSOLVENT NETWORKS.**

In the event of a community network insolvency, the commissioner shall determine whether one or more community networks or health plan companies are willing and able to provide replacement coverage to all of the failed community network's enrollees, and if so, the commissioner shall facilitate the provision of the replacement coverage. If such replacement coverage is not available, the commissioner shall randomly assign enrollees of the insolvent community network to other community networks and health plan companies in the service area, in proportion to their market share, for the remaining terms of the enrollees' contracts with the insolvent network. The other community networks and health plan companies must accept the allocated enrollees under their policy or contract most similar to the enrollees' contracts with the insolvent community network. The allocation must keep groups together. Enrollees with special continuity of care needs may, in the commissioner's discretion, be given a choice of replacement coverage rather than random assignment. Individuals and groups that are assigned randomly may choose a different community network or health plan company when their contracts expire, on the same basis as any other individual or group. The replacement health plan company must comply with any guaranteed renewal or other renewal provisions of the prior coverage, including but not limited to, provisions regarding preexisting conditions and health conditions that developed during prior coverage.

**Sec. 14. [62N.34] INSOLVENCY FUNDING.**

(a) In the event of an insolvency of a community network, all other community networks and health plan companies shall be assessed a surcharge, if necessary to pay expenses and claims set forth in paragraph (b), based on average annual premiums on health plans as defined in section 62A.011. For purposes of this section, "average annual premiums" means annual premiums averaged over the three most recent calendar years for which information is available preceding the calendar year in which the community network became insolvent. The total of all such surcharges upon a community network or health plan company

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shall not, in any one calendar year, exceed two percent of the community network's or health plan company's average annual premium in this state on health plans as defined in section 62A.011.

(b) Money raised by the assessment shall be used to pay for the following, to the extent that they exceed the community network's deposit and other remaining assets:

(1) expenses in connection with the insolvency and transfer of enrollees;

(2) outstanding fee-for-service claims from nonparticipating providers, discounted by 25 percent of the claim amount. Claims incurred after the implementation of the fee schedules provided under chapter 62P will be reimbursed at the fee schedule amount discounted by 25 percent. Providers may not seek to recover the unpaid portion of their claim from enrollees; and

(3) premiums to community networks and health plan companies that take enrollees of the insolvent community network, prorated to account for premiums already paid to the insolvent community network on behalf of those enrollees, to purchase coverage for time periods for which the insolvent community network can no longer provide coverage.

(c) In any year in which an assessment is made, the commissioner, in consultation with community networks and other health carriers, shall report to the legislature and governor on the continuing viability of the assessment approach and on the merits of potential alternative funding sources.

#### Sec. 15. [62N.35] BORDER ISSUES.

To the extent feasible and appropriate, community networks that also operate under the health maintenance organization or similar prepaid health care law of another state must be licensed and regulated by this state in a manner that avoids unnecessary duplication and expense for the community network. The commissioner shall communicate with regulatory authorities in neighboring states to explore the feasibility of cooperative approaches to streamline regulation of border community networks, such as joint financial audits, and shall report to the legislature on any changes to Minnesota law that may be needed to implement appropriate collaborative approaches to regulation.

#### Sec. 16. STUDY OF SOLVENCY REGULATION OF INTEGRATED SERVICE NETWORKS.

The commissioners of health and commerce shall develop the solvency standards for the integrated service networks created by Minnesota Statutes, chapter 62N. The solvency standards for integrated service networks must be effective no later than January 1, 1996.

The standards may use a risk-based capital standard as an integral tool to assess solvency of the integrated service networks. The standards may require that integrated service networks file the risk based capital calculation as part of the annual financial statement. The risk-based capital standard for integrated

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service networks may be based upon the national association of insurance commissioners health organization risk based capital standards currently under development, with any necessary modifications to reflect the unique risk characteristics of integrated service networks. Those modifications must be based upon an actuarial analysis of the effect on risk.

#### Sec. 17. MONITORING OF REINSURANCE ACCESSIBILITY FOR COMMUNITY NETWORKS.

The commissioners of commerce and health shall monitor the private sector market for reinsurance, in order to determine whether community integrated service networks are able to purchase reinsurance at competitive rates. If the commissioners find that the private market for reinsurance is not accessible or not affordable to community integrated service networks, the commissioners shall recommend to the legislature a voluntary or mandatory reinsurance purchasing pool for community integrated service networks. The commissioners' recommendations shall address the conditions under which community networks would be permitted or required to participate in the pool and the role of the state in overseeing or administering the pool.

#### Sec. 18. REVISOR INSTRUCTIONS.

The revisor of statutes shall recode section 6 establishing an expanded provider network from Minnesota Statutes, chapter 62N to Minnesota Statutes, chapter 62Q, and change all references to that section in Minnesota Statutes accordingly.

#### Sec. 19. EFFECTIVE DATE.

Sections 1 to 18 are effective July 1, 1994.

## ARTICLE 2

### REQUIREMENTS FOR ALL HEALTH PLAN COMPANIES

Section 1. Minnesota Statutes 1993 Supplement, section 62J.33, is amended by adding a subdivision to read:

Subd. 3. OFFICE OF CONSUMER INFORMATION. The commissioner shall create an office of consumer information to assist health plan company enrollees and to serve as a resource center for enrollees. The office shall operate within the information clearinghouse. The functions of the office are:

- (1) to assist enrollees in understanding their rights;
- (2) to explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, integrated service networks, and the departments of health and commerce;

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(3) to provide information on coverage options in each regional coordinating board region of the state;

(4) to provide information on the availability of purchasing pools and enrollee subsidies; and

(5) to help consumers use the health care system to obtain coverage.

The office of consumer information shall not provide legal services to consumers and shall not represent a consumer or enrollee. The office of consumer information shall not serve as an advocate for consumers in disputes with health plan companies. Nothing in this subdivision shall interfere with the ombudsman program established under section 256B.031, subdivision 6, or other existing ombudsman programs.

Sec. 2. Minnesota Statutes 1993 Supplement, section 62J.33, is amended by adding a subdivision to read:

Subd. 4. INFORMATION ON HEALTH PLAN COMPANIES. The information clearinghouse shall provide information on all health plan companies operating in a specific geographic area to consumers and purchasers who request it.

Sec. 3. Minnesota Statutes 1993 Supplement, section 62J.33, is amended by adding a subdivision to read:

Subd. 5. DISTRIBUTION OF DATA ON QUALITY. The commissioner shall make available through the clearinghouse hospital quality data collected under section 62J.45, subdivision 4b, and health plan company quality data collected under section 62J.45, subdivision 4c.

Sec. 4. Minnesota Statutes 1993 Supplement, section 62J.45, is amended by adding a subdivision to read:

Subd. 4a. EVALUATION OF CONSUMER SATISFACTION; PROVIDER INFORMATION PILOT STUDY. (a) The commissioner may make a grant to the data institute to develop and implement a mechanism for collecting comparative data on consumer satisfaction through adoption of a standard consumer satisfaction survey. As a condition of receiving this grant, the data institute shall appoint a consumer advisory group which shall consist of 13 individuals, representing enrollees from public and private health plan companies and programs and two uninsured consumers, to advise the data institute on issues of concern to consumers. The advisory group must have at least one member from each regional coordinating board region of the state. The advisory group expires June 30, 1997. This survey shall include enrollees in community integrated service networks, integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. The data institute shall determine a mechanism for the inclusion of the uninsured. Health plan companies and group purchasers shall provide enrollment information, including the

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names, addresses, and telephone numbers of enrollees and former enrollees and other data necessary for the completion of this study to the data institute. This enrollment information provided by the health plan companies and group purchasers is classified as private data on individuals, as defined in section 13.02, subdivision 12. The data institute shall provide raw unaggregated data to the data analysis unit. The data institute may analyze and prepare findings from the raw, unaggregated data, and the findings from this survey may be included in the health plan company report cards, and in other reports developed by the data analysis unit, in consultation with the data institute, to be disseminated by the information clearinghouse. The raw unaggregated data is classified as private data on individuals as defined in section 13.02, subdivision 12. The survey may include information on the following subjects:

- (1) enrollees' overall satisfaction with their health care plan;
- (2) consumers' perception of access to emergency, urgent, routine, and preventive care, including locations, hours, waiting times, and access to care when needed;
- (3) premiums and costs;
- (4) technical competence of providers;
- (5) communication, courtesy, respect, reassurance, and support;
- (6) choice and continuity of providers;
- (7) continuity of care;
- (8) outcomes of care;
- (9) services offered by the plan, including range of services, coverage for preventive and routine services, and coverage for illness and hospitalization;
- (10) availability of information; and
- (11) paperwork.

(b) The commissioner, in consultation with the data institute, shall develop a pilot study to collect comparative data from health care providers on opportunities and barriers to the provision of quality, cost-effective health care. The provider information pilot study shall include providers in community integrated service networks, integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. Health plan companies and group purchasers shall provide to the commissioner providers' names, health plan assignment, and other appropriate data necessary for the commissioner to conduct the study. The provider information pilot study shall examine factors that increase and hinder access to the provision of quality, cost-effective health care. The study may examine:

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- (1) administrative barriers and facilitators;
- (2) time spent obtaining permission for appropriate and necessary treatments;
- (3) latitude to order appropriate and necessary tests, pharmaceuticals, and referrals to specialty providers;
- (4) assistance available for decreasing administrative and other routine paperwork activities;
- (5) continuing education opportunities provided;
- (6) access to readily available information on diagnoses, diseases, outcomes, and new technologies;
- (7) continuous quality improvement activities;
- (8) inclusion in administrative decision-making;
- (9) access to social services and other services that facilitate continuity of care;
- (10) economic incentives and disincentives;
- (11) peer review procedures; and
- (12) the prerogative to address public health needs.

In selecting additional data for collection, the commissioner shall consider the: (1) statistical validity of the indicator; (2) public need for the information; (3) estimated expense of collecting and reporting the indicator; and (4) usefulness of the indicator to identify barriers and opportunities to improve quality care provision within health plan companies.

Sec. 5. Minnesota Statutes 1993 Supplement, section 62J.45, is amended by adding a subdivision to read:

Subd. 4b. HOSPITAL QUALITY INDICATORS. The commissioner, in consultation with the data institute, shall develop a system for collecting data on hospital quality. The commissioner shall require a licensed hospital to collect and report data as needed for the system. Data to be collected shall include structural characteristics including staff-mix and nurse-patient ratios. In selecting additional data for collection, the commissioner shall consider: (1) feasibility and statistical validity of the indicator; (2) purchaser and public demand for the indicator; (3) estimated expense of collecting and reporting the indicator; and (4) usefulness of the indicator for internal improvement purposes.

Sec. 6. Minnesota Statutes 1993 Supplement, section 62J.45, is amended by adding a subdivision to read:

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Subd. 4c. QUALITY REPORT CARDS. (a) Each health plan company shall report annually by April 1 to the commissioner specific quality indicators, in the form specified by the commissioner in consultation with the data institute. The quality indicators must be reported using standard definitions and measurement processes as specified by the commissioner. Wherever possible, the commissioner's specifications must be consistent with any outlined in the health plan employer data and information set (HEDIS 2.0). The commissioner, in consultation with the data institute, may modify the quality indicators to be reported to incorporate improvements in quality measurement tools. When HEDIS 2.0 indicators or health care financing administration approved quality indicators for medical assistance and Medicare are used, the commissioner is exempt from rulemaking. For additions or modifications to the HEDIS indicators or if other quality indicators are added, the commissioner shall proceed through rulemaking pursuant to chapter 14. The data analysis unit shall develop quality report cards, and these report cards shall be disseminated through the information clearinghouse.

(b) Data shall be collected by county and high-risk and special needs populations as well as by health plan but shall not be reported. The commissioner, in consultation with the data institute and counties, shall provide this data to a community health board as defined in section 145A.02 in a manner that would not allow the identification of individuals.

Sec. 7. Minnesota Statutes 1992, section 62M.02, subdivision 5, is amended to read:

Subd. 5. CERTIFICATION. "Certification" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and that it, based on the information provided, meets the utilization review requirements of the applicable health plan and the health carrier will then pay for the covered benefit, provided the preexisting limitation provisions, the general exclusion provisions, and any deductible, copayment, coinsurance, or other policy requirements have been met.

Sec. 8. Minnesota Statutes 1992, section 62M.02, subdivision 21, is amended to read:

Subd. 21. UTILIZATION REVIEW ORGANIZATION. "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network or an integrated service network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed

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under section 60A.23, subdivision 8, which conducts utilization review and determines certification of an admission, extension of stay, or other health care services for a Minnesota resident; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state.

Sec. 9. Minnesota Statutes 1992, section 62M.03, subdivision 1, is amended to read:

Subdivision 1. **LICENSED UTILIZATION REVIEW ORGANIZATION.** Beginning January 1, 1993, any organization that is ~~licensed in this state and that meets the definition of~~ utilization review organization in section 62M.02, subdivision 21, must be licensed under chapter 60A, 62C, 62D, 62N, or 64B, or registered under this chapter and must comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a. Each licensed community integrated service network, integrated service network, or health maintenance organization that has an employed staff model of providing health care services shall comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a for any services provided by providers under contract.

Sec. 10. Minnesota Statutes 1992, section 62M.03, subdivision 2, is amended to read:

Subd. 2. **NONLICENSED UTILIZATION REVIEW ORGANIZATION.** An organization that meets the definition of a utilization review organization under section 62M.02, subdivision 21, that is not licensed in this state that performs utilization review services for Minnesota residents must register with the commissioner of commerce and must certify compliance with sections 62M.01 to 62M.16.

Initial registration must occur no later than January 1, 1993. The registration is effective for two years and may be renewed for another two years by written request. Each utilization review organization registered under this chapter shall notify the commissioner of commerce within 30 days of any change in the name, address, or ownership of the organization.

Sec. 11. Minnesota Statutes 1992, section 62M.03, subdivision 3, is amended to read:

Subd. 3. **PENALTIES AND ENFORCEMENTS.** If a ~~nonlicensed~~ utilization review organization fails to comply with sections 62M.01 to 62M.16, the organization may not provide utilization review services for any Minnesota resident. The commissioner of commerce may issue a cease and desist order under section 45.027, subdivision 5, to enforce this provision. The cease and desist order is subject to appeal under chapter 14. A nonlicensed utilization review organization that fails to comply with the provisions of sections 62M.01 to 62M.16 is subject to all applicable penalty and enforcement provisions of section 72A.201. Each utilization review organization licensed under chapter 60A, 62C, 62D, 62N, or 64B shall comply with sections 62M.01 to 62M.16 as a condition of licensure.

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Sec. 12. Minnesota Statutes 1992, section 62M.05, subdivision 3, is amended to read:

Subd. 3. **NOTIFICATION OF DETERMINATIONS.** A utilization review organization must have written procedures for providing notification of its determinations on all certifications in accordance with the following:

(a) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the hospital, attending physician, or applicable service provider within ten business days of the determination in accordance with section 72A.20, subdivision 4a, or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to, the enrollee or patient; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number."

(b) When a determination is made not to certify a hospital or surgical facility admission or extension of a hospital stay, or other service requiring review determination, within one working day after making the decision the attending physician and hospital must be notified by telephone and a written notification must be sent to the hospital, attending physician, and enrollee or patient. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the attending physician or provider with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

Sec. 13. Minnesota Statutes 1992, section 62M.06, subdivision 3, is amended to read:

Subd. 3. **STANDARD APPEAL.** The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) Each utilization review organization shall notify in writing the enrollee or patient, attending physician, and claims administrator of its determination on the appeal as soon as practical, but in no case later than 45 days after receiving the required documentation on the appeal.

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the health care provider.

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(c) Prior to upholding the original decision not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the original determination not to certify.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the patient, enrollee, or attending physician when the initial determination is made.

(e) An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases where an appeal to reverse a determination not to certify for clinical reasons is unsuccessful, the utilization review organization must, upon request of the attending physician, ensure that a physician of the utilization review organization's choice in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

#### Sec. 14. [62Q.01] DEFINITIONS.

Subdivision 1. APPLICABILITY. For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. COMMISSIONER. "Commissioner" means the commissioner of health.

Subd. 3. HEALTH PLAN. "Health plan" means a health plan as defined in section 62A.011 or a policy, contract, or certificate issued by a community integrated service network; an integrated service network; or an all-payer insurer as defined in section 62P.02.

Subd. 4. HEALTH PLAN COMPANY. "Health plan company" means:

(1) a health carrier as defined under section 62A.011, subdivision 2;

(2) an integrated service network as defined under section 62N.02, subdivision 8;

(3) an all-payer insurer as defined under section 62P.02; or

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(4) a community integrated service network as defined under section 62N.02, subdivision 4a.

**Sec. 15. [62Q.03] PROCESS FOR DEFINING, DEVELOPING, AND IMPLEMENTING A RISK ADJUSTMENT SYSTEM.**

Subdivision 1. PURPOSE. Risk adjustment is a vital element of the state's strategy for achieving a more equitable, efficient system of health care delivery and financing for all state residents. Risk adjustment is needed to: remove current disincentives in the health care system to insure and serve high risk and special needs populations; promote fair competition among health plan companies on the basis of their ability to efficiently and effectively provide services rather than on the health status of those in a given insurance pool; and help assure the viability of all health plan companies, including community integrated service networks. It is the commitment of the state to develop and implement a risk adjustment system by July 1, 1997, and to continue to improve and refine risk adjustment over time. The process for designing and implementing risk adjustment shall be open, explicit, utilize resources and expertise from both the private and public sectors, and include at least the representation described in subdivision 4. The process shall take into account the formative nature of risk adjustment as an emerging science, and shall develop and implement risk adjustment to allow continual modifications, expansions, and refinements over time. The process shall have at least two stages, as described in subdivision 2 and 3.

Subd. 2. FIRST STAGE OF RISK ADJUSTMENT DEVELOPMENT PROCESS. The objective of the first stage is to report to the legislature by January 15, 1995, with recommendations on the process, organization, resource needs, and specific work plan to define, develop, and implement a risk adjustment mechanism by July 1, 1997, and to continually improve risk adjustment over time. The report shall address the specific issues listed in subdivision 5, and shall also identify any additional policy issues, questions and concerns that must be addressed to facilitate development and implementation of risk adjustment.

Subd. 3. SECOND STAGE OF THE RISK ADJUSTMENT DEVELOPMENT PROCESS. The second stage of the process, following review and any modification by the legislature of the January 15, 1995 report, shall be to carry out the work plan to develop and implement a risk adjustment mechanism by July 1, 1997, and to continue to improve and refine a risk adjustment over time. The second stage of the process shall be carried out by the association created in subdivision 6.

Subd. 4. EXPERT PANEL. The commissioners of health and commerce shall convene an expert advisory panel comprised of, but not limited to, the board members of the Minnesota risk adjustment association, as described in subdivision 8, and experts from the fields of epidemiology, health services research, and health economics. The commissioners may also convene technical work groups that may include members of the expert advisory panel and other persons, all selected in the sole discretion of the commissioners. The expert

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advisory panel and the workgroups shall assist and advise the commissioners of health and commerce in preparing the implementation report described in subdivision 5.

Subd. 5. IMPLEMENTATION REPORT TO THE LEGISLATURE. The commissioners of health and commerce shall submit a report to the legislature by January 15, 1995, with recommendations on the process, organization, resource needs, and specific work plan to define, develop, and implement a risk adjustment system by July 1, 1997, and to continually improve risk adjustment over time. In developing the January 15, 1995 report, the commissioners of commerce and health must consider and describe the following:

(1) the relationship of risk adjustment to the implementation of universal coverage and community rating;

(2) the role of reinsurance in the risk adjustment system, as a short-term alternative in the absence of a risk adjustment methodology;

(3) the relationship of the risk adjustment system to the implementation of reforms in underwriting and rating requirements;

(4) the potential role of the health coverage reinsurance association in the risk adjustment system;

(5) the need for mandatory participation of all health plan companies in the risk adjustment system;

(6) current and emerging applications of risk adjustment methodologies used for reimbursement purposes at the state and national level and the reliability and validity of current risk assessment and risk adjustment methodologies;

(7) the levels and types of risk to be distributed through the risk adjustment system;

(8) the extent to which prepaid contracting by public programs needs to be addressed by the risk adjustment methodology;

(9) a plan for testing of the risk adjustment options being proposed, including simulations using existing health plan data, and development and testing of models on simulated data to assess the feasibility and efficacy of specific methodologies;

(10) the appropriate role of the state in the supervision of the risk adjustment association created pursuant to subdivision 6;

(11) risk adjustment methodologies that take into account differences among health plan companies due to their relative efficiencies, characteristics, and relative to existing insured contracts, new business, underwriting, or rating restrictions required or permitted by law; and

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(12) methods to encourage health plan companies to enroll higher risk populations.

To the extent possible, the implementation report shall identify a specific methodology or methodologies that may serve as a starting point for risk adjustment, explain the advantages and disadvantages of each such methodology, and provide a specific workplan for implementing the methodology.

Subd. 6. CREATION OF RISK ADJUSTMENT ASSOCIATION. The Minnesota risk adjustment association is created on July 1, 1994, and may operate as a nonprofit unincorporated association.

Subd. 7. PURPOSE OF ASSOCIATION. The association is established to carry out the purposes of subdivision 1, as further elaborated on by the implementation report described in subdivision 5 and by legislation enacted in 1995 or subsequently.

Subd. 8. GOVERNANCE. (a) The association shall be governed by an interim 19-member board as follows: one provider member appointed by the Minnesota Hospital Association; one provider member appointed by the Minnesota Medical Association; one provider member appointed by the governor; three members appointed by the Minnesota Council of HMOs to include an HMO with at least 50 percent of total membership enrolled through a public program; three members appointed by Blue Cross and Blue Shield of Minnesota, to include a member from a Blue Cross and Blue Shield of Minnesota affiliated health plan with fewer than 50,000 enrollees and located outside the Minneapolis-St. Paul metropolitan area; two members appointed by the Insurance Federation of Minnesota; one member appointed by the Minnesota Association of Counties; and three public members appointed by the governor, to include at least one representative of a public program. The commissioners of health, commerce, human services, and employee relations shall be nonvoting ex-officio members.

(b) The board may elect officers and establish committees as necessary.

(c) A majority of the members of the board constitutes a quorum for the transaction of business.

(d) Approval by a majority of the board members present is required for any action of the board.

(e) Interim board members shall be appointed by July 1, 1994, and shall serve until a new board is elected according to the plan developed by the association.

(f) A member may designate a representative to act as a member of the interim board in the member's absence.

Subd. 9. DATA COLLECTION. The board of the association shall consider antitrust implications and establish procedures to assure that pricing and

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other competitive information is appropriately shared among competitors in the health care market or members of the board. Any information shared shall be distributed only for the purposes of administering or developing any of the tasks identified in subdivisions 2 and 4. In developing these procedures, the board of the association may consider the identification of a state agency or other appropriate third party to receive information of a confidential or competitive nature.

Subd. 10. SUPERVISION. The association's activities shall be supervised by the commissioners of health and commerce.

Subd. 11. REPORTING. The board of the association shall provide a status report on its activities to the health care commission on a quarterly basis.

#### Sec. 16. [62Q.07] ACTION PLANS.

Subdivision 1. ACTION PLANS REQUIRED. (a) To increase public awareness and accountability of health plan companies, all health plan companies must annually file with the applicable commissioner an action plan that satisfies the requirements of this section beginning July 1, 1994, as a condition of doing business in Minnesota. Each health plan company must also file its action plan with the information clearinghouse. Action plans are required solely to provide information to consumers, purchasers, and the larger community as a first step toward greater accountability of health plan companies. The sole function of the commissioner in relation to the action plans is to ensure that each health plan company files a complete action plan, that the action plan is truthful and not misleading, and that the action plan is reviewed by appropriate community agencies.

(b) If a commissioner responsible for regulating a health plan company required to file an action plan under this section has reason to believe an action plan is false or misleading, the commissioner may conduct an investigation to determine whether the action plan is truthful and not misleading, and may require the health plan company to submit any information that the commissioner reasonably deems necessary to complete the investigation. If the commissioner determines that an action plan is false or misleading, the commissioner may require the health plan company to file an amended plan or may take any action authorized under chapter 72A.

Subd. 2. CONTENTS OF ACTION PLANS. (a) An action plan must include a detailed description of all of the health plan company's methods and procedures, standards, qualifications, criteria, and credentialing requirements for designating the providers who are eligible to participate in the health plan company's provider network, including any limitations on the numbers of providers to be included in the network. This description must be updated by the health plan company and filed with the applicable agency on a quarterly basis.

(b) An action plan must include the number of full-time equivalent physicians, by specialty, nonphysician providers, and allied health providers used to provide services. The action plan must also describe how the health plan com-

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pany intends to encourage the use of nonphysician providers, midlevel practitioners, and allied health professionals, through at least consumer education, physician education, and referral and advisement systems. The annual action plan must also include data that is broken down by type of provider, reflecting actual utilization of midlevel practitioners and allied professionals by enrollees of the health plan company during the previous year. Until July 1, 1995, a health plan company may use estimates if actual data is not available. For purposes of this paragraph, "provider" has the meaning given in section 62J.03, subdivision 8.

(c) An action plan must include a description of the health plan company's policy on determining the number and the type of providers that are necessary to deliver cost-effective health care to its enrollees. The action plan must also include the health plan company's strategy, including provider recruitment and retention activities, for ensuring that sufficient providers are available to its enrollees.

(d) An action plan must include a description of actions taken or planned by the health plan company to ensure that information from report cards, outcome studies, and complaints is used internally to improve quality of the services provided by the health plan company.

(e) An action plan must include a detailed description of the health plan company's policies and procedures for enrolling and serving high risk and special needs populations. This description must also include the barriers that are present for the high risk and special needs population and how the health plan company is addressing these barriers in order to provide greater access to these populations. "High risk and special needs populations" includes, but is not limited to, recipients of medical assistance, general assistance medical care, and MinnesotaCare; persons with chronic conditions or disabilities; individuals within certain racial, cultural, and ethnic communities; individuals and families with low income; adolescents; the elderly; individuals with limited or no English language proficiency; persons with high-cost preexisting conditions; homeless persons; chemically dependent persons; persons with serious and persistent mental illness and children with severe emotional disturbance; and persons who are at high-risk of requiring treatment. The action plan must also reflect actual utilization of providers by enrollees defined by this section as high risk or special needs populations during the previous year. For purposes of this paragraph, "provider" has the meaning given in section 62J.03, subdivision 8.

(f) An action plan must include a general description of any action the health plan company has taken and those it intends to take to offer health coverage options to rural communities and other communities not currently served by the health plan company.

(g) A health plan company other than a large managed care plan company may satisfy any of the requirements of the action plan in paragraphs (a) to (f) by stating that it has no policies, procedures, practices, or requirements, either written or unwritten, or formal or informal, and has undertaken no activities or

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plans on the issues required to be addressed in the action plan, provided that the statement is truthful and not misleading. For purposes of this paragraph, "large managed care plan company" means a health maintenance organization, integrated service network, or other health plan company that employs or contracts with health care providers, that has more than 50,000 enrollees in this state. If a health plan company employs or contracts with providers for some of its health plans and does not do so for other health plans that it offers, the health plan company is a large managed care plan company if it has more than 50,000 enrollees in this state in health plans for which it does employ or contract with providers.

**Sec. 17. [62Q.09] PROHIBITION ON EXCLUSIVE RELATIONSHIPS.**

Subdivision 1. PROHIBITION ON EXCLUSIVE CONTRACTS. No provider or health plan company shall restrict any person's right to provide health services or procedures to another provider or health plan company, unless the person is an employee.

Subd. 2. PROHIBITION ON RESTRICTIVE CONTRACT TERMS. No provider or person providing goods or health services to a provider shall enter into any contract or subcontract with any health plan company on terms that require the provider or person not to contract with any other health plan company, unless the provider or person is an employee.

Subd. 3. ENFORCEMENT. Either the commissioner of health or commerce shall periodically review contracts among health care providing entities and health plan companies to determine compliance with this section. Any provider may submit a contract to the commissioner for review if the provider believes this section has been violated. Any provision of a contract found to violate this section is null and void, and the commissioner may seek civil penalties in an amount not to exceed \$25,000 for each such contract.

Subd. 4. APPLICATION; VOLUNTARY RENEWAL. This section applies to contracts entered into on or after the effective date of this section. This section does not prohibit the voluntary renewal of exclusive contracts entered into prior to the effective date of this section.

Subd. 5. SUNSET. This section expires January 1, 1997.

**Sec. 18. [62Q.10] NONDISCRIMINATION.**

If a health plan company, with the exception of a community integrated service network or an indemnity insurer licensed under chapter 60A who does not offer a product through a preferred provider network, offers coverage of a health care service as part of its plan, it may not deny provider network status to a qualified health care provider type who meets the credentialing requirements of the health plan company solely because the provider is an allied independent health care provider as defined in section 62N.255.

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**Sec. 19. [62Q.11] DISPUTE RESOLUTION.**

Subdivision 1. ESTABLISHED. The commissioners of health and commerce shall make dispute resolution processes available to encourage early settlement of disputes in order to avoid the time and cost associated with litigation and other formal adversarial hearings. For purposes of this section, "dispute resolution" means the use of negotiation, mediation, arbitration, mediation-arbitration, neutral fact finding, and minitrials. These processes shall be non-binding unless otherwise agreed to by all parties to the dispute.

Subd. 2. REQUIREMENTS. (a) If an enrollee, health care provider, or applicant for network provider status chooses to use a dispute resolution process prior to the filing of a formal claim or of a lawsuit, the health plan company must participate.

(b) If an enrollee, health care provider, or applicant for network provider status chooses to use a dispute resolution process after the filing of a lawsuit, the health plan company must participate in dispute resolution, including, but not limited to, alternative dispute resolution under rule 114 of the Minnesota general rules of practice.

(c) The commissioners of health and commerce shall inform and educate health plan companies' enrollees about dispute resolution and its benefits.

(d) A health plan company may encourage but not require an enrollee to submit a complaint to alternative dispute resolution.

**Sec. 20. [62Q.12] DENIAL OF ACCESS.**

No health plan company may deny access to a covered health care service unless the denial is made by, or under the direction of, or subject to the review of a health care professional licensed to provide the service in question.

**Sec. 21. [62Q.135] CONTRACTING FOR CHEMICAL DEPENDENCY SERVICES.**

No health plan company shall contract with a chemical dependency treatment program, unless the program participates in the chemical dependency treatment accountability plan established by the commissioner of human services. The commissioner of human services shall make data on chemical dependency services and outcomes collected through this program available to health plan companies.

**Sec. 22. [62Q.14] RESTRICTIONS ON ENROLLEE SERVICES.**

No health plan company may restrict the choice of an enrollee as to where the enrollee receives services related to:

(1) the voluntary planning of the conception and bearing of children, provided that this clause does not refer to abortion services;

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(2) the diagnosis of infertility;

(3) the testing and treatment of a sexually transmitted disease; and

(4) the testing for AIDS or other HIV-related conditions.

**Sec. 23. [62Q.16] MID-MONTH TERMINATION PROHIBITED.**

The termination of a person's coverage under any health plan as defined in section 62A.011, subdivision 3, with the exception of individual health plans, issued or renewed on or after January 1, 1995, must provide coverage until the end of the month in which coverage was terminated.

**Sec. 24. UTILIZATION REVIEW STUDY.**

The commissioners of health and commerce shall study means of funding the registration required by Minnesota Statutes, section 62M.03, and of monitoring and enforcing the requirements of Minnesota Statutes, chapter 62M. They shall jointly report their recommendations to the legislature by January 15, 1995.

**Sec. 25. EFFECTIVE DATE.**

Sections 1, 5, 6, 14 to 17, and 24 are effective the day following final enactment. Sections 7 to 13 and 23 are effective January 1, 1995. Section 2 to 4, and 18 to 21 are effective July 1, 1994. Section 22 is effective January 1, 1995, and applies to policies and contracts issued or renewed on or after that date.

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**ARTICLE 3**

**THE REGULATED ALL-PAYER OPTION**

Section 1. Minnesota Statutes 1993 Supplement, section 62P.01, is amended to read:

**62P.01 REGULATED ALL-PAYER ~~SYSTEM~~ OPTION.**

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

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Minnesota residents. The purpose of the regulated all-payer option is to provide an alternative to integrated service networks for those consumers, providers, third-party payers, and group purchasers who prefer to participate in a fee-for-service system. The initial goal of the all-payer option is to reduce administrative costs and burdens by including the all-payer option in a uniform, standardized system of billing forms and procedures and utilization review. The longer-term goal of the all-payer option is to establish a uniform reimbursement system, reimbursement and utilization controls, and quality standards and monitoring; to ensure that the annual growth in the costs for all services not provided through integrated service networks will remain within the growth limits established under section 62J.04; and to ensure that quality for these services is maintained or improved.

Sec. 2. **[62P.02] DEFINITIONS.**

(a) For purposes of this chapter, the following definitions apply:

(b) "All-payer insurer" means a health carrier as defined in section 62A.011, subdivision 2. The term does not include community integrated service networks or integrated service networks licensed under chapter 62N.

(c) "All-payer reimbursement level" means the reimbursement amount specified by the all-payer reimbursement system.

(d) "All-payer reimbursement system" means the Minnesota-specific physician and independent provider fee schedule, the Minnesota-specific hospital reimbursement system, and other provider payment methods established under this chapter or rules adopted under this chapter.

(e) "Commissioner" means the commissioner of health.

(f) "Health care provider" has the meaning given in section 62J.03, subdivision 8.

Sec. 3. Minnesota Statutes 1993 Supplement, section 62P.03, is amended to read:

**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;

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(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;

(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 option shall begin to be phased in with full implementation of the all-payer reimbursement system by July 1, ~~1996~~ 1997. During the transition period, expenditure limits for health carriers shall be established in accordance with section 62P.04 and health care provider revenue limits shall be established in accordance with section 62P.05.

Sec. 4. Minnesota Statutes 1993 Supplement, section 62P.04, is amended to read:

**62P.04 EXPENDITURE INTERIM HEALTH PLAN COMPANY EXPENDITURE LIMITS FOR HEALTH PLAN COMPANY.**

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

(b) "Health carrier plan company" has the definition provided in section ~~62A.014~~ 62Q.01.

(c) "Total expenditures" means incurred claims or expenditures on health care services, administrative expenses, charitable contributions, and all other payments made by health plan companies out of premium revenues.

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(d) "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 "Net expenditures" means total expenditures minus exempted 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

(e) "Exempted taxes and assessments" means direct payments for taxes to government agencies, contributions to the Minnesota comprehensive health association, the medical assistance 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, assessments by the Minnesota risk adjustment association, and any new assessments imposed by federal or state law.

(f) "Consumer cost-sharing or subscriber liability" means enrollee coinsurance, copayment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. **ESTABLISHMENT.** The commissioner of health shall establish limits on the increase in ~~total net~~ expenditures by each health carrier plan company for calendar years 1994 and 1995, 1996, and 1997. 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~~ plan companies that are affiliates may elect to meet one combined expenditure limit.

Subd. 3. **DETERMINATION OF EXPENDITURES.** Health ~~carriers~~ plan companies shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993; ~~and by~~ April 1, 1995, for calendar year 1994; April 1, 1996, for calendar year 1995; April 1, 1997, for calendar year 1996; and April 1, 1998, for calendar year 1997 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~~ plan companies. 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~~ plan company 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~~ plan companies must be submitted to the commissioner by ~~September 1, 1993~~ September 1, 1994. Community integrated service networks may submit the information with their application for licensure.

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The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.

Subd. 4. **MONITORING OF RESERVES.** (a) The commissioner commissioners of health and commerce shall monitor health carrier plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates 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 plan companies 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, currently reviewed by the departments of health or commerce, may be approved for those health carriers plan companies unless the health carrier plan company 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.

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year. These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as an integrated service network or community integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end of the quarter and enrollment changes within each service area of the new organization. The reserve calculations shall be maintained by the commissioners as trade secret information, except to the extent that such information is also required to be filed by another provision of state law and is not treated as trade secret information under such other provisions.

(d) Health plan companies in paragraph (c) whose reserves are less than the required minimum or more than the required maximum at the end of the fiscal year shall submit a plan of corrective action to the commissioner of health or commerce under subdivision 7.

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(e) The commissioner of commerce, in consultation with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements.

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~~ plan companies that exceeded their expenditure ~~target limit~~ 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~~ plan companies that exceeded their combined expenditure limit for calendar years 1994 and 1995. The commissioner shall notify each health ~~carrier~~ plan company that the commissioner has determined that the ~~carrier~~ health plan company exceeded its expenditure limit, at least 30 days before publishing the list, and shall provide each ~~carrier~~ health plan company with ten days to provide an explanation for exceeding the expenditure ~~target limit~~. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

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

Subd. 7. **ENFORCEMENT.** (a) The commissioners of health and commerce shall enforce the reserve limits referenced in subdivision 4, with respect to the health ~~carriers~~ plan companies that each commissioner respectively regulates. Each commissioner shall require health ~~carriers~~ plan companies 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~~ The plan of correction must address the following:

- (1) actuarial assumptions used in forecasting future financial results;
- (2) trend assumptions used in setting future premiums;
- (3) demographic, geographic, and private and public sector mix of the population covered by the health plan company;
- (4) proposed rate increases or decreases;
- (5) growth limits applied under section 62J.04, subdivision 1, paragraph (b);  
and

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(6) other factors deemed appropriate by the health plan company or commissioner.

If the health plan company's reserves exceed the required maximum, the plan of correction shall address how the health plan company will come into compliance and set forth a timetable within which compliance would be achieved. The plan of correction may propose premium refunds, credits for prior premiums paid, policyholder dividends, or any combination of these or other methods which will benefit enrollees and/or Minnesota residents and are such that the reserve requirements can reasonably be expected to be met. The commissioner's evaluation of the plan of correction must consider:

(1) whether implementation of the plan would provide the company with an unfair advantage in the market;

(2) the extent to which the reserve excess was created by any movement of enrolled persons to another organization formed by the company;

(3) whether any proposed premium refund, credit, and/or dividend represents an equitable allocation to policyholders covered in prior periods as determined using sound actuarial practice; and

(4) any other factors deemed appropriate by the applicable commissioner.

(b) The plan of correction is subject to approval by the commissioner of health or commerce, as applicable. If such a plan is not approved by the applicable commissioner, the applicable commissioner shall enter an order stating the steps that the health plan company must take to come into compliance. Within 30 days of the date of such order, the health plan company must file a notice of appeal with the applicable commissioner or comply with the commissioner's order. If an appeal is filed, such appeal is governed by chapter 14.

(c) Health plan companies that exceed the expenditure limits based on two-year average expenditure data or whose reserves exceed the limits referenced in subdivision 4 (1994 and 1995, 1996 and 1997) shall be required by the appropriate commissioner to pay back the amount ~~overspent~~ exceeding the expenditure limit through an assessment on the ~~carrier~~ health plan company. A health plan company may appeal the commissioner's order to pay back the amount exceeding the expenditure limit by mailing to the commissioner a written notice of appeal within 30 days from the date the commissioner's order was mailed. The contested case and judicial review provisions of chapter 14 apply to the appeal. The health plan company shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 3.762 to 3.765, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the health care access fund. The appropriate commissioner may approve a different repayment method to take into account the ~~carrier's~~ health plan company's financial condition. Health plan companies shall comply with the limits but shall also guarantee that their contractual obligations are met. Health plan

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companies are prohibited from meeting spending obligations by increasing subscriber liability, including copayments and deductibles and amounts in excess of benefit plan maximums.

Sec. 5. Minnesota Statutes 1993 Supplement, section 62P.05, is amended to read:

**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, 1996, and 1997. 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, certain taxes and assessments including the MinnesotaCare provider tax and provider surcharge, any new assessments imposed by federal or state law, research and education costs, donations, grants, and legislative initiatives that materially change health care ~~costs~~ revenues, 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~~ 1994. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner. ~~A health care provider's revenues for purposes of these growth limits are net of the contributions, surecharges, taxes, and assessments listed in section 62P.04, subdivision 1, 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 inpatient~~ revenue per adjusted admission and net ~~outpatient~~ revenue per outpatient visit. The commissioner shall monitor the revenue of physicians and other health care providers by examining revenue per patient per year or revenue per encounter. For purposes of this section, definitions related to the implementation of limits for providers other than hospitals are included in Minnesota Rules, chapter 4650, and definitions related to the implementation of limits for hospitals are included in Minnesota Rules, chapter 4651. 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~~ exceeding the revenue limits during the following calendar year.

Pharmacists may adjust their revenue figures for increases in drug product costs that are set by the manufacturer. The commissioner shall consult with pharmacy groups, including pharmacies, wholesalers, drug manufacturers, health plans, and other interested parties, to determine the methodology for measuring and implementing the interim growth limits while taking into account the adjustments for drug product costs.

The commissioner shall monitor providers meeting the growth limits based on their current fees on an annual basis. The fee charged for each service must be based on a weighted average across 12 months and compared to the weighted average for the previous 12-month period. The percentage increase in the average fee from 1993 to 1994, from 1994 to 1995, from 1995 to 1996, and from 1996 to 1997 is subject to the growth limits established under section 62J.04, subdivision 1, paragraph (b). The audit process may include a review of the provider's monthly fee schedule, and a random claims analysis for the provider during different parts of the year to monitor variations in fees. The commissioner shall require providers that exceed growth limits, based on annual fees, to pay back during the following calendar year the amount of fees received exceeding the limit.

The commissioner shall notify each provider that has exceeded its revenue or fee limit, at least 30 days before taking action, and shall provide each provider with ten days to provide an explanation for exceeding the revenue or fee limit. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

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.

A provider may appeal the commissioner's order to pay back the amount exceeding the revenue or fee limit by mailing a written notice of appeal to the commissioner within 30 days after the commissioner's order was mailed. The

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contested case and judicial review provisions of chapter 14 apply to the appeal. The provider shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 3.762 to 3.765, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the health care access fund.

**Sec. 6. [62P.07] SCOPE.**

Subdivision 1. GENERAL APPLICABILITY. (a) Minnesota health care providers shall comply with the requirements and rules established under this chapter for: (1) all health care services provided to Minnesota residents who are not enrolled in a community integrated service network or an integrated service network; (2) all out-of-network services provided to enrollees of community integrated service networks and integrated service networks; and (3) all health care services provided to persons covered by an all-payer insurer.

(b) All-payer insurers shall comply with the requirements and rules established under this chapter for all coverage provided.

(c) Community integrated service networks and integrated service networks shall comply with the requirements and rules established under this chapter when reimbursing health care providers for out-of-network services.

Subd. 2. PROGRAMS EXCLUDED. This chapter does not apply to services reimbursed under Medicare, medical assistance, general assistance medical care, the MinnesotaCare program, or worker's compensation programs.

Subd. 3. PAYMENT REQUIRED AT ALL-PAYER LEVEL. (a) All reimbursements to Minnesota health care providers from all-payer insurers, for services provided to covered persons, shall be at the all-payer reimbursement level.

(b) All-payer insurers shall reimburse out-of-state health care providers for nonemergency services provided to covered persons at the all-payer reimbursement level. For purposes of this paragraph, "nonemergency services" means services that do not meet the definition of "emergency care" under Minnesota Rules, part 4685.0100, subpart 5.

(c) Community integrated service networks and integrated service networks shall reimburse Minnesota health care providers for out-of-network services at the all-payer reimbursement level.

(d) Community integrated service networks and integrated service networks shall reimburse out-of-network health care providers located out-of-state for nonemergency out-of-network services at the all-payer reimbursement level. For purposes of this paragraph, "nonemergency out-of-network services" means out-of-network services that do not meet the definition of "emergency care" under Minnesota Rules, part 4685.0100, subpart 5.

Subd. 4. BALANCE BILLING PROHIBITED. Minnesota health care pro-

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viders shall accept reimbursement at the all-payer reimbursement level, including applicable copayments, deductibles, and coinsurance, as payment in full for services provided to Minnesota residents and persons covered by all-payer insurers, and for out-of-network services provided to enrollees of community integrated service networks and integrated service networks.

**Sec. 7. [62P.09] DUTIES OF THE COMMISSIONER.**

Subdivision 1. GENERAL DUTIES. The commissioner of health is responsible for developing and administering the all-payer option. The commissioner shall:

(1) develop, implement, and administer fee schedules for physicians and providers with independent billing rights;

(2) develop, implement, and administer a reimbursement system for hospitals and other institutional providers, but excluding intermediate care facilities for the mentally retarded, nursing homes, state-operated community service sites operated by the commissioner of human services, and regional treatment centers;

(3) modify and adjust all-payer reimbursement levels so that health care spending under the all-payer option does not exceed the growth limits on health care spending established under section 62J.04;

(4) collect data from all-payer insurers, health care providers, and patients to monitor revenues, spending, and quality of care;

(5) provide incentives for the appropriate utilization of services and the appropriate use and distribution of technology;

(6) coordinate the development and administration of the all-payer option with the development and administration of the integrated service network system; and

(7) develop and implement a fair and efficient system for resolving appeals by providers and insurers.

Subd. 2. COORDINATION. The commissioner shall regularly consult with the commissioner of commerce in developing and administering the all-payer option and in applying the all-payer reimbursement system to health carriers regulated by the commissioner of commerce.

Subd. 3. TIMELINES FOR IMPLEMENTATION. In developing and implementing the all-payer option, the commissioner shall comply with the following implementation schedule:

(a) The phase-in of standardized billing requirements must be completed following the timetable set forth in article 9.

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(b) The phase-in of the all-payer reimbursement system must begin January 1, 1996, or upon the date rules for the all-payer option reimbursement system are adopted, whichever is later.

(c) The all-payer reimbursement system must be fully implemented by July 1, 1997.

Subd. 4. ADVISORY COMMITTEE. The commissioner shall convene an advisory committee made up of a broad array of health care professionals that will be affected by the fee schedule. Recommendations of this committee must be submitted to the commissioner by November 15, 1994, and may be incorporated in the implementation report due January 1, 1995.

Subd. 5. RULEMAKING. The commissioner shall adopt rules to establish and administer the all-payer option. The rules must include, but are not limited to: (1) the reimbursement methods used in the all-payer option reimbursement system; (2) a plan and implementation schedule to phase-in the all-payer reimbursement system, beginning January 1, 1996; and (3) mechanisms to ensure compliance by all-payer insurers, health care providers, and patients with the all-payer reimbursement system and the growth limits established under section 62J.04. The commissioner shall seek to ensure that the rules for the all-payer option are adopted by January 1, 1996. The commissioner shall comply with section 62J.07, subdivision 3, when adopting rules for the all-payer option.

#### **Sec. 8. [62P.11] PAYMENT TO PHYSICIANS AND INDEPENDENT PROVIDERS.**

Subdivision 1. FEE SCHEDULE. The commissioner shall adopt a Minnesota-specific fee schedule, based upon the Medicare resource based relative value scale, to reimburse physicians and other independent providers. The fee schedule must assign each service a relative value unit that measures the relative resources required to provide the service. Payment levels for each service must be determined by multiplying relative value units by a conversion factor that converts relative value units into monetary payment. The conversion factor used to derive the fee schedule must be set at a level that is consistent with current relevant health care spending, subject to the state's growth limits as defined in section 62J.04. The conversion factor must be set at a level that equalizes total aggregate expenditures for a given period before and after implementation of the all-payer option.

Subd. 2. DEVELOPMENT AND MODIFICATION OF RELATIVE VALUE UNITS. (a) When appropriate, the relative value unit for each service shall be the Medicare value adjusted to reflect Minnesota health care costs. The commissioner may assign a different relative value to a service if, in the judgment of the commissioner, the Medicare relative value unit is not accurate. The commissioner may also develop or adopt relative value units for services not covered under the Medicare resource based relative value scale. Except as provided in paragraph (b), modifications or additions to relative value units are subject to the rulemaking requirements of chapter 14.

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(b) The commissioner may modify the relative value units used in the Minnesota-specific fee schedule, or change the number of services assigned relative value units, to reflect changes and improvements in the Medicare resource based relative value scale. When adopting these federal changes, the commissioner is exempt from the rulemaking requirements of chapter 14, but shall publish a notice of modifications and additions to relative value units in the State Register 30 days before they take effect.

Subd. 3. DEVELOPMENT OF THE CONVERSION FACTOR. The commissioner shall develop a conversion factor using actual Minnesota claims data available to the commissioner.

**Sec. 9. [62P.13] VOLUME PERFORMANCE STANDARD FOR PHYSICIAN AND OUTPATIENT SERVICES.**

Subdivision 1. DEVELOPMENT. The commissioner shall establish an annual, statewide volume performance standard for physician and outpatient services. The volume performance standard shall serve as an expenditure target and must be set at a level that is consistent with achieving the growth limits pursuant to section 62J.04. The volume performance standard must combine expenditures for all services provided by physicians and other independent providers and all ambulatory care services that are not provided through an integrated service network. The statewide volume performance standard must be developed from aggregate and encounter level data reported to the state, including the claims database established under section 62J.38, when it becomes operational.

Subd. 2. APPLICATION. The commissioner shall compare actual expenditures for physician and outpatient services with the volume performance standard in order to keep the all-payer option expenditures within the statewide growth limits. If total expenditures during a particular year exceed the expenditure target for that year, the commissioner shall update the fee schedule rates for the second year following the year in which the target was exceeded, by adjusting the conversion factor, in order to offset this increase.

**Sec. 10. [62P.15] REIMBURSEMENT.**

The commissioner, as part of the implementation report due January 1, 1995, shall recommend to the legislature and the governor which health care professionals should be paid at the full fee schedule rate and which at a partial rate, for services covered in the fee schedule.

**Sec. 11. [62P.17] PAYMENT FOR SERVICES NOT IN THE FEE SCHEDULE.**

The commissioner shall examine options for paying for services not covered in the fee schedule and shall present recommendations to the legislature and the governor as part of the implementation report due January 1, 1995. The options examined by the commissioner must include, but are not limited to, updates and

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modifications to the Medicare resource based relative value scale; development of additional relative value units; development of a fee schedule based on a percentage of usual, customary, and reasonable charges; and use of rate of increase controls.

**Sec. 12. [62P.19] PAYMENT FOR URBAN AND SELECTED RURAL HOSPITALS.**

Subdivision 1. ESTABLISHMENT OF RATE. The commissioner shall develop a Minnesota-specific hospital reimbursement system to pay for inpatient services in those acute-care general hospitals not qualifying for reimbursement under section 62P.25. In developing this system, the commissioner shall consider the all-patient refined diagnosis related groups system and other diagnosis related groups systems. Payment rates must be standardized on a statewide basis based on Minnesota specific claims level data available to the commissioner. Rates must be consistent with the overall growth limit for health care spending. Payment rates may be adjusted for area wage rates and other factors, including uncompensated care. The commissioner shall recommend any needed adjustments to the legislature and governor as part of the implementation report due January 1, 1995.

Subd. 2. SHORT STAY AND LONG STAY OUTLIERS. The reimbursement system must provide, on a budget neutral basis, lower charges for self-pay patients with short or low cost stays. The commissioner shall phase out this exception once universal coverage is achieved. The commissioner, as part of the implementation report due January 1, 1995, shall recommend to the legislature and the governor whether an outlier payment for long stays is needed.

**Sec. 13. [62P.21] STATEWIDE VOLUME PERFORMANCE STANDARD FOR HOSPITALS.**

Subdivision 1. DEVELOPMENT. The commissioner shall establish an annual, statewide volume performance standard for inpatient hospital expenditures. The volume performance standard shall serve as an expenditure target and must be set at a level that is consistent with meeting the limits on health care spending growth.

Subd. 2. APPLICATION. The commissioner shall compare actual inpatient hospital expenditures with the volume performance standard in order to keep all-payer option expenditures within the statewide growth limits. If aggregate inpatient hospital expenditures for a particular year exceed the volume performance standard, the commissioner shall adjust the annual increase in payment levels for the following year.

**Sec. 14. [62P.23] FLEXIBILITY IN APPLYING THE VOLUME PERFORMANCE STANDARD; REVIEW.**

Subdivision 1. REALLOCATION. The commissioner may reallocate spending limits between the inpatient hospital services volume performance standard

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and the physician and outpatient services volume performance standard, if this promotes the efficient use of health care services and does not cause total health care spending in the all-payer option to exceed the level allowed by the growth limits on health care spending.

Subd. 2. REVIEW. The commissioner shall review the effectiveness of the volume performance standard after the first three years of operation and shall recommend any necessary changes to the legislature and the governor.

**Sec. 15. [62P.25] REIMBURSEMENT FOR SMALL RURAL HOSPITALS.**

All-payer insurers shall pay small rural hospitals on the basis of reasonable charges, subject to a rate of increase control. For purposes of this requirement, a "small rural hospital" means a hospital with 40 or fewer licensed beds that is located at least 25 miles from another facility licensed under sections 144.50 to 144.58 and operating as an acute care community hospital. The commissioner shall recommend to the legislature and the governor a methodology for determining reasonable charges as part of the implementation report due January 1, 1995.

**Sec. 16. [62P.27] PAYMENT FOR OUTPATIENT SERVICES.**

Outpatient services provided in acute-care general hospitals and freestanding ambulatory surgery centers shall be paid on the basis of approved charges, subject to rate of increase controls. The rate of increase allowed must be consistent with the volume performance standard for physician and outpatient services.

**Sec. 17. [62P.29] OTHER INSTITUTIONAL PROVIDERS.**

Subdivision 1. SPECIALTY HOSPITALS AND HOSPITAL UNITS. The commissioner shall develop payment mechanisms for specialty hospitals providing pediatric and psychiatric care and distinct psychiatric and rehabilitation units in hospitals. The commissioner shall present these recommendations to the legislature and governor as part of the implementation report due January 1, 1995.

Subd. 2. OTHER PROVIDERS. The commissioner shall apply rate of increase limits on charges or fees to other nonhospital institutional providers. These providers include, but are not limited to, home health agencies, substance abuse treatment centers, and nursing homes, to the extent their services are included in the all-payer option. In setting rate of increase limits for institutional providers, the commissioner shall consider outcomes, comprehensiveness of services, and the special needs and severity of illness of patients treated by individual providers.

**Sec. 18. [62P.31] LIMITATIONS ON ALL-PAYER OPTION.**

Beginning July 1, 1997, all-payer insurers shall not employ or contract with

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health care providers, establish a network of exclusive or preferred providers, or negotiate provider payments that differ from the all-payer fee schedule. Preferred provider organizations may continue to provide care to their existing enrollees, without becoming licensed as an integrated service network, through December 31, 1997.

**Sec. 19. [62P.33] RECOMMENDATIONS FOR A USER FEE.**

The commissioner of health shall present to the legislature, as part of the implementation plan due January 1, 1996, recommendations for establishing and collecting a user fee from all-payer insurers. The user fee must be set at a level that reflects the state's investment in fee schedules, standard utilization reviews, quality monitoring, and other regulatory and administrative functions provided for the regulated all-payer option. The commissioner may consult actuaries in developing recommendations for and setting the level of the user fee. The commissioner may also present recommendations to establish additional fees and assessments if the commissioner determines they are needed to assure equal levels of accountability between the integrated service network system and the regulated all-payer option in terms of public health goals, serving high-risk and special needs populations, and other obligations imposed on the integrated service network system.

Sec. 20. Minnesota Statutes 1992, section 72A.20, is amended by adding a subdivision to read:

Subd. 31. REASONABLE, ADEQUATE, AND NOT PREDATORY PREMIUMS. Premiums charged by a health plan company, as defined in section 62Q.01, shall be reasonable, adequate, and not predatory in relation to the benefits, considering actuarial projection of the cost of providing or paying for the covered health services, considering the costs of administration, and in relation to the reserves and surplus required by law.

**Sec. 21. STUDY OF STANDARD UTILIZATION REVIEW CRITERIA FOR SERVICES.**

The commissioner of health, after consulting with providers, utilization review organizations, the practice parameters advisory committee, and the health technology advisory committee, shall report to the legislature by July 1, 1995, and recommended clinical criteria for determining the necessity, appropriateness, and efficacy of five frequently used health care services for which standard criteria for utilization review would decrease providers' administrative costs.

**Sec. 22. INSTRUCTION TO THE REVISOR.**

The revisor, in the next edition of Minnesota Statutes, shall replace the term "regulated all-payer system" and similar terms with "regulated all-payer option" and similar terms in sections 62J.04, 62J.09, 62J.152, 62P.01 and 62P.03.

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Sec. 23. **EFFECTIVE DATE.**

Sections 1 to 22 are effective the day following final enactment.

ARTICLE 4

**FUTURE REQUIREMENTS FOR HEALTH PLAN COMPANIES**

Section 1. [62J.48] **CRITERIA FOR REIMBURSEMENT.**

All ambulance services licensed under section 144.802 are eligible for reimbursement under the integrated service network system and the regulated all-payer option. The commissioner shall require community integrated service networks, integrated service networks, and all-payer insurers to adopt the following reimbursement policies.

(1) All scheduled or prearranged air and ground ambulance transports must be reimbursed if requested by an attending physician or nurse, and, if the person is an enrollee in an integrated service network or community integrated service network, if approved by a designated representative of an integrated service network or a community service network who is immediately available on a 24-hour basis. The designated representative must be a registered nurse or a physician assistant with at least three years of critical care or trauma experience, or a licensed physician.

(2) Reimbursement must be provided for all emergency ambulance calls in which a patient is transported or medical treatment rendered.

(3) Special transportation services must not be billed or reimbursed if the patient needs medical attention immediately before transportation.

Sec. 2. Minnesota Statutes 1993 Supplement, section 62N.06, subdivision 1, is amended to read:

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 an existing 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, that does not explicitly mention the provider's relationship within an integrated service network, or a future integrated service network, 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

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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 service 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.

Sec. 3. [625N.14] OFFICE OF CONSUMER SERVICES.

Subdivision 1. DUTIES. Every integrated service network must have an office of consumer services which will be responsible for dealing with all enrollee complaints and inquiries. The integrated service network, through its office of consumer services, will be responsible for:

(1) soliciting consumer comment on the quality and accessibility of services available;

(2) disseminating information to consumers on the integrated service network's enrollee complaint resolutions system;

(3) receiving unsolicited comments on and complaints about services;

(4) taking prompt action upon consumer complaints; and

(5) providing for and participating in alternative dispute resolution processes including the fact-finding and dispute resolution process established under section 62Q.30.

Subd. 2. CONTACT WITH COMMISSIONER. Each integrated service network shall designate a contact person for direct communication with the commissioner. Integrated service network complaint files must be maintained by the integrated service network for seven years and must be made available upon the request of the commissioner. The commissioner shall periodically summarize the number, type, and resolution of complaints received by the health department from integrated service network enrollees, and shall make that information available through the office of consumer information. The commissioner may at any time inspect the integrated service network's office of consumer services complaint files.

Subd. 3. ENROLLEE MEMBERSHIP CARDS. Integrated service networks shall issue enrollee membership cards to each enrollee of the integrated service network. The enrollee card shall contain, at minimum, the following information:

(1) the telephone number of the integrated service network's office of consumer services;

(2) the telephone number of the state's office of consumer information; and

(3) the telephone number of the department of health or local ombuds-person.

The membership cards shall also conform to the requirements set forth in section 62J.60.

Subd. 4. ENROLLEE DOCUMENTS. Each integrated service network, through its office of consumer services, is responsible for providing enrollees, upon request, with any reasonable information desired by an enrollee. This information may include duplicate copies of the evidence of coverage form required under section 62N.11; an annually updated list of addresses and telephone numbers of available integrated service network providers, including midlevel practitioners and allied professionals; and information on the enrollee complaint system of the integrated service network.

#### **Sec. 4. [62N.38] FEDERAL AGENCY PARTICIPATION.**

Subdivision 1. PARTICIPATION. An integrated service network may be organized by a department, agency, or instrumentality of the United States government.

Subd. 2. ENROLLEES. An integrated service network organized under subdivision 1 may limit its enrollment to those persons entitled to care under the federal program responsible for the integrated service network.

Subd. 3. PARTICIPATION IN STATE PROGRAMS. An integrated service network organized under subdivision 1 may request that the commissioner of health waive the requirement of section 62N.10, subdivision 4 with regard to some or all of the programs listed in that provision. The commissioner shall grant the waiver unless the commissioner determines that the applicant does not plan to provide care to low-income persons who are otherwise eligible for enrollment in the integrated service network. The integrated service network may withdraw its waiver with respect to some or all of the programs listed in section 62N.10, subdivision 4 at any time, as long as it is willing and able to enroll in the programs previously waived on the same basis as other integrated service networks.

Subd. 4. SOLVENCY. The commissioner shall consult with federal officials to develop procedures to allow integrated service networks organized under subdivision 1 to use the United States government as a guaranteeing organization.

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Subd. 5. VETERANS. In developing and implementing initiatives to expand access to health care, the commissioner shall recognize the unique problems of veterans and consider methods to reach underserved portions of the veteran population.

**Sec. 5. [62N.381] AMBULANCE SERVICE RATE NEGOTIATION.**

Subdivision 1. APPLICABILITY. This section applies to all reimbursement rate negotiations between ambulance services and community integrated service networks or integrated service networks.

Subd. 2. RANGE OF RATES. The reimbursement rate negotiated for a contract period must not be more than 20 percent above or below the individual ambulance service's current customary charges, plus the rate of growth allowed under section 62J.04, subdivision 1. If the network and ambulance service cannot agree on a reimbursement rate, each party shall submit their rate proposal along with supportive data to the commissioner.

Subd. 3. DEVELOPMENT OF CRITERIA. The commissioner, in consultation with representatives of the Minnesota Ambulance Association, regional emergency medical services programs, community integrated service networks and integrated service networks, shall develop guidelines to use in reviewing rate proposals and making a final reimbursement rate determination.

Subd. 4. REVIEW OF RATE PROPOSALS. The commissioner, using the guidelines developed under subdivision 3, shall review the rate proposals of the ambulance service and community integrated service network or integrated service network and shall adopt either the network's or the ambulance service's proposal. The commissioner shall require the network and ambulance service to adhere to this reimbursement rate for the contract period.

Subd. 5. EXPIRATION. This section expires July 1, 1996.

**Sec. 6. [62Q.19] ESSENTIAL COMMUNITY PROVIDERS.**

Subdivision 1. DESIGNATION. The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations as defined in section 62Q.07, subdivision 2, paragraph (e), underserved, and other special needs populations; and

(2) a commitment to serve low-income and underserved populations by meeting the following requirements:

(i) has nonprofit status in accordance with chapter 317A;

(ii) has tax exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);

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(iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and

(iv) does not restrict access or services because of a client's financial limitation; or

(3) status as a local government or community health board as defined in chapter 145A.

The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

Subd. 2. APPLICATION. Any provider may apply to the commissioner for designation as an essential community provider within two years after the effective date of the rules adopted by the commissioner to implement this section.

Subd. 3. HEALTH PLAN COMPANY AFFILIATION. A health plan company must offer a provider contract to any designated essential community provider located within the area served by the health plan company. A health plan company shall not restrict enrollee access to the essential community provider for the population that the essential community provider is certified to serve. A health plan company may also make other providers available to this same population. A health plan company may require an essential community provider to meet all data requirements, utilization review, and quality assurance requirements on the same basis as other health plan providers.

Subd. 4. ESSENTIAL COMMUNITY PROVIDER RESPONSIBILITIES. Essential community providers must agree to serve enrollees of all health plan companies operating in the area that the essential community provider is certified to serve.

Subd. 5. CONTRACT PAYMENT RATES. An essential community provider and a health plan company may negotiate the payment rate for covered services provided by the essential community provider. This rate must be competitive with rates paid to other health plan providers for the same or similar services.

Subd. 6. TERMINATION. The designation as an essential community provider is terminated five years after it is granted, and the former essential community provider has no rights or privileges beyond those of any other health care provider.

Subd. 7. RECOMMENDATIONS AND RULEMAKING ON ESSENTIAL COMMUNITY PROVIDERS. (a) As part of the implementation plan due January 1, 1995, the commissioner shall present proposed rules and any

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necessary recommendations for legislation for defining essential community providers, using the criteria established under subdivision 1, and defining the relationship between essential community providers and health plan companies.

(b) By January 1, 1996, the commissioner shall adopt rules for establishing essential community providers and for governing their relationship with health plan companies. The commissioner shall also identify and address any conflict of interest issues regarding essential community provider designation for local governments.

**Sec. 7. [62Q.21] UNIVERSAL STANDARD BENEFITS SET.**

Subdivision 1. MANDATORY OFFERING. Effective January 1, 1996, each health plan company shall offer the universal standard benefits set to its enrollees.

Subd. 2. STANDARD BENEFIT SET. Effective July 1, 1997, health plan companies shall offer, sell, issue, or renew only the universal standard benefits set and the cost-sharing and supplemental coverage options established in accordance with sections 62Q.25 and 62Q.27.

Subd. 3. GENERAL DESCRIPTION. The universal standard benefits set must contain all appropriate and necessary health care services. Benefits necessary to meet public health goals, adequately serve high risk and special needs populations, facilitate the utilization of cost effective alternatives to traditional inpatient acute and extended health care delivery, or meet other objectives of health care reform shall be considered by the commissioner for inclusion in the universal standard benefits set. Appropriate and necessary dental services must be included.

Subd. 4. BENEFIT SET RECOMMENDATIONS. The commissioner of health, in consultation with the Minnesota health care commission and the commissioners of human services and commerce, shall develop the universal standard benefits set and report these recommendations to the legislature by January 1, 1995. The commissioners shall include in this report a definition for appropriate and necessary care, in terms of type, frequency, level, setting, and duration of services which address the enrollee's mental and physical condition. In developing this definition, the commissioners shall consider that a benefit set that excludes genuinely appropriate and necessary services will not reduce or contain costs, but will only transfer those costs onto individuals and the public sector. Therefore, the definition of appropriate and necessary care must be sufficiently broad to address the needs of those with chronic conditions or disabilities, including those who need health services to improve their functioning, and those for whom maintenance of health may not be possible and those for whom preventing deterioration in their health conditions might not be achievable, and meet other health care reform objectives. In developing the universal standard benefits set, the commissioners shall take into account factors including, but not limited to:

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- (1) information regarding the benefits, risks, and cost-effectiveness of health care interventions;
- (2) development of practice parameters;
- (3) technology assessments;
- (4) medical innovations;
- (5) health status assessments;
- (6) identification of unmet needs or particular barriers to access;
- (7) public health goals;
- (8) expenditure limits and available funding;
- (9) cost savings resulting from the inclusion of a health care service that will decrease the utilization of other health care services in the benefit set;
- (10) cost efficient and effective alternatives to inpatient health care services for acute or extended health care needs, such as home health care services; and
- (11) the desirability of including coverage for all court-ordered mental health services for juveniles.

**Subd. 5. ADVISORY COMMITTEE ON THE UNIVERSAL BENEFITS SET.** The commissioner shall appoint an advisory committee to develop recommendations regarding the services other than dental services to be included in the universal benefits set. The committee must include representatives of health care providers, purchasers, consumers, health plan companies, and counties. The health care provider representatives must include both physicians and allied independent health care providers representing both physical and mental health conditions. The committee shall report these recommendations to the commissioner by October 1, 1994.

**Subd. 6. ADVISORY COMMITTEE ON DENTAL SERVICES.** The commissioner shall appoint an advisory committee to develop recommendations regarding the level of appropriate and necessary dental services to be included in the universal standard benefits set. The committee shall also develop recommendations on an appropriate system to deliver dental services. In its analysis the committee shall study the quality and cost-effectiveness of dental services delivered through capitated dental networks, discounted dental preferred provider organizations, and independent practice dentistry. The committee shall report these recommendations to the commissioner by October 1, 1994.

**Subd. 7. CHEMICAL DEPENDENCY SERVICES.** If chemical dependency services are included in the universal standard benefits set, the commissioner shall consider the cost effectiveness of requiring health plan companies and chemical dependency facilities to use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660.

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Sec. 8. [62Q.23] GENERAL SERVICES.

(a) Health plan companies shall comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(b) Health plan companies shall comply with sections 62A.047, 62A.27, and any other coverage required under chapter 62A of newborn infants, dependent children who do not reside with a covered person, handicapped children and dependents, and adopted children. A health plan company providing dependent coverage shall comply with section 62A.302.

(c) Health plan companies shall comply with the equal access requirements of section 62A.15.

Sec. 9. [62Q.25] SUPPLEMENTAL COVERAGE.

Health plan companies may choose to offer separate supplemental coverage for services not covered under the universal benefits set. Health plan companies may offer any Medicare supplement, Medicare select, or other Medicare-related product otherwise permitted for any type of health plan company 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.

Sec. 10. [62Q.27] ENROLLEE COST-SHARING.

(a) The commissioner, as part of the implementation plan due January 1, 1995, shall present to the legislature recommendations and draft legislation to establish up to five standardized benefit plans which may be offered by each health plan company. 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. Each plan offered may include out-of-network coverage options.

(b) For purposes of this section, "enrollee 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 following principles must apply to cost-sharing:

(1) enrollees must have a choice of cost-sharing arrangements;

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

(3) cost-sharing for recipients of medical assistance, general assistance medical care, or the MinnesotaCare program must be determined by applicable law and rules governing these programs;

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(4) cost-sharing must be capped at an annual limit determined by the commissioner to protect individuals and families from severe financial hardship and to protect individuals with substantial health care needs;

(5) cost-sharing must not be applied to preventive health services as defined in Minnesota Rules, part 4685.0801, subpart 8;

(6) the impact of enrollee cost-sharing requirements on appropriate utilization must be considered when cost-sharing requirements are developed;

(7) additional requirements may be established to assist enrollees for whom an inducement in addition to the elimination of cost-sharing 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;

(8) a copayment may be no greater than 25 percent of the paid charges for the service or product;

(9) 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

(10) 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.

(d) The commissioner shall consider whether a health plan company may return to the enrollee all or part of an enrollee's premium as an incentive for completing preventive care, and may return all or part of an enrollee's cost-sharing for participating in health education, improving health, or reducing health risks.

#### Sec. 11. [62Q.29] STATE-ADMINISTERED PUBLIC PROGRAMS.

Public agencies, in conjunction with the department of health and the department of human services, on behalf of eligible recipients enrolled in public programs such as medical assistance, general assistance medical care, and MinnesotaCare, may contract with health plan companies to provide services included in these programs, but not included in the universal standard benefits set.

#### Sec. 12. [62Q.30] EXPEDITED FACT FINDING AND DISPUTE RESOLUTION PROCESS.

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The commissioner shall establish an expedited fact finding and dispute resolution process to assist enrollees of integrated service networks and all-payer insurers with contested treatment, coverage, and service issues to be in effect July 1, 1997. The commissioner may order an integrated service network or an all-payer insurer to provide or pay for a service that is within the universal standard benefits set. If the disputed issue relates to whether a service is appropriate and necessary, the commissioner shall issue an order only after consulting with appropriate experts knowledgeable, trained, and practicing in the area in dispute, reviewing pertinent literature, and considering the availability of satisfactory alternatives. The commissioner shall take steps including but not limited to fining, suspending, or revoking the license of an integrated service network or an all-payer insurer that is the subject of repeated orders by the commissioner that suggests a pattern of inappropriate underutilization.

#### Sec. 13. COMPLAINT PROCEDURE.

The commissioners of health and commerce shall develop an internal grievance procedure and appeals process to be used by all health plan companies. The commissioner shall make a report of recommendations to the legislature by January 1, 1995. In developing the report and recommendations, the commissioner shall consider the current prepaid medical assistance and health maintenance organization internal grievance procedure as models.

#### Sec. 14. EFFECTIVE DATE.

- (a) Sections 2 and 7 are effective the day following final enactment.
- (b) Sections 1, 3, 4, 6, 10, 12, and 13 are effective July 1, 1994.
- (c) Section 5 is effective January 1, 1995.
- (d) Sections 8, 9, and 11 are effective July 1, 1997.

### ARTICLE 5

#### IMPLEMENTATION AND TRANSITION PLANS

##### Section 1. [62Q.41] ANNUAL IMPLEMENTATION REPORT.

The commissioner of health, in consultation with the Minnesota health care commission, shall develop an annual implementation report to be submitted to the legislature each year beginning January 1, 1995, describing the progress and status of rule development and implementation of the integrated service network system and the regulated all-payer option, and providing recommendations for legislative changes that the commissioner determines may be needed.

##### Sec. 2. TRANSITION PLAN.

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The commissioner of health, in consultation with the Minnesota health care commission, shall develop a plan to facilitate the transition from the existing health care delivery and financing system to the integrated service network system and the regulated all-payer option. The plan may include recommendations for integrated service network requirements or other requirements that should become applicable to some or all health plan companies prior to July 1, 1997, and recommendations for requirements that should be modified or waived during a transition period after July 1, 1997, as health plan companies convert to integrated service networks or to the regulated all-payer option. The transition plan must be submitted to the legislature by January 1, 1995.

### Sec. 3. INTEGRATED STATE ADMINISTERED PUBLIC PROGRAM.

The commissioner of human services in consultation with representatives of counties and consumer groups shall develop an implementation plan for the integration of MinnesotaCare and general assistance medical care into a single cost effective program by July 1, 1996, adding medical assistance into this integrated program under a federal demonstration project waiver by July 1, 1997. The commissioner shall submit the plan including necessary implementation legislation to the legislature by February 1, 1995. The legislation must include:

(1) a definition of services covered by the integrated program, excluding supplemental and long-term care benefits, and supporting actuarial data;

(2) a single set of criteria to determine eligibility for the integrated program;

(3) a request to seek a federal demonstration project waiver to include medical assistance in the integrated program; and

(4) a plan to define the scope and delivery of supplemental long-term care benefits to special populations.

The commissioner will present an update and an initial budget analysis to the legislative commission on health care access no later than December 1, 1994.

### Sec. 4. STATE ADMINISTERED PUBLIC PROGRAM PHASE-IN.

(a) The commissioner of human services shall present to the legislature and the governor, as part of the implementation report due January 1, 1996, a plan to incorporate state administered health programs into the all-payer option and the integrated service network system. The plan must identify the federal waivers and approvals required. The plan must also provide a schedule for phasing in the state administered health programs beginning July 1, 1997, and for increasing reimbursement levels in stages over the phase-in period. For purposes of this section, "state administered health programs" means the medical assistance, general assistance medical care, and MinnesotaCare programs.

(b) The commissioners of human services and employee relations shall include with the plan required under paragraph (a) recommendations, including proposed legislation, for a coordinated program for purchasing health care services for the state employees group insurance program and recipients of state administered health programs, to be phased in beginning July 1, 1997.

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(c) The recommendations shall include a requirement that health plan companies interested in contracting to serve enrollees or recipients of the programs listed in paragraph (b) submit a bid to provide services to all enrollees and recipients of those programs residing within the plan's service area.

(d) The commissioners of human services and employee relations must convene an advisory task force to assist with the preparation of plans, recommendations, and legislation required by this section. The task force must include representatives of recipients of the publicly paid health care programs, providers with substantial experience in providing services to recipients of these programs, county human services, exclusive representatives of state employees, and other affected persons.

(e) The commissioners of human services and employee relations may begin integrating administrative functions relating to the purchase of health care prior to July 1, 1997, that do not affect eligibility or coverage policy for medical assistance, general assistance medical care, or MinnesotaCare enrollees. All integration shall be included in the report required under paragraph (a).

#### Sec. 5. RECODIFICATION AND HEALTH PLAN COMPANY REGULATORY REFORM.

Subdivision 1. PROPOSED LEGISLATION. The commissioners of health and commerce, in consultation with the Minnesota health care commission and the legislative commission on health care access, shall draft proposed legislation to recodify, simplify, and standardize all statutes, rules, regulatory requirements, and procedures relating to health plan companies. The recodification and regulatory reform must become effective simultaneously with the full implementation of the integrated service network system and the regulated all-payer option on July 1, 1997. The commissioners of health and commerce shall submit to the legislature by January 1, 1996, a report on the recodification and regulatory reform with proposed legislation.

Subd. 2. ADVISORY TASK FORCE. The commissioner of health shall convene an advisory task force to advise the commissioner on the recodification and reform of regulatory requirements under this section. The task force must include representatives of health plan companies, consumers, counties, employers, labor unions, providers, and other affected persons.

#### Sec. 6. HEALTH REFORM DEMONSTRATION MODELS.

The commissioner of health, in consultation with appropriate state agencies, is authorized to seek federal and private foundation grants to supplement any funds appropriated under this act in order to conduct demonstration models to develop the implementation strategies for the various components of health care reform. The model projects may include the following:

- (1) risk adjustment formulas;

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(2) integration of special needs populations into integrated service networks;

(3) organization of health services delivery by post-secondary educational facilities;

(4) establishment of rural purchasing pools and cooperative service arrangements;

(5) integration of rural public health nursing agency services with rural community integrated service networks;

(6) development of appropriate access services which facilitate enrollment of low-income or special needs populations into integrated service networks;

(7) evaluation methods for the action plans prepared by health plan companies; and

(8) integration of services provided by licensed school nurses into integrated service networks.

#### Sec. 7. 24-HOUR COVERAGE.

As part of the implementation report submitted on January 1, 1996, as required under Minnesota Statutes, section 62Q.41, the commissioners of health and labor and industry shall develop a 24-hour coverage plan incorporating and coordinating the health component of workers' compensation with health care coverage to be offered by an integrated service network. The commissioners shall also make recommendations of any legislative changes that may be needed to implement this plan.

#### Sec. 8. AMBULANCE RATE STUDY.

(a) The commissioner of health in consultation with the Minnesota ambulance association and the regional emergency medical services systems shall study the feasibility and desirability of establishing a system of ambulance rate regulation. The commissioner shall report findings, conclusions, and recommendations to the legislature by February 1, 1995, as part of the report on the financial condition of licensed ambulance services in Minnesota required in Laws 1993, First Special Session chapter 1, article 1, section 3, subdivision 4.

(b) If the commissioner, under paragraph (a), recommends establishing a system of ambulance rate regulation, the commissioner, in consultation with the Minnesota ambulance association and the regional emergency medical services systems, shall develop a system of ambulance rate regulations for the integrated service network and all-payer option systems. The commissioner shall present recommendations and an implementation plan for this rate regulation system to the legislature by January 1, 1996.

#### Sec. 9. SINGLE PAYER STUDY.

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The legislative audit commission is requested to direct the legislative auditor to conduct an evaluation of the administrative cost of paying Minnesota health care providers through the multiple payers that currently reimburse the providers. The legislative auditor shall also analyze the administrative cost of paying Minnesota health care providers through one state government agency and, alternatively, through one private sector health carrier. "Administrative cost" includes: (1) the difference between all revenues received and all claims paid out by all publicly financed health programs and all private sector health carriers; and (2) billing costs for Minnesota health care providers. The legislative auditor shall also study the different types of administrative expenses, including costs that relate to the enhancement of quality of care. The report must, to the extent possible, rely solely on data collected from Minnesota health care providers, health carriers, and other group purchasers. The legislative auditor shall report findings of this study to the legislature by January 15, 1995.

#### Sec. 10. CONTINUED STUDY OF MEDICAL EDUCATION AND RESEARCH COSTS.

Subdivision 1. PURPOSE. The legislature finds that health care research and the preparation of future health care practitioners are of great importance to the quality of health care available to the citizens of this state; that medical education and research must be designed to meet the health needs of the population and the changing needs of the health care delivery system; and that the cost of medical education and research should not place institutions engaged in these activities at a competitive disadvantage in the marketplace.

Subd. 2. SCOPE OF STUDY. The commissioner of health shall continue the study developed as part of Minnesota Statutes, section 62J.045, on the impact of state health care reform on the financing of medical education and research activities in the state. The study shall address issues related to the institutions engaged in these activities, including hospitals, medical centers, and health plan companies, and will report on the need for alternative funding mechanisms for medical education and research activities. The commissioner shall monitor ongoing public and private sector activities related to the study of the financing of medical education and research activities and include a description of these activities in the final report as applicable. The commissioner shall submit a report on the study findings, including recommendations on mechanisms to finance medical education and research activities, to the legislature by February 15, 1995.

Subd. 3. RECOMMENDATIONS. The study shall explore both private and public alternatives for funding medical education and research activities. The study shall include recommendations which, when implemented, would:

(1) help to assure the coordination between federal and state funding mechanisms;

(2) help assure adequate funding to support medical education and research activities;

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(3) create alternative funding mechanisms, if necessary, to assure that medical education and research are responsive to the health needs of the population and the needs of Minnesota's health delivery system;

(4) help to assure that any changes in funding for medical education and health care research do not destabilize institutions that currently conduct, sponsor, or otherwise engage in health care research and medical education; and

(5) allocate the costs of medical education and research fairly across the health care system.

Subd. 4. TASK FORCE. The commissioner may appoint an advisory task force to provide expertise and advice on the study. The task force may include up to 20 members. The commissioner shall take under consideration representation of the following groups: the Minnesota association of public teaching hospitals and other nonteaching hospitals; private academic medical centers; the University of Minnesota medical school and its primary care residency programs; payer organizations including managed care, nonprofit health service plan organizations, and commercial carriers; other providers including the Minnesota medical association, the Minnesota nurses association, and others; a representative of the health technology advisory committee; employers; consumers; and medical researchers. The task force shall include representation of rural areas in the state.

#### Sec. 11. PREPAID MEDICAL ASSISTANCE PLAN STUDY.

The commissioners of health and human services shall study the coordination between health care reform and the prepaid medical assistance plan. The study must also determine whether there have been cost savings, cost increases, or cost shifting under current implementation of the prepaid medical assistance plan. The commissioners shall jointly report their findings to the legislature by January 1, 1995.

#### Sec. 12. EFFECTIVE DATE.

Sections 1 to 11 are effective the day following final enactment.

### ARTICLE 6

#### UNIVERSAL COVERAGE

##### Section 1. [62Q.165] UNIVERSAL COVERAGE.

It is the commitment of the state to achieve universal health coverage for all Minnesotans by July 1, 1997. In order to achieve this commitment, the following goals must be met:

(1) every Minnesotan shall have health coverage and shall contribute to the costs of coverage based on ability to pay;

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(2) no Minnesotan shall be denied coverage or forced to pay more because of health status;

(3) quality health care services must be accessible to all Minnesotans;

(4) all health care purchasers must be placed on an equal footing in the health care marketplace; and

(5) a comprehensive and affordable health plan must be available to all Minnesotans.

## Sec. 2. [62Q.17] VOLUNTARY PURCHASING POOLS.

Subdivision 1. PERMISSION TO FORM. Notwithstanding section 62A.10, employers, groups, and individuals may voluntarily form purchasing pools, solely for the purpose of negotiating and purchasing health plan coverage from health plan companies for members of the pool.

Subd. 2. COMMON FACTORS. All participants in a purchasing pool must live within a common geographic region, be employed in a similar occupation, or share some common factor as approved by the commissioner.

Subd. 3. GOVERNING STRUCTURE. Each pool must have a governing structure controlled by its members. The governing structure of the pool is responsible for administration of the pool. The governing structure shall review and evaluate all bids for coverage from health plan companies, shall determine criteria for joining and leaving the pool, and may design incentives for healthy lifestyles and health promotion programs. The governing structure may design uniform entrance standards for all employers, except small employers as defined under section 62L.02. Small employers must be permitted to enter any pool if the small employer meets the pool's membership requirements. Pools must provide as much choice in health plans to members as is financially possible. The governing structure may charge all members a fee for administrative purposes.

Subd. 4. ENROLLMENT. Pools must have an annual open enrollment period of not less than 15 days, during which all individuals or groups that qualify for membership may enter the pool without any preexisting condition limitations or exclusions or exclusionary riders, except those permitted under chapter 62L for groups or section 62A.65 for individuals. Pools must reach and maintain an enrolled population of at least 1,000 members within six months of formation. If a pool fails to reach or maintain the minimum enrollment, all coverage subsequently purchased through the purchasing pool must be regulated through existing applicable laws and forego all advantages under this section.

Subd. 5. MEMBERS. The governing structure of the pool shall set a minimum time period for membership. Members must stay in the purchasing pool for the entire minimum period to avoid paying a penalty. Penalties for early withdrawal from the purchasing pool shall be established by the governing structure.

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Subd. 6. EMPLOYER-BASED PURCHASING POOLS. Employer-based purchasing pools must, with respect to small employers as defined in section 62L.02, meet all the requirements of chapter 62L. The experience of the pool must be pooled and the rates blended across all groups. Pools may decide to create tiers within the pool, based on experience of group members. These tiers must be designed within the requirements of section 62L.08. The governing structure may establish criteria limiting movement between tiers. Tiers must be phased out within two years of the pool's creation.

Subd. 7. INDIVIDUAL MEMBERS. Purchasing pools that contain individual members must meet all of the underwriting and rate restrictions found in the individual health plan market.

Subd. 8. REPORTS. Prior to the initial effective date of coverage, and annually thereafter, each pool shall file a report with the information clearinghouse. The information clearinghouse must use the report to promote the purchasing pools. The annual report must contain the following information:

- (1) the number of lives in the pool;
- (2) the geographic area the pool intends to cover;
- (3) the number of health plans offered;
- (4) a description of the benefits under each plan;
- (5) a description of the premium structure, including any copayments or deductibles, of each plan offered;
- (6) evidence of compliance with chapter 62L;
- (7) a sample of marketing information, including a phone number where the pool may be contacted; and
- (8) a list of all administrative fees charged.

**Sec. 3. [62Q.18] UNIVERSAL COVERAGE; INSURANCE REFORMS.**

Subdivision 1. DEFINITION. For purposes of this section,

- (1) "continuous coverage" has the meaning given in section 62L.02;
- (2) "guaranteed issue" means:
  - (i) for individual health plans, that a health plan company shall not decline an application by an individual for any individual health plan offered by that health plan company, including coverage for a dependent of the individual to whom the health plan has been or would be issued; and
  - (ii) for group health plans, that a health plan company shall not decline an application by a group for any group health plan offered by that health plan

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company and shall not decline to cover under the group health plan any person eligible for coverage under the group's eligibility requirements, including persons who become eligible after initial issuance of the group health plan;

(3) "qualifying coverage" has the meaning given in section 62L.02; and

(4) "underwriting restrictions" has the meaning given in section 62L.03, subdivision 4.

Subd. 2. INDIVIDUAL MANDATE. Effective July 1, 1997, each Minnesota resident shall obtain and maintain qualifying coverage.

Subd. 3. GUARANTEED ISSUE. (a) Effective July 1, 1997, each health plan company shall offer, sell, issue, or renew each of its individual health plan forms on a guaranteed issue basis to any Minnesota resident.

(b) Effective July 1, 1997, each health plan company shall offer, sell, issue, or renew each of its group health plan forms to any employer that has its principal place of business in this state on a guaranteed issue basis, provided that the guaranteed issue requirement does not apply to employees, dependents, or other persons to be covered, who are not residents of this state.

Subd. 4. UNDERWRITING RESTRICTIONS LIMITED. Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan that has underwriting restrictions that apply to a Minnesota resident, except as expressly permitted under this section.

Subd. 5. PREEXISTING CONDITION LIMITATIONS. Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan that contains a preexisting condition limitation or exclusion or exclusionary rider that applies to a Minnesota resident, except a limitation which is no longer than 12 months and applies only to a person who has not maintained continuous coverage. An unexpired preexisting condition limitation from previous qualifying coverage may be carried over to new coverage under a health plan, if the unexpired condition is one permitted under this section. A Minnesota resident who has not maintained continuous coverage may be subjected to a new 12-month preexisting condition limitation after each break in continuous coverage.

Subd. 6. LIMITS ON PREMIUM RATE VARIATIONS. (a) Effective July 1, 1995, the premium rate variations permitted under sections 62A.65 and 62L.08 become:

(1) for factors other than age and geography, 12.5 percent of the index rate; and

(2) for age, 25 percent of the index rate.

(b) Effective July 1, 1996, the premium variations permitted under sections 62A.65 and 62L.08 become:

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(1) for factors other than age and geography, 7.5 percent of the index rate; and

(2) for age, 15 percent of the index rate.

(c) Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan, that is subject to section 62A.65 or 62L.08, for which the premium rate varies between covered persons on the basis of any factor other than:

(1) for individual health plans, differences in benefits or benefit design, and for group health plans, actuarially valid differences in benefits or benefit design;

(2) the number of persons to be covered by the health plan;

(3) actuarially valid differences in expected costs between adults and children;

(4) healthy lifestyle discounts authorized by statute; and

(5) for individual health plans, geographic variations permitted under section 62A.65, and for group health plans, geographic variations permitted under section 62L.08.

(d) All premium rate variations permitted under paragraph (c) are subject to the approval of the commissioner.

(e) Notwithstanding paragraphs (a), (b), and (c), no health plan company shall renew any individual or group health plan, except in compliance with this paragraph. No premium rate for any policy holder or contract holder shall increase or decrease upon renewal, as a result of this subdivision, by more than 15 percent per year. The increase or decrease described in this paragraph is in addition to any premium increase or decrease caused by legally permissible factors other than this subdivision. If a premium increase or decrease is constrained by this paragraph, the health plan company may implement the remaining portion of the increase or decrease at the time of subsequent annual renewals, but never to exceed 15 percent per year for paragraphs (a), (b), and (c) combined.

Subd. 7. PORTABILITY OF COVERAGE. (a) Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew any group or individual health plan that does not provide for guaranteed issue, with full credit for previous qualifying coverage against any preexisting condition limitation that would otherwise apply under subdivision 5. No health plan shall be subject to any other type of underwriting restriction.

(b) Effective July 1, 1995, no health plan company shall offer, sell, issue, or renew any group or individual health plan that does not, with respect to individuals who maintain continuous coverage and whose immediately preceding qualifying coverage is a health plan issued by medical assistance under chapter 256B,

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general assistance medical care under chapter 256D, or the MinnesotaCare plan established under section 256.9352,

(1) make coverage available on a guaranteed issue basis; and

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or exclusion.

(c) Paragraph (b) applies to individuals whose immediately preceding qualifying coverage is medical assistance under chapter 256B, general assistance medical care under chapter 256D, or the MinnesotaCare plan established under section 256.9352, only if the individual has disenrolled from the public program or will disenroll upon issuance of the new coverage. Paragraph (b) does not apply if the public program uses or will use public funds to pay the premiums for an individual who remains or will remain enrolled in the public program. No public funds may be used to purchase private coverage available under this paragraph. This paragraph does not prohibit public payment of premiums to continue private sector coverage originally obtained prior to enrollment in the public program, where otherwise permitted by state or federal law. Portability coverage under this paragraph is subject to the provisions of section 62A.65, subdivision 5, clause (b).

(d) Effective July 1, 1994, no health plan company shall offer, sell, issue, or renew any group health plan that does not, with respect to individuals who maintain continuous coverage:

(1) make coverage available on a guaranteed issue basis; and

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or exclusion.

To the extent that this paragraph conflicts with chapter 62L, with respect to small employers as defined in section 62L.02, chapter 62L governs.

Subd. 8. COMPREHENSIVE HEALTH ASSOCIATION. Effective July 1, 1997, the comprehensive health association created in section 62E.10 shall not accept new applicants for enrollment, except for medicare-related coverage described in section 62E.12 and for coverage described in section 62E.18.

Subd. 9. CONTINGENCY; FUTURE LEGISLATION. This section, except for subdivision 7, paragraphs (b), (c), and (d), is not intended to be implemented prior to legislation enacted to achieve the objectives of sections 1, 5, 6, and 7. Subdivision 6 is not effective until an effective date is specified in 1995 legislation.

#### Sec. 4. MARKET REFORM STRATEGIES STUDY.

The health care commission shall study and recommend to the legislature by January 1, 1995, insurance market reforms designed to promote the formation of large purchasing pools to be available to individuals and small employers by July 1, 1997. The health care commission shall study:

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(1) integrating workers' compensation and the medical component of automobile no-fault coverage with coverage purchased through a purchasing pool;

(2) integrating public and private sector financing mechanisms to extend MinnesotaCare subsidies to employees and dependents who are eligible for employer-based coverage without eroding existing coverage;

(3) requiring purchasing pools to make available to consumers all plans that submit bids to the pool;

(4) whether some or all purchasers should be required to obtain coverage through a public or private pool;

(5) the impact and effectiveness of the Minnesota employees insurance program under section 43A.317 and the public employees insurance plan under section 43A.316; and

(6) how statewide or regional purchasing pools could be developed for all individuals and small groups that do not have access to a private purchasing pool, and for the MinnesotaCare program and other state-subsidized health care programs, by expanding the Minnesota employees insurance program currently operated by the department of employee relations or by other means.

#### **Sec. 5. SURVEY OF THE UNINSURED AND EVALUATION OF EXISTING REFORMS.**

Subdivision 1. SURVEY. The Minnesota health care commission shall authorize a survey of Minnesota households and employers to provide current data on the uninsured population and assess the effectiveness of the existing health care reforms. As part of this survey, the commissioner of human services shall conduct a survey of the MinnesotaCare population to determine the effects of existing health care reforms on this population. Results of this survey shall be presented to the legislature by January 15, 1995.

Subd. 2. EVALUATION. The commissioner of health, in consultation with the health care commission and the commissioners of human services and commerce, shall evaluate the effect of existing reforms and the effect of the MinnesotaCare program on the uninsured population. Based on this evaluation, the commissioners of health, commerce, and human services shall recommend modifications to existing reforms as necessary to continue to make progress toward universal coverage by 1997 and report these modifications to the legislature by January 15, 1996.

#### **Sec. 6. HEALTH CARE AFFORDABILITY STUDY.**

(a) The commissioner of health, in consultation with the commissioners of human services, commerce, and revenue, shall study and report to the Minnesota health care commission by October 1, 1994, the various factors that affect health care affordability, including out-of-pocket spending, insurance premiums, and taxes.

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(b) Based on the study in paragraph (a), the Minnesota health care commission shall recommend to the legislature by January 15, 1995, a specific percentage of income that overall health care costs to a family or individual should not exceed.

(c) The recommendations in paragraph (b) must be used by the commissioners of health and human services to develop an appropriate premium subsidy and sliding fee scale for a permanent health care subsidy program.

#### Sec. 7. FINANCING STUDY.

The Minnesota health care commission, in consultation with the commissioners of health, commerce, human services, and revenue, and representatives of county government shall report to the legislature by January 1, 1995, with an implementation schedule and plan for a stable, long-term health care funding system for all government health programs. The report must include recommendations for overhauling the current system, specific financing methods, and detailed cost estimates for an expanded, fully-funded subsidy program to guarantee universal coverage to all Minnesota residents. The report must include an inventory and analysis of the existing system of government financing of health care. It must include recommendations for capturing savings that will accrue under health care reform and reallocating them to offset additional costs of universal coverage. The commission may contract for actuarial, finance, and taxation expertise.

The study must take into account the following goals and guiding principles:

(a) To the extent possible, universal coverage should be achieved without a net increase in total health spending, taxes, or government spending by recapturing savings and reallocating resources within the system.

(b) To the extent that universal coverage will require additional funding, revenues may be raised by reducing other general fund spending or through a variety of funding options, including broad-based taxes such as income or payroll, as long as they can be adjusted to provide appropriate offsets for low-income individuals. Taxing items that are considered to be health risks and contribute to preventable illness and injury shall be considered as a possible funding source.

(c) Financing reform should ensure adequate and equitable financing of all necessary components of the health system.

(d) Activities that benefit the entire community, such as core public health activities, including collection of data on health status and community health needs, and medical education should be financed by broad-based funding sources. Funding mechanisms should promote collaboration between the public and private sectors.

(e) Personal health care services for individuals who are enrolled in a health plan should be provided or paid for by the health plan.

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(f) Government subsidy programs for low-income Minnesotans should be financed by broad-based funding sources.

(g) Funding mechanisms that are inequitable or create undesirable incentives, such as the Minnesota comprehensive health association assessment, should be restructured.

#### Sec. 8. PREEXISTING CONDITIONS STUDY.

The health care commission shall study the feasibility and impact of the following:

- (1) eliminating preexisting condition limitations in steps;
- (2) standardizing preexisting condition limitations;
- (3) narrowing the preexisting condition limitation period from 12 months to six months; and
- (4) requiring limited coverage of services for preexisting conditions.

The health care commission shall provide a written report to the legislature on or before December 15, 1994.

#### Sec. 9. REQUIRED OFFER OF INDIVIDUAL HEALTH PLANS.

The health care commission shall study the effects and desirability of the requirement that all health plan companies offer individual health plans. The health care commission shall provide a written report, including recommendations on implementation, to the legislature on or before December 15, 1994.

#### Sec. 10. EFFECTIVE DATE.

Sections 1 and 4 to 9 are effective the day following final enactment. Sections 2 and 3 are effective July 1, 1994.

### ARTICLE 7

#### PUBLIC HEALTH

##### Section 1. [62Q.075] LOCAL PUBLIC ACCOUNTABILITY AND COLLABORATION PLAN.

Subdivision 1. DEFINITION. For purposes of this section, "managed care organization" means a health maintenance organization, community integrated service network, or integrated service network.

Subd. 2. REQUIREMENT. Beginning July 1, 1995, all managed care organizations shall annually file with the action plans required under section 62Q.07

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a plan describing the actions the managed care organization has taken and those it intends to take to contribute to achieving public health goals for each service area in which an enrollee of the managed care organization resides. This plan must be jointly developed in collaboration with the local public health units, appropriate regional coordinating boards, and other community organizations providing health services within the same service area as the managed care organization. Local government units with responsibilities and authority defined under chapters 145A and 256E may designate individuals to participate in the collaborative planning with the managed care organization to provide expertise and represent community needs and goals as identified under chapters 145A and 256E.

Subd. 3. CONTENTS. The plan must address the following:

(a) specific measurement strategies and a description of any activities which contribute to public health goals and needs of high risk and special needs populations as defined and developed under chapters 145A and 256E;

(b) description of the process by which the managed care organization will coordinate its activities with the community health boards, regional coordinating boards, and other relevant community organizations servicing the same area;

(c) documentation indicating that local public health units and local government unit designees were involved in the development of the plan;

(d) documentation of compliance with the plan filed the previous year, including data on the previously identified progress measures.

Subd. 4. REVIEW. Upon receipt of the plan, the appropriate commissioner shall provide a copy to the regional coordinating boards, local community health boards, and other relevant community organizations within the managed care organization's service area. After reviewing the plan, these community groups may submit written comments on the plan to either the commissioner of health or commerce, as applicable, and may advise the commissioner of the managed care organization's effectiveness in assisting to achieve regional public health goals. The plan may be reviewed by the county boards, or city councils acting as a local board of health in accordance with chapter 145A, within the managed care organization's service area to determine whether the plan is consistent with the goals and objectives of the plans required under chapters 145A and 256E and whether the plan meets the needs of the community. The county board, or applicable city council, may also review and make recommendations on the availability and accessibility of services provided by the managed care organization. The county board, or applicable city council, may submit written comments to the appropriate commissioner, and may advise the commissioner of the managed care organization's effectiveness in assisting to meet the needs and goals as defined under the responsibilities of chapters 145A and 256E. Copies of these written comments must be provided to the managed care organization. The plan and any comments submitted must be filed with the information clearinghouse to be distributed to the public.

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**Sec. 2. [62Q.32] LOCAL OMBUDSPERSON.**

County board or community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services through a health plan company. The ombudsperson's functions may include, but are not limited to:

(a) mediation or advocacy on behalf of a person accessing the complaint and appeal procedures to ensure that necessary medical services are provided by the health plan company; and

(b) investigation of the quality of services provided to a person and determine the extent to which quality assurance mechanisms are needed or any other system change may be needed.

**Sec. 3. [62Q.33] LOCAL GOVERNMENT PUBLIC HEALTH FUNCTIONS.**

Subdivision 1. FINDINGS. The legislature finds that the local government public health functions of community assessment, policy development, and assurance of service delivery are essential elements in consumer protection and in achieving the objectives of health care reform in Minnesota. The legislature further finds that the site-based and population-based services provided by state and local health departments are a critical strategy for the long-term containment of health care costs. The legislature further finds that without adequate resources, the local government public health system will lack the capacity to fulfill these functions in a manner consistent with the needs of a reformed health care delivery system.

Subd. 2. REPORT ON SYSTEM DEVELOPMENT. The commissioner of health, in consultation with the state community health services advisory committee and the commissioner of human services, and representatives of local health departments, county government, a municipal government acting as a local board of health, the Minnesota health care commission, area Indian health services, health care providers, and citizens concerned about public health, shall coordinate the process for defining implementation and financing responsibilities of the local government core public health functions. The commissioner shall submit recommendations and an initial and final report on local government core public health functions according to the timeline established in subdivision 5.

Subd. 3. CORE PUBLIC HEALTH FUNCTIONS. (a) The report required by subdivision 2 must describe the local government core public health functions of: assessment of community health needs; goal-determination, public policy, and program development for addressing these needs; and assurance of service availability and accessibility to meet community health goals and needs. The report must further describe activities for implementation of these functions that are the continuing responsibility of the local government public health system, taking into account the ongoing reform of the health care delivery system.

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(b) The activities to be defined in terms of the local government core public health functions include, but are not limited to:

- (1) consumer protection and advocacy;
- (2) targeted outreach and linkage to personal services;
- (3) health status monitoring and disease surveillance;
- (4) investigation and control of diseases and injuries;
- (5) protection of the environment, work places, housing, food, and water;
- (6) laboratory services to support disease control and environmental protection;
- (7) health education and information;
- (8) community mobilization for health-related issues;
- (9) training and education of public health professionals;
- (10) public health leadership and administration;
- (11) emergency medical services;
- (12) violence prevention; and
- (13) other activities that have the potential to improve the health of the population or special needs populations and reduce the need for or cost of health care services.

**Subd. 4. CAPACITY BUILDING, ACCOUNTABILITY AND FUNDING.**  
The recommendations required by subdivision 2 shall include:

- (1) a definition of minimum outcomes for implementing core public health functions, including a local ombudsperson under the assurance of services function;
- (2) the identification of counties and applicable cities with public health programs that need additional assistance to meet the minimum outcomes;
- (3) a budget for supporting all functions needed to achieve the minimum outcomes, including the local ombudsperson assurance of services function;
- (4) an analysis of the costs and benefits expected from achieving the minimum outcomes;
- (5) strategies for improving local government public health functions throughout the state to meet the minimum outcomes including: (i) funding distribution for local government public health functions necessary to meet the minimum outcomes; and (ii) strategies for the financing of personal health care

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services within the uniform benefits set and identifying appropriate mechanisms for the delivery of these services; and

(6) a recommended level of dedicated funding for local government public health functions in terms of a percentage of total health service expenditures by the state or in terms of a per capita basis, including methods of allocating the dedicated funds to local government.

Subd. 5. TIMELINE. (a) By October 1, 1994, the commissioner shall submit to the legislative commission on health care access the initial report and recommendations required by subdivisions 2 to 4.

(b) By February 15, 1995, the commissioner, in cooperation with the legislative commission on health care access, shall submit a final report to the legislature, with specific recommendations for capacity building and financing to be implemented over the period from January 1, 1996, through December 31, 1997.

(c) By January 1, 1997, and by January 1 of each odd-numbered year thereafter, the commissioner shall present to the legislature an updated report and recommendations.

#### Sec. 4. PUBLIC HEALTH GOALS REPORT.

The commissioner of health shall provide a written report to the legislature by January 1, 1996, of recommendations on how providers and payers participating in the regulated all-payer option shall participate in achieving public health goals.

#### Sec. 5. EFFECTIVE DATE.

Sections 1 to 4 are effective the day following final enactment.

### ARTICLE 8

#### CONFORMING AND MISCELLANEOUS CHANGES

Section 1. Minnesota Statutes 1992, section 60A.02, subdivision 3, is amended to read:

Subd. 3. **INSURANCE.** (a) "Insurance" is any agreement whereby one party, for a consideration, undertakes to indemnify another to a specified amount against loss or damage from specified causes, or to do some act of value to the assured in case of such loss or damage. A program of self-insurance, self-insurance revolving fund or pool established under section 471.981 is not insurance for purposes of this subdivision.

(b) Notwithstanding paragraph (a), capitation payments to a capitated entity by an employer that maintains a program of self-insurance described in this

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paragraph, do not constitute insurance with respect to the receipt of the payments. The payments are not premium revenues for the purpose of calculating liability for otherwise applicable state taxes, assessments, or surcharges, with the exception of:

(1) the MinnesotaCare provider tax;

(2) the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d); and

(3) effective July 1, 1995, assessments by the Minnesota comprehensive health association.

This paragraph applies only where:

(1) the capitated entity does not bear risk in excess of 110 percent of the self-insurance program's expected costs;

(2) the employer does not carry stop loss, excess loss, or similar coverage with an attachment point lower than 120 percent of the self-insurance program's expected costs;

(3) the capitated entity and the employer comply with the data submission and administrative simplification provisions of chapter 62J;

(4) the capitated entity and the employer comply with the provider tax pass-through provisions of section 295.582;

(5) the capitated entity's required minimum reserves reflect the risk borne by the capitated entity under this paragraph, with an appropriate adjustment for the 110 percent limit on risk borne by the capitated entity;

(6) on or after July 1, 1994, but prior to January 1, 1995, the employer has at least 1,500 current employees, as defined in section 62L.02, or, on or after January 1, 1995, the employer has at least 750 current employees, as defined in section 62L.02;

(7) the employer does not exclude any eligible employees or their dependents, both as defined in section 62L.02, from coverage offered by the employer, under this paragraph or any other health coverage, insured or self-insured, offered by the employer, on the basis of the health status or health history of the person. For purposes of this subdivision, a capitated entity must be licensed as a health maintenance organization, integrated service network, or community integrated service network, or must be a preferred provider organization. For purposes of this section, a preferred provider organization is a health plan company that contracts with providers to provide health care to its enrollees. All other insurance as defined in paragraph (a), even if maintained by an employer that also offers programs of self-insurance, continues to be subject to all applicable state regulations.

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This paragraph expires December 31, 1997.

Sec. 2. Minnesota Statutes 1992, section 60A.15, subdivision 1, is amended to read:

Subdivision 1. **DOMESTIC AND FOREIGN COMPANIES:** (a) On or before April 1, June 1, and December 1 of each year, every domestic and foreign company, including town and farmers' mutual insurance companies, domestic mutual insurance companies, marine insurance companies, health maintenance organizations, integrated service networks, community integrated service networks, and nonprofit health service plan corporations, shall pay to the commissioner of revenue installments equal to one-third of the insurer's total estimated tax for the current year. Except as provided in paragraphs (b) and (e), installments must be based on a sum equal to two percent of the premiums described in paragraph (c).

(b) For town and farmers' mutual insurance companies and mutual property and casualty insurance companies other than those (i) writing life insurance, or (ii) whose total assets on December 31, 1989, exceeded \$1,600,000,000, the installments must be based on an amount equal to the following percentages of the premiums described in paragraph (c):

(1) for premiums paid after December 31, 1988, and before January 1, 1992, one percent; and

(2) for premiums paid after December 31, 1991, one-half of one percent.

(c) Installments under paragraph (a), (b), or (e) are percentages of gross premiums less return premiums on all direct business received by the insurer in this state, or by its agents for it, in cash or otherwise, during such year.

(d) Failure of a company to make payments of at least one-third of either (1) the total tax paid during the previous calendar year or (2) 80 percent of the actual tax for the current calendar year shall subject the company to the penalty and interest provided in this section, unless the total tax for the current tax year is \$500 or less.

(e) For health maintenance organizations ~~and~~ nonprofit health services plan corporations, integrated service networks, and community integrated service networks, the installments must be based on an amount equal to one percent of premiums described in paragraph (c) that are paid after December 31, 1995.

(f) Premiums under ~~the children's health plan~~ medical assistance, the ~~health right plan~~ MinnesotaCare program, and ~~the~~ Minnesota comprehensive health insurance plan are not subject to tax under this section.

Sec. 3. Minnesota Statutes 1993 Supplement, section 61B.20, subdivision 13, is amended to read:

Subd. 13. **MEMBER INSURER.** "Member insurer" means an insurer

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licensed or holding a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 61B.19, subdivision 2, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn. The term does not include:

(1) a nonprofit hospital or medical service organization, other than a nonprofit health service plan corporation that operates under chapter 62C;

(2) a health maintenance organization;

(3) a fraternal benefit society;

(4) a mandatory state pooling plan;

(5) a mutual assessment company or an entity that operates on an assessment basis;

(6) an insurance exchange; or

(7) an integrated service network or a community integrated service network; or

(8) an entity similar to those listed in clauses (1) to ~~(6)~~ (7).

Sec. 4. Minnesota Statutes 1992, section 62A.48, subdivision 1, is amended to read:

Subdivision 1. **POLICY REQUIREMENTS.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term care policy must cover prescribed long-term care in nursing facilities and at least the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy AA must include: a maximum lifetime benefit limit of at least \$100,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums. Coverage under a long-term care policy A must include: a maximum lifetime benefit limit of at least \$50,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums. Prior hospitalization may not be required under a long-term care policy.

Coverage under either policy designation must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage. Coverage under either policy designation may include a waiting period of up to 90 days before benefits are paid, but there

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must be no more than one waiting period per benefit period; for purposes of this sentence, "days" means calendar days. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to be homebound or house confined to receive home care services. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

No individual long-term care policy shall be offered or delivered in this state until the insurer has received from the insured a written designation of at least one person, in addition to the insured, who is to receive notice of cancellation of the policy for nonpayment of premium. The insured has the right to designate up to a total of three persons who are to receive the notice of cancellation, in addition to the insured. The form used for the written designation must inform the insured that designation of one person is required and that designation of up to two additional persons is optional and must provide space clearly designated for listing between one and three persons. The designation shall include each person's full name, home address, and telephone number. Each time an individual policy is renewed or continued, the insurer shall notify the insured of the right to change this written designation.

The insurer may file a policy form that utilizes a plan of care prepared as provided under section 62A.46, subdivision 5, clause (1) or (2).

Sec. 5. Minnesota Statutes 1992, section 62D.02, subdivision 4, is amended to read:

Subd. 4. (a) "Health maintenance organization" means a nonprofit corporation organized under chapter 317A, or a local governmental unit as defined in subdivision 11, controlled and operated as provided in sections 62D.01 to 62D.30, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

(b) Notwithstanding paragraph (a), an organization licensed as a health maintenance organization that accepts payments for health care services on a capitated basis, or under another similar risk sharing agreement, from a program of self-insurance as described in section 60A.02, subdivision 3, paragraph (b), shall not be regulated as a health maintenance organization with respect to the

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receipt of the payments. The payments are not premium revenues for the purpose of calculating the health maintenance organization's liability for otherwise applicable state taxes, assessments, or surcharges, with the exception of:

(1) the MinnesotaCare provider tax;

(2) the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d); and

(3) effective July 1, 1995, assessments by the Minnesota comprehensive health association.

This paragraph applies only where:

(1) the health maintenance organization does not bear risk in excess of 110 percent of the self-insurance program's expected costs;

(2) the employer does not carry stop loss, excess loss, or similar coverage with an attachment point lower than 120 percent of the self-insurance program's expected costs;

(3) the health maintenance organization and the employer comply with the data submission and administrative simplification provisions of chapter 62J;

(4) the health maintenance organization and the employer comply with the provider tax pass-through provisions of section 295.582;

(5) the health maintenance organization's required minimum reserves reflect the risk borne by the health maintenance organization under this paragraph, with an appropriate adjustment for the 110 percent limit on risk borne by the community network;

(6) on or after July 1, 1994, but prior to January 1, 1995, the employer has at least 1,500 current employees, as defined in section 62L.02, or, on or after January 1, 1995, the employer has at least 750 current employees, as defined in section 62L.02;

(7) the employer does not exclude any eligible employees or their dependents, both as defined in section 62L.02, from coverage offered by the employer, under this paragraph or any other health coverage, insured or self-insured, offered by the employer, on the basis of the health status or health history of the person.

This paragraph expires December 31, 1997.

Sec. 6. Minnesota Statutes 1992, section 62D.04, is amended by adding a subdivision to read:

Subd. 5. PARTICIPATION; GOVERNMENT PROGRAMS. Health maintenance organizations shall, as a condition of receiving and retaining a certificate of authority, participate in the medical assistance, general assistance medical care, and MinnesotaCare programs. The participation required from

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health maintenance organizations shall be pursuant to rules adopted under section 256B.0644.

Sec. 7. Minnesota Statutes 1992, section 62E.02, subdivision 10, is amended to read:

Subd. 10. **INSURER.** "Insurer" means those companies operating pursuant to chapter 62A or 62C and offering, selling, issuing, or renewing policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations, integrated service networks, or community integrated service networks.

Sec. 8. Minnesota Statutes 1992, section 62E.02, subdivision 18, is amended to read:

Subd. 18. **WRITING CARRIER.** "Writing carrier" means the insurer or insurers ~~and~~ health maintenance organization or organizations, integrated service network or networks, and community integrated service network or networks selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

Sec. 9. Minnesota Statutes 1992, section 62E.02, subdivision 20, is amended to read:

Subd. 20. **COMPREHENSIVE INSURANCE PLAN OR STATE PLAN.** "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization, integrated service network, or community integrated service network coverage offered by the association through the writing carrier.

Sec. 10. Minnesota Statutes 1992, section 62E.02, subdivision 23, is amended to read:

Subd. 23. **CONTRIBUTING MEMBER.** "Contributing member" means those companies regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; integrated service network and community integrated service networks regulated under chapter 62N; fraternal benefit societies regulated under chapter 64B; the private employers insurance program established in section 43A.317, effective July 1, 1993; and joint self-insurance plans regulated under chapter 62H. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization, integrated service network, or community integrated service network shall be considered to be accident and health insurance premiums.

Sec. 11. Minnesota Statutes 1992, section 62E.10, subdivision 1, is amended to read:

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Subdivision 1. **CREATION; TAX EXEMPTION.** There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers; self-insurers; fraternal; joint self-insurance plans regulated under chapter 62H; the private employers insurance program established in section 43A.317, effective July 1, 1993; ~~and~~ health maintenance organizations; integrated service networks; and community integrated service networks licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

Sec. 12. Minnesota Statutes 1992, section 62E.10, subdivision 2, is amended to read:

Subd. 2. **BOARD OF DIRECTORS; ORGANIZATION.** The board of directors of the association shall be made up of nine members as follows: five insurer directors selected by participating members, subject to approval by the commissioner; four public directors selected by the commissioner, at least two of whom must be plan enrollees. Public members may include licensed insurance agents. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, ~~or~~ health maintenance contract payment, integrated service network, or community integrated service network payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Insurer directors may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Sec. 13. Minnesota Statutes 1992, section 62E.10, subdivision 3, is amended to read:

Subd. 3. **MANDATORY MEMBERSHIP.** All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, ~~or~~ health maintenance organization, integrated service network, or community integrated service network business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 14.001 to 14.69.

Sec. 14. Minnesota Statutes 1993 Supplement, section 62J.03, subdivision 6, is amended to read:

Subd. 6. **GROUP PURCHASER.** "Group purchaser" means a person or

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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; community 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. 15. Minnesota Statutes 1992, section 62J.03, is amended by adding a subdivision to read:

Subd. 10. HEALTH PLAN COMPANY. "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4.

Sec. 16. Minnesota Statutes 1993 Supplement, section 62J.04, subdivision 1, is amended to read:

Subdivision 1. **LIMITS ON THE RATE OF GROWTH.** (a) The commissioner of health shall set annual limits on the rate of growth of public and private spending on health care services for Minnesota residents, as provided in paragraph (b). The limits on growth must be set at levels the commissioner determines to be realistic and achievable but that will reduce the rate of growth in health care spending by at least ten percent per year 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;

(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;

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(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. 17. Minnesota Statutes 1993 Supplement, section 62J.04, subdivision 1a, is amended 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~~ 31 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~~ February 15 of each year on differences between 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 the actual expenditures based on data collected, and the impact and validity of growth limits within the overall health care reform strategy.

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

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its, the 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 growth limits, 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 option~~ 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 amounts exceeding the limit~~ 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 amounts over the limit~~ from individual providers who exceed the ~~spending~~ growth limits.

(e) The commissioner, in consultation with the Minnesota health care commission, shall research and make recommendations to the legislature regarding the implementation of growth limits for integrated service networks and the regulated all-payer option. The commissioner must consider both spending and revenue approaches and will report on the implementation of the interim limits as defined in sections 62P.04 and 62P.05. The commissioner must examine and make recommendations on the use of annual update factors based on volume performance standards as a mechanism for achieving controls on spending in the all-payer option. The commissioner must make recommendations regarding the enforcement mechanism and must consider mechanisms to adjust future growth limits as well as mechanisms to establish financial penalties for noncompliance. The commissioner must also address the feasibility of system-wide limits imposed on all integrated service networks.

(f) The commissioner shall report to the legislative commission on health care access by December 1, 1994, on trends in aggregate spending and premium revenue for health plan companies. The commissioner shall use data submitted under section 62P.04 and other available data to complete this report.

Sec. 18. Minnesota Statutes 1992, section 62J.04, is amended by adding a subdivision to read:

Subd. 9. GROWTH LIMITS; FEDERAL PROGRAMS. The commissioners of health and human services shall establish a rate methodology for Medicare and Medicaid risk-based contracting with health plan companies that is consistent with statewide growth limits. The methodology shall be presented for

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review by the Minnesota health care commission and the legislative commission on health care access prior to the submission of a waiver request to the health care financing administration and subsequent implementation of the methodology.

Sec. 19. Minnesota Statutes 1992, section 62J.05, subdivision 2, is amended to read:

Subd. 2. **MEMBERSHIP.** (a) **NUMBER.** The Minnesota health care commission consists of ~~25~~ 27 members, as specified in this subdivision. A member may designate a representative to act as a member of the commission in the member's absence. The governor and legislature shall coordinate appointments under this subdivision to ensure gender balance and ensure that geographic areas of the state are represented in proportion to their population.

(b) **HEALTH PLAN COMPANIES.** The commission includes four members representing health plan companies, including one member appointed by the Minnesota Council of Health Maintenance Organizations, one member appointed by the Insurance Federation of Minnesota, one member appointed by Blue Cross and Blue Shield of Minnesota, and one member appointed by the governor.

(c) **HEALTH CARE PROVIDERS.** The commission includes six members representing health care providers, including one member appointed by the Minnesota Hospital Association, one member appointed by the Minnesota Medical Association, one member appointed by the Minnesota Nurses' Association, one rural physician appointed by the governor, and two members appointed by the governor to represent providers other than hospitals, physicians, and nurses.

(d) **EMPLOYERS.** The commission includes four members representing employers, including (1) two members appointed by the Minnesota Chamber of Commerce, including one self-insured employer and one small employer; and (2) two members appointed by the governor.

(e) **CONSUMERS.** The commission includes ~~five~~ seven consumer members, including three members appointed by the governor, one of whom must represent persons over age 65; one member appointed by the consortium of citizens with disabilities to represent consumers with physical disabilities or chronic illness; one member appointed by the mental health association of Minnesota, in consultation with the Minnesota chapter of the society of Americans for recovery, to represent consumers with mental illness or chemical dependency; one appointed under the rules of the senate; and one appointed under the rules of the house of representatives.

(f) **EMPLOYEE UNIONS.** The commission includes three representatives of labor unions, including two appointed by the AFL-CIO Minnesota and one appointed by the governor to represent other unions.

(g) **STATE AGENCIES.** The commission includes the commissioners of commerce, employee relations, and human services.

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(h) **CHAIR.** The governor shall designate the chair of the commission from among the governor's appointees.

**Sec. 20. [62J.051] DISTRIBUTION OF HEALTH CARE TECHNOLOGY, FACILITIES, AND FUNCTIONS; PUBLIC FORUMS.**

The commission may promote and facilitate an open, voluntary, nonregulatory, and public process for regional and statewide discussion regarding the appropriate distribution of health care technologies, facilities, and functions. The process must include the participation of consumers, employers and other group purchasers, providers, health plan companies, and the health care technology industry. The commission shall ensure opportunities for broadbased public input from other interested persons and organizations as well. The purpose of the process is to create an open public forum with the goal of facilitating collaboration for the distribution of a particular technology, facility, or function to achieve health reform goals. Participation in the forums is voluntary and agreements or distribution plans that may be recommended through this process are not mandatory or binding on any person or organization. The recommendations may be considered by the commissioner of health for purposes of the antitrust exception process under sections 62J.2911 to 62J.2921, and the process for reviewing major spending commitments under section 62J.17, but are not binding on the commissioner. The commission may develop criteria for selecting specific technologies, facilities, and functions for discussion and may establish procedures and ground rules for discussion and the development of recommended agreements or distribution plans. The commission may appoint advisory committees to facilitate discussion and planning and may request that regional coordinating boards serve as or convene regional public forums.

Sec. 21. Minnesota Statutes 1993 Supplement, section 62J.09, subdivision 1a, is amended to read:

Subd. 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:

- (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 ~~as~~ a community integrated service network or integrated service network within the region. This assistance must complement assistance provided by the commissioner under section 62N.23.

Sec. 22. Minnesota Statutes 1993 Supplement, section 62J.09, subdivision 2, is amended to read:

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Subd. 2. **MEMBERSHIP.** (a) **NUMBER OF MEMBERS.** Each regional coordinating board consists of 17 members as provided in this subdivision. A member may designate a representative to act as a member of the board 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.

(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 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 appointed by the Minnesota chamber of commerce from nominations provided by 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. 23. Minnesota Statutes 1993 Supplement, section 62J.23, subdivision 4, is amended to read:

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Subd. 4. ~~INTEGRATED SERVICE~~ **CHAPTER 62N NETWORKS.** (a) The legislature finds that the formation and operation of integrated service networks and community 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 incentives. Accordingly, it is the public policy of the state of Minnesota to support the development of integrated service networks and community 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 community integrated service networks or to impose liability for arrangements between an integrated service network or a community integrated service network and its participating entities.

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

Sec. 24. Minnesota Statutes 1993 Supplement, section 62J.2916, subdivision 2, is amended to read:

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 or members designated by the commissioner. The commissioner or the commissioner's designee or designees 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

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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 or designees 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.

(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. 25. Minnesota Statutes 1993 Supplement, section 62J.32, subdivision 4, is amended to read:

Subd. 4. **PRACTICE PARAMETER ADVISORY COMMITTEE.** (a) The commissioner shall convene a ~~15-member~~ 17-member practice parameter advisory committee comprised of eight health care professionals, and representatives of the research community and the medical technology industry. One representative of the research community must be an individual with expertise in pharmacology or pharmaceutical economics who is familiar with the results of the pharmaceutical care research project at the University of Minnesota and the potential cost savings that can be achieved through use of a comprehensive pharmaceutical care model. 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, except that its existence does not terminate and members do not receive per diem compensation.

(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. 26. Minnesota Statutes 1993 Supplement, section 62J.35, subdivision 2, is amended to read:

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

Sec. 27. Minnesota Statutes 1993 Supplement, section 62J.35, subdivision 3, is amended to read:

Subd. 3. **DATA PRIVACY.** All data received under this section or under section 62J.04, 62J.37, 62J.38, 62J.41, or 62J.42 is private or nonpublic, ~~as applicable~~ except to the extent that it is given a different classification elsewhere in this chapter. The commissioner shall establish procedures and safeguards to ensure that data released by the commissioner is in a form that does not identify 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. 28. Minnesota Statutes 1993 Supplement, section 62J.38, is amended to read:

#### **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~~ April 1, 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, emergency and out-of-area care, pharmacy services and prescription drugs, mental health services, chemical dependency services, other expenditures, subscriber liability, 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. 29. Minnesota Statutes 1993 Supplement, section 62J.41, subdivision 2, is amended to read:

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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~~ April 1, 1994. Health care providers shall submit data for the 1994 calendar year by ~~February 15~~ April 1, 1995, and each ~~February 15~~ April 1 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.

Sec. 30. Minnesota Statutes 1993 Supplement, section 62J.45, subdivision 11, is amended to read:

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.

(d) The commissioner and the board shall not allow a group purchaser or health care provider to use or have access to data collected by the data institute, unless the group purchaser or health care provider cooperates with the data collection efforts of the data institute by submitting all data requested in the form and manner specified by the board. The commissioner and the board shall prohibit group purchasers and health care providers from transferring, providing, or sharing data obtained from the data institute with a group purchaser or health care provider that does not cooperate with the data collection efforts of the data institute.

Sec. 31. [62J.47] **MORATORIUM ON MERGERS OR ACQUISITIONS BY HEALTH CARRIERS.**

Subdivision 1. DEFINITIONS. For purposes of this section, "health carrier" has the meaning given in section 62A.011, subdivision 2.

Subd. 2. RESTRICTIONS. Until July 1, 1996, the following health carriers

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are prohibited from merging with, or acquiring, directly or indirectly, any other health carrier:

(1) a health carrier whose number of enrollees residing in the state in the previous calendar year exceeds five percent of the total number of insured persons in that year residing in the state of Minnesota; and

(2) a health carrier whose number of enrollees residing in the seven-county metropolitan area in the previous calendar year exceeds ten percent of the total number of insured persons in that year residing in the seven-county metropolitan area.

Subd. 3. ENFORCEMENT. The district court in Ramsey county has jurisdiction to enjoin an alleged violation of subdivision 2. The attorney general may bring an action to enjoin an alleged violation. The commissioner of health or commerce shall not issue or renew a license or certificate of authority to any health carrier in violation of subdivision 2.

Subd. 4. EXCEPTIONS. This section does not apply to:

(1) any merger or direct or indirect acquisition approved by the commissioner that is intended to assure continuous coverage for enrollees and avoid liquidation or insolvency under chapter 60B;

(2) any merger or direct or indirect acquisition that develops pursuant to a letter of intent, memorandum of understanding, or other agreement signed before March 17, 1994;

(3) any merger or direct or indirect acquisition that develops pursuant to an affiliation for which a letter of intent, memorandum of understanding, or other agreement was signed before March 17, 1994; or

(4) any merger or direct or indirect acquisition of health carriers that are related organizations, as defined in section 317A.011, subdivision 18, as of March 17, 1994.

Sec. 32. [62J.65] EXEMPTION.

Patient revenues derived from non-Minnesota patients are exempt from the regulated all-payer system and Medicare balance billing prohibition under section 62J.25.

Sec. 33. Minnesota Statutes 1993 Supplement, section 62N.01, is amended to read:

**62N.01 CITATION AND PURPOSE.**

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

Subd. 2. **PURPOSE.** ~~Sections 62N.01 to 62N.24 allow~~ This chapter allows

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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. 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. 34. Minnesota Statutes 1993 Supplement, section 62N.02, subdivision 1, is amended to read:

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

Sec. 35. Minnesota Statutes 1993 Supplement, section 62N.065, subdivision 1, is amended to read:

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.24~~ this chapter; 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.

Sec. 36. Minnesota Statutes 1993 Supplement, section 62N.10, subdivision 1, is amended to read:

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

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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 develop and complete the action plans required by law;  
and

(5) 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.

Sec. 37. Minnesota Statutes 1993 Supplement, section 62N.10, subdivision 2, is amended to read:

Subd. 2. **FEES.** Licensees shall pay an initial fee and a renewal fee each following year to be established by the commissioner of health. The fee must be imposed at a rate sufficient to cover the cost of regulation.

Sec. 38. Minnesota Statutes 1993 Supplement, section 62N.22, is amended to read:

#### 62N.22 DISCLOSURE OF COMMISSIONS.

Before selling, ~~or offering to sell,~~ any coverage or enrollment in a community integrated service network or an integrated service network, a person selling the coverage or enrollment shall disclose in writing 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. 39. Minnesota Statutes 1992, section 144.1485, is amended to read:

#### 144.1485 DATA BASE ON HEALTH PERSONNEL.

(a) The commissioner of health shall develop and maintain a data base on health services personnel. The commissioner shall use this information to assist local communities and units of state government to develop plans for the recruitment and retention of health personnel. Information collected in the data base must include, but is not limited to, data on levels of educational preparation, specialty, and place of employment. The commissioner may collect information through the registration and licensure systems of the state health licensing boards.

(b) Health professionals who report their practice or place of employment address to the commissioner of health under section 144.052 may request in writing that their practice or place of employment address be classified as pri-

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vate data on individuals, as defined in section 13.02, subdivision 12. The commissioner shall grant the classification upon receipt of a signed statement by the health professional that the classification is required for the safety of the health professional, if the statement also provides a valid, existing address where the health professional consents to receive service of process. The commissioner shall use the mailing address in place of the practice or place of employment address in all documents available to the general public. The practice or place of employment address and any information provided in the classification request, other than the mailing address, are private data on individuals and may be provided to other state agencies. The practice or place of employment address may be used to develop summary reports that show in aggregate the distribution of health care providers in Minnesota.

Sec. 40. Minnesota Statutes 1993 Supplement, section 144.1486, is amended to read:

#### 144.1486 RURAL COMMUNITY HEALTH CENTERS.

The commissioner of health shall develop and implement a program to establish community health centers in rural areas of Minnesota that are underserved by health care providers. The program shall provide rural communities and community organizations with technical assistance, capital grants for start-up costs, and short-term assistance with operating costs. The technical assistance component of the program must provide assistance in review of practice management, market analysis, practice feasibility analysis, medical records system analysis, and scheduling and patient flow analysis. The program must: (1) include a local match requirement for state dollars received; (2) require local communities, through instrumentalities of the state of Minnesota or nonprofit boards comprised of local residents, to operate and own their community's health care program; (3) encourage the use of midlevel practitioners; and (4) incorporate a quality assurance strategy that provides regular evaluation of clinical performance and allows peer review comparisons for rural practices. The commissioner shall report to the legislature on implementation of the program by February 15, 1994.

Subdivision 1. COMMUNITY HEALTH CENTER. "Community health center" means a community owned and operated primary and preventive health care practice that meets the unique, essential health care needs of a specified population.

Subd. 2. PROGRAM GOALS. The Minnesota community health center program shall increase health care access for residents of rural Minnesota by creating new community health centers in areas where they are needed and maintaining essential rural health care services. The program is not intended to duplicate the work of current health care providers.

Subd. 3. GRANTS. (a) The commissioner shall provide grants to communities for planning and establishing community health centers through the Minnesota community health center program. Grant recipients shall develop and implement a strategy that allows them to become self-sufficient and qualify for other supplemental funding and enhanced reimbursement. The commissioner

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shall coordinate the grant program with the federal rural health clinic, federally qualified health center, and migrant and community health center programs to encourage federal certification. The commissioner may award planning, project, and initial operating expense grants, as provided in paragraphs (b) to (d).

(b) Planning grants may be awarded to communities to plan and develop state funded community health centers, federally qualified health centers, or migrant and community health centers.

(c) Project grants may be awarded to communities for community health center start-up or expansion, and the conversion of existing practices to community health centers. Start-up grants may be used for facilities, capital equipment, moving expenses, initial staffing, and setup. Communities must provide reasonable assurance of their ability to obtain health care providers and effectively utilize existing health care provider resources. Funded community health center projects must become operational before funding expires. Communities may obtain funding for conversion of existing health care practices to community health centers. Communities with existing community health centers may apply for grants to add sites in underserved areas. Governing boards must include representatives of new service areas.

(d) Centers may apply for grants for up to two years to subsidize initial operating expenses. Applicants for initial operating expense grants must demonstrate that expenses exceed revenues by a minimum of ten percent or demonstrate other extreme need that cannot be met using organizational reserves.

Subd. 4. ELIGIBILITY REQUIREMENTS. In order to qualify for community health center program funding, a project must:

(1) be located in a rural shortage area that is a medically underserved, federal health professional shortage, or governor designated shortage area. "Rural" means an area of the state outside the ten-county Twin Cities metropolitan area and outside of the Duluth, St. Cloud, East Grand Forks, Moorhead, Rochester, and LaCrosse census defined urbanized areas;

(2) represent or propose the formation of a nonprofit corporation with local resident governance, or be a governmental entity. Applicants in the process of forming a nonprofit corporation may have a nonprofit coapplicant serve as financial agent through the remainder of the formation period. With the exception of governmental entities, all applicants must submit application for nonprofit incorporation and 501(c)(3) tax-exempt status within six months of accepting community health center grant funds;

(3) result in a locally owned and operated community health center that provides primary and preventive health care services, and incorporates quality assurance, regular reviews of clinical performance, and peer review;

(4) seek to employ midlevel professionals, where appropriate;

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(5) demonstrate community and popular support and provide a 20 percent local match of state funding; and

(6) propose to serve an area that is not currently served by a federally certified medical organization.

**Subd. 5. REVIEW PROCESS, RATING CRITERIA AND POINT ALLOCATION.** (a) The commissioner shall establish grant application guidelines and procedures that allow the commissioner to assess relative need and the applicant's ability to plan and manage a health care project. Program documentation must communicate program objectives, philosophy, expectations, and other conditions of funding to potential applicants.

The commissioner shall establish an impartial review process to objectively evaluate grant applications. Proposals must be categorized, ranked, and funded using a 100-point rating scale. Fifty-two points shall be assigned to relative need and 48 points to project merit.

(b) The scoring of relative need must be based on proposed service area factors, including but not limited to:

(1) population below 200 percent of poverty;

(2) geographic barriers based on average travel time and distance to the next nearest source of primary care that is accessible to Medicaid and Medicare recipients and uninsured low-income individuals;

(3) a shortage of primary care health professionals, based on the ratio of the population in the service area to the number of full-time equivalent primary care physicians in the service area; and

(4) other community health issues including a high unemployment rate, high percentage of uninsured population, high growth rate of minority and special populations, high teenage pregnancy rate, high morbidity rates due to specific diseases, late entry into prenatal care, high percentage geriatric population, high infant mortality rate, high percentage of low birth weight, cultural and language barriers, high percentage minority population, excessive average travel time and distance to next nearest source of subsidized primary care.

(c) Project merit shall be determined based on expected benefit from the project, organizational capability to develop and manage the project, and probability of success, including but not limited to the following factors:

(1) proposed scope of health services;

(2) clinical management plan;

(3) governance;

(4) financial and administrative management; and

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(5) community support, integration, collaboration, resources, and innovation.

The commissioner may elect not to award any of the community health center grants if applications fail to meet criteria or lack merit. The commissioner's decision on an application is final.

Subd. 6. ELIGIBLE EXPENDITURES. Grant recipients may use grant funds for the following types of expenditures:

(1) salaries and benefits for employees, to the extent they are involved in project planning and implementation;

(2) purchase, repair, and maintenance of necessary medical and dental equipment and furnishings;

(3) purchase of office, medical, and dental supplies;

(4) in-state travel to obtain training or improve coordination;

(5) initial operating expenses of community health centers;

(6) programs or plans to improve the coordination, effectiveness, or efficiency of the primary health care delivery system;

(7) facilities;

(8) necessary consultant fees; and

(9) reimbursement to rural-based primary care practitioners for equipment, supplies, and furnishings that are transferred to community health centers. Up to 65 percent of the grant funds may be used to reimburse owners of rural practices for the reasonable market value of usable facilities, equipment, furnishings, supplies, and other resources that the community health center chooses to purchase.

Grant funds shall not be used to reimburse applicants for preexisting debt amortization, entertainment, and lobbying expenses.

Subd. 7. SPECIAL CONSIDERATION. The commissioner, through the office of rural health, shall make special efforts to identify areas of the state where need is the greatest, notify representatives of those areas about grant opportunities, and encourage them to submit applications.

Subd. 8. REQUIREMENTS. The commissioner shall develop a list of requirements for community health centers and a tracking and reporting system to assess benefits realized from the program to ensure that projects are on schedule and effectively utilizing state funds.

The commissioner shall require community health centers established through the grant program to:

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(1) abide by all federal and state laws, rules, regulations, and executive orders;

(2) establish policies, procedures, and services equivalent to those required for federally certified rural health clinics or federally qualified health centers. Written policies are required for description of services, medical management, drugs, biologicals and review of policies;

(3) become a Minnesota nonprofit corporation and apply for 501(c)(3) tax-exempt status within six months of accepting state funding. Local governmental or tribal entities are exempt from this requirement;

(4) establish a governing board composed of nine to 25 members who are residents of the area served and representative of the social, economic, linguistic, ethnic, and racial target population. At least 35 percent of the board must represent consumers;

(5) establish corporate bylaws that reflect all functions and responsibilities of the board;

(6) develop an appropriate management and organizational structure with clear lines of authority and responsibility to the board;

(7) provide for adequate patient management and continuity of care on site and from referral sources;

(8) establish quality assurance and risk management programs, policies, and procedures;

(9) develop a strategic staffing plan to acquire an appropriate mix of primary care providers and clinical support staff;

(10) establish billing policies and procedures to maximize patient collections, except where federal regulations or contractual obligations prohibit the use of these measures;

(11) develop and implement policies and procedures, including a sliding scale fee schedule, that assure that no person will be denied services because of inability to pay;

(12) establish an accounting and internal control system in accordance with sound financial management principles;

(13) provide a local match equal to 20 percent of the grant amount;

(14) work cooperatively with the local community and other health care organizations, other grant recipients, and the office of rural health;

(15) obtain an independent annual audit and submit audit results to the office of rural health;

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(16) maintain detailed records and, upon request, make these records available to the commissioner for examination; and

(17) pursue supplemental funding sources, when practical, for implementation and initial operating expenses.

Subd. 9. PRECAUTIONS. The commissioner may withhold, delay, or cancel grant funding if a grant recipient does not comply with program requirements and objectives.

Subd. 10. TECHNICAL ASSISTANCE. The commissioner may provide, contract for, or provide supplemental funding for technical assistance to community health centers in the areas of clinical operations, medical practice management, community development, and program management.

**Sec. 41. [144.1492] STATE RURAL HEALTH NETWORK REFORM INITIATIVE.**

Subdivision 1. PURPOSE AND MATCHING FUNDS. The commissioner of health shall apply for federal grant funding under the state rural health network reform initiative, a health care financing administration program to provide grant funds to states to encourage innovations in rural health financing and delivery systems. The commissioner may use state funds appropriated to the department of health for the provision of technical assistance for community integrated service network development as matching funds for the federal grant.

Subd. 2. USE OF FEDERAL FUNDS. If the department of health receives federal funding under the state rural health network reform initiative, the department shall use these funds to implement a program to provide technical assistance and grants to rural communities to establish health care networks and to develop and test a rural health network reform model.

Subd. 3. ELIGIBLE APPLICANTS AND CRITERIA FOR AWARDING OF GRANTS TO RURAL COMMUNITIES. (a) Funding which the department receives to award grants to rural communities to establish health care networks shall be awarded through a request for proposals process. Planning grant funds may be used for community facilitation and initial network development activities including incorporation as a nonprofit organization or cooperative, assessment of network models, and determination of the best fit for the community. Implementation grant funds can be used to enable incorporated nonprofit organizations and cooperatives to purchase technical services needed for further network development such as legal, actuarial, financial, marketing, and administrative services.

(b) In order to be eligible to apply for a planning or implementation grant under the federally funded health care network reform program, an organization must be located in a rural area of Minnesota excluding the seven-county Twin Cities metropolitan area and the census-defined urbanized areas of Duluth, Rochester, St. Cloud, and Moorhead. The proposed network organization must

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also meet or plan to meet the criteria for a community integrated service network.

(c) In determining which organizations will receive grants, the commissioner may consider the following factors:

(1) the applicant's description of their plans for health care network development, their need for technical assistance, and other technical assistance resources available to the applicant. The applicant must clearly describe the service area to be served by the network, how the grant funds will be used, what will be accomplished, and the expected results. 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 applicant and the health care network. The applicant should demonstrate support from private and public health care providers in the service area, local community and government leaders, and the regional coordinating board for the area. Evidence of such support may include a commitment of financial support, in-kind services, or cash, for development of the network;

(3) the size and demographic characteristics of the population in the service area for the proposed network and the distance of the service area from the nearest metropolitan area; and

(4) the technical assistance resources available to the applicant from non-state sources and the financial ability of the applicant to purchase technical assistance services with nonstate funds.

Sec. 42. Minnesota Statutes 1993 Supplement, section 144.335, subdivision 3a, is amended to read:

Subd. 3a. **PATIENT CONSENT TO RELEASE OF RECORDS; LIABILITY.** (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release, unless the release is specifically authorized by law. Except as provided in paragraph (c), a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

(b) This subdivision does not prohibit the release of health records for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency.

(c) Notwithstanding paragraph (a), if a patient explicitly gives informed consent to the release of health records for the purposes and pursuant to the restrictions in clauses (1) and (2), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the current treatment of the patient;

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(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

(i) the use or release of the records complies with sections 72A.49 to 72A.505;

(ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and

(iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient.

(d) Until June 1, ~~1994~~ 1996, paragraph (a) does not prohibit the release of health records to qualified personnel solely for purposes of medical or scientific research, if the patient has not objected to a release for research purposes and the provider who releases the records makes a reasonable effort to determine that:

(i) the use or disclosure does not violate any limitations under which the record was collected;

(ii) the use or disclosure in individually identifiable form is necessary to accomplish the research or statistical purpose for which the use or disclosure is to be made;

(iii) the recipient has established and maintains adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; and

(iv) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited.

(e) A person who negligently or intentionally releases a health record in violation of this subdivision, or who forges a signature on a consent form, or who obtains under false pretenses the consent form or health records of another person, or who, without the person's consent, alters a consent form, is liable to the patient for compensatory damages caused by an unauthorized release, plus costs and reasonable attorney's fees.

(f) Upon the written request of a spouse, parent, child, or sibling of a patient being evaluated for or diagnosed with mental illness, a provider shall inquire of a patient whether the patient wishes to authorize a specific individual to receive information regarding the patient's current and proposed course of treatment. If the patient so authorizes, the provider shall communicate to the designated individual the patient's current and proposed course of treatment. Paragraph (a) applies to consents given under this paragraph.

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Sec. 43. Minnesota Statutes 1992, section 144.335, is amended by adding a subdivision to read:

**Subd. 5a. NOTICE OF RIGHTS; INFORMATION ON RELEASE.** A provider shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records. The notice must include an explanation of:

(1) disclosures of health records that may be made without the written consent of the patient, including the type of records and to whom the records may be disclosed; and

(2) the right of the patient to have access to and obtain copies of the patient's health records and other information about the patient that is maintained by the provider.

The notice requirements of this paragraph are satisfied if the notice is included with the notice and copy of the patient and resident bill of rights under section 144.652 or if it is displayed prominently in the provider's place of business. The commissioner of health shall develop the notice required in this subdivision and publish it in the State Register.

Sec. 44. Minnesota Statutes 1992, section 144.581, subdivision 2, is amended to read:

**Subd. 2. USE OF HOSPITAL FUNDS FOR CORPORATE PROJECTS.** In the event that the municipality, political subdivision, state agency, or other governmental entity provides direct financial subsidy to the hospital from tax revenue at the time an undertaking authorized under subdivision 1, clauses (a) to (g), is established or funded, the hospital may not contribute funds to the undertaking for more than three years and thereafter all funds must be repaid, with interest in no more than ten years.

Sec. 45. Minnesota Statutes 1993 Supplement, section 144.802, subdivision 3b, is amended to read:

**Subd. 3b. SUMMARY APPROVAL OF PRIMARY SERVICE AREAS.** Except for submission of a written application to the commissioner on a form provided by the commissioner, an application to provide changes in a primary service area shall be exempt from subdivisions 3, paragraphs (d) to (g); and 4, if:

(1) the application is for a change of primary service area to improve coverage, to improve coordination with 911 emergency dispatching, or to improve efficiency of operations;

(2) the application requests redefinition of contiguous or overlapping primary service areas;

(3) the application shows approval from ~~all the ambulance licensees whose primary service area is either contiguous, overlapping, or both, with those of the current and proposed primary service area of the applicant areas~~ are directly affected by a change in the applicant's primary service area;

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(4) the application shows that the applicant requested review and comment on the application, and has included those comments received from: all county boards in the areas of coverage included in the application; all community health boards in the areas of coverage included in the application; all directors of 911 public safety answering point areas in the areas of coverage included in the application; and all regional emergency medical systems areas designated under section 144.8093 in the areas of coverage included in the application; and

(5) the application shows consideration of the factors listed in subdivision 3, paragraph (g).

Sec. 46. Minnesota Statutes 1993 Supplement, section 144A.071, subdivision 4a, as amended by 1994 H.F. No. 3210, article 3, section 4, if enacted, is amended to read:

Subd. 4a. **EXCEPTIONS FOR REPLACEMENT BEDS.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the new facility is constructed on the same site as the destroyed facility or on another site subject to the restrictions in section 144A.073, subdivision 5;

(v) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(vi) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

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(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed 25 percent of the appraised value of the facility or \$500,000, whichever is less;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed 25 percent of the appraised value of the facility or \$500,000, whichever is less. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or \$200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new

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construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of \$200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility condemned as part of an economic redevelopment plan in a city of the first class, provided the new facility is located within one mile of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under existing reimbursement rules;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed 25 percent of the appraised value of the facility or \$500,000, whichever is less;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly-constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1995;

(o) to allow a project which will be completed in conjunction with an

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approved moratorium exception project for a nursing home in southern Cass county and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993; ~~or~~

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a \$100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (d). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify up to 24 nursing home beds in a facility located in St. Louis county which, as of January 1, 1993, has a licensed capacity of 26 hospital beds and 24 nursing home beds under the following conditions:

(1) no more than 12 nursing home beds can be licensed and certified during fiscal year 1995; and

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(2) the additional 12 nursing home beds can be licensed and certified during fiscal year 1996 only if the 1994 occupancy rate for nursing homes within a 25-mile radius of the facility exceeds 96 percent.

This facility shall not be required to comply with the new construction standards contained in the nursing home licensure rules for resident bedrooms;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned and operated by the same organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital.

The total project construction cost estimate for the project must not exceed the cost estimate submitted for the replacement of the nursing facility in connection with the moratorium exception process initiated under section 144A.073 in 1993.

At the time of licensure and certification of the 117 nursing facility beds in the new location, the facility may layaway the remaining 21 nursing facility beds, which shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657. The 21 nursing facility beds on layaway status may be relicensed and recertified within the identifiable complex of health care facilities in which the beds are currently located upon recommendation by the commissioner of human services;

(s) to license and certify a newly constructed 118-bed facility in Crow Wing county when the following conditions are met:

(1) the owner of the new facility delicensures an existing 68-bed facility located in the same county;

(2) the owner of the new facility delicensures 60 beds in three-bed rooms in other owned facilities located in the seven-county metropolitan area; and

(3) the project results in a ten-bed reduction in the number of licensed beds operated statewide by the owner of the new facility.

All beds in the newly constructed facility shall be licensed as nursing home beds regardless of the licensure of beds at the closed facility;

(t) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; was not owned by a hospital corporation; had a licensed capacity of 64 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate

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for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process; or

(u) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (d). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified.

Sec. 47. Minnesota Statutes 1992, section 145.64, subdivision 1, is amended to read:

Subdivision 1. **DATA AND INFORMATION.** All data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery. No person described in section 145.63 shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization. The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional arising out of the matter or matters which are the subject of consideration by the review organization. Information, documents or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness cannot be asked about the witness' testimony before a review organization or opinions formed by the witness as a result of its hearings.

The confidentiality protection and protection from discovery or introduc-

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tion into evidence provided in this subdivision shall also apply to the governing body of the review organization and shall not be waived as a result of referral of a matter from the review organization to the governing body or consideration by the governing body of decisions, recommendations, or documentation of the review organization.

The governing body of a hospital, health maintenance organization, community integrated service network, or integrated service network, that is owned or operated by a governmental entity, may close a meeting to discuss decisions, recommendations, deliberations, or documentation of the review organization. A meeting may not be closed except by a majority vote of the governing body in a public meeting. The closed meeting must be tape recorded and the tape must be retained by the governing body for five years.

Sec. 48. Minnesota Statutes 1993 Supplement, section 151.21, subdivision 7, is amended to read:

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. This section does not apply when a pharmacist is dispensing a prescribed drug to persons covered under a managed health care plan that maintains a mandatory or closed drug formulary.~~

Sec. 49. Minnesota Statutes 1993 Supplement, section 151.21, subdivision 8, is amended to read:

Subd. 8. ~~The following drugs are excluded from this section: coumadin, dilantin, lanoxin, premarin, theophylline, synthroid, tegretol, and phenobarbital. The drug formulary committee established under section 256B.0625, subdivision 13, shall establish a list of drug products that are to be excluded from this section. This list shall be updated on an annual basis and shall be provided to the board for dissemination to pharmacists licensed in the state.~~

Sec. 50. Minnesota Statutes 1993 Supplement, section 256.9353, subdivision 3, is amended to read:

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 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 determined by the commissioner to have a basis of eligibility for medical assistance shall apply for and cooperate with the requirements of medical assistance by the last day of the third month following admission to an

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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.

(c) Admissions for inpatient hospital services paid for under section 256.9362, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256.9362, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

Sec. 51. Minnesota Statutes 1993 Supplement, section 256.9353, subdivision 7, is amended to read:

Subd. 7. **COPAYMENTS AND COINSURANCE.** The MinnesotaCare 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 inpatient out-of-pocket maximum of \$1,000 per individual and \$3,000 per family;

(2) \$3 per prescription for adult enrollees; and

(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. Enrollees who are not eligible for medical assistance with or without a spenddown shall be financially responsible for the coinsurance amount and amounts which exceed the \$10,000 benefit limit. MinnesotaCare shall be financially responsible for the spenddown amount up to the \$10,000 benefit limit for enrollees who are eligible for medical assistance with a spenddown; enrollees who are eligible for medical assistance with a spenddown are financially responsible for amounts which exceed the \$10,000 benefit limit.~~

Sec. 52. Minnesota Statutes 1993 Supplement, section 256.9354, subdivision 1, is amended to read:

Subdivision 1. **CHILDREN; EXPANSION AND CONTINUATION OF**

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**ELIGIBILITY. (a) 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 150 percent of the federal poverty guidelines and who are not eligible for medical assistance without a spenddown 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.

**(b) EXPANSION OF ELIGIBILITY.** Eligibility for 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. The enrollment requirements in this paragraph apply to enrollment under subdivisions 1 to 5. Parents who enroll in the MinnesotaCare 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. If one spouse in a household enrolls, the other spouse in the household must also enroll, 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 of 25 years who is financially dependent upon a parent. Proof of school enrollment will be required.

**(c) CONTINUATION OF ELIGIBILITY.** Individuals who initially enroll in the MinnesotaCare plan under the eligibility criteria in subdivisions 2 to 5 remain eligible for the MinnesotaCare plan, regardless of age, place of residence, or the presence or absence of children in the same household, as long as all other eligibility criteria are met and residence in Minnesota and continuous enrollment in the MinnesotaCare plan or medical assistance are maintained. In order for either parent or either spouse in a household to remain enrolled, both must remain enrolled, unless other insurance is available.

Sec. 53. Minnesota Statutes 1993 Supplement, 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 without a spenddown under chapter 256B. 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 MinnesotaCare.

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Sec. 54. Minnesota Statutes 1993 Supplement, section 256.9354, subdivision 6, is amended to read:

Subd. 6. **APPLICANTS POTENTIALLY ELIGIBLE FOR MEDICAL ASSISTANCE.** Individuals who apply for MinnesotaCare, but who are potentially eligible for medical assistance without a spenddown 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. 55. Minnesota Statutes 1993 Supplement, section 256.9354, is amended by adding a subdivision to read:

Subd. 7. **GENERAL ASSISTANCE MEDICAL CARE.** A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same month, except that a MinnesotaCare enrollee may be eligible for retroactive general assistance medical care according to section 256D.03, subdivision 3, paragraph (b).

Sec. 56. Minnesota Statutes 1993 Supplement, section 256.9357, subdivision 2, is amended to read:

Subd. 2. **MUST NOT HAVE ACCESS TO EMPLOYER-SUBSIDIZED COVERAGE.** (a) To be eligible for subsidized premium payments based on a sliding scale, a family or individual must not have access to subsidized health coverage through an employer, and must not have had access to subsidized health coverage through an employer for the 18 months prior to application for subsidized coverage under the MinnesotaCare plan. The requirement that the family or individual must not have had access to employer-subsidized coverage during the previous 18 months does not apply if employer-subsidized coverage was lost for reasons that would not disqualify the individual for unemployment benefits under section 268.09 and the family or individual has not had access to employer-subsidized coverage since the layoff. If employer-subsidized coverage was lost for reasons that disqualify an individual for unemployment benefits under section 268.09, children of that individual are exempt from the requirement of no access to employer subsidized coverage for the 18 months prior to

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application, as long as the children have not had access to employer subsidized coverage since the disqualifying event.

(b) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee, excluding dependent coverage, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

Sec. 57. Minnesota Statutes 1993 Supplement, section 256.9362, subdivision 6, is amended to read:

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.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256.9353, subdivision 3, paragraph (c), the hospital may not seek payment from the enrollee for the amount of the reduction.

Sec. 58. Minnesota Statutes 1993 Supplement, section 256.9363, subdivision 6, is amended to read:

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

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MinnesotaCare benefit limit to the managed care plan or its participating providers.

Sec. 59. Minnesota Statutes 1993 Supplement, section 256.9363, subdivision 7, is amended to read:

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; and

(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

(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 spend-down requirements.

Sec. 60. Minnesota Statutes 1993 Supplement, section 256.9363, subdivision 9, is amended to read:

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Subd. 9. **RATE SETTING.** Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

Sec. 61. Minnesota Statutes 1993 Supplement, section 256.9657, subdivision 3, is amended to read:

Subd. 3. **HEALTH MAINTENANCE ORGANIZATION; INTEGRATED SERVICE NETWORK SURCHARGE.** (a) 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 and community integrated service network licensed by the commissioner under ~~sections 62N.01 to 62N.22~~ chapter 62N 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, or community integrated service network~~ as reported to the commissioner of health according to the schedule in subdivision 4.

(b) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization, integrated service network, or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wrap-around subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization, an integrated service network, or a community integrated service network and the health care financing administration of the federal Department of Health and Human Services, for services to a Medicare beneficiary; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization, integrated service network, or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization, integrated service network, or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

Sec. 62. Minnesota Statutes 1993 Supplement, section 256.9695, subdivision 3, as amended by 1994 House File No. 3210, article 3, section 49, if enacted, is amended to read:

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Subd. 3. **TRANSITION.** Except as provided in section 256.969, subdivision 8, the commissioner shall establish a transition period for the calculation of payment rates from July 1, 1989, to the implementation date of the upgrade to the Medicaid management information system or July 1, 1992, whichever is earlier.

During the transition period:

(a) Changes resulting from section 256.969, subdivisions 7, 9, 10, 11, and 13, shall not be implemented, except as provided in section 256.969, subdivisions 12 and 20.

(b) The beginning of the 1991 rate year shall be delayed and the rates notification requirement shall not be applicable.

(c) Operating payment rates shall be indexed from the hospital's most recent fiscal year ending prior to January 1, 1991, by prorating the hospital cost index methodology in effect on January 1, 1989. For payments made for admissions occurring on or after June 1, 1990, until the implementation date of the upgrade to the Medicaid management information system the hospital cost index excluding the technology factor shall not exceed five percent. This hospital cost index limitation shall not apply to hospitals that meet the requirements of section 256.969, subdivision 20, paragraphs (a) and (b).

(d) Property and pass-through payment rates shall be maintained at the most recent payment rate effective for June 1, 1990. However, all hospitals are subject to the hospital cost index limitation of subdivision 2c, for two complete fiscal years. Property and pass-through costs shall be retroactively settled through the transition period. The laws in effect on the day before July 1, 1989, apply to the retroactive settlement.

(e) If the upgrade to the Medicaid management information system has not been completed by July 1, 1992, the commissioner shall make adjustments for admissions occurring on or after that date as follows:

(1) provide a ten percent increase to hospitals that meet the requirements of section 256.969, subdivision 20, or, upon written request from the hospital to the commissioner, 50 percent of the rate change that the commissioner estimates will occur after the upgrade to the Medicaid management information system; and

(2) adjust the Minnesota and local trade area rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be determined using claim specific payment changes that result from the rebased rates and revised methodology in effect after the systems upgrade. Any adjustment that is greater than zero shall be ratably reduced by 20 percent. In addition, every adjustment shall be reduced for payments under clause (1), and differences in the hospital cost index. Hospitals shall revise claims so that ser-

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vices provided by rehabilitation units of hospitals are reported separately. The adjustment shall be in effect until the amount due to or owed by the hospital is fully paid over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5, except that a hospital with a 20 percent or greater negative adjustment that exceeds \$1,000,000 for admissions occurring from July 1, 1992, to December 31, 1992, must use a schedule that is three times the number of admissions under adjustment and the adjustment shall be in effect only over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5. The adjustment for admissions occurring from July 1, 1992 to December 31, 1992, shall be based on claims paid as of August 1, 1993, and the adjustment shall begin with the effective date of rules governing rebasing. The adjustment for admissions occurring from January 1, 1993, to the effective date of the rules shall be based on claims paid as of February 1, 1994, and shall begin after the first adjustment period is fully paid. For purposes of appeals under subdivision 1, the adjustment shall be considered payment at the time of admission.

Sec. 63. Minnesota Statutes 1993 Supplement, section 256B.0917, subdivision 2, is amended to read:

**Subd. 2. DESIGN OF SAIL PROJECTS; LOCAL LONG-TERM CARE COORDINATING TEAM.** (a) The commissioner of human services in conjunction with the interagency long-term care planning committee's long-range strategic plan shall contract with SAIL projects in four to six counties or groups of counties to demonstrate the feasibility and cost-effectiveness of a local long-term care strategy that is consistent with the state's long-term care goals identified in subdivision 1. The commissioner shall publish a notice in the State Register announcing the availability of project funding and giving instructions for making an application. The instructions for the application shall identify the amount of funding available for project components.

(b) To be selected for the project, a county board or boards must establish a long-term care coordinating team consisting of county social service agencies, public health nursing service agencies, local boards of health, a representative of local nursing home providers, a representative of local home care providers, and the area agencies on aging in a geographic area which is responsible for:

(1) developing a local long-term care strategy consistent with state goals and objectives;

(2) submitting an application to be selected as a project;

(3) coordinating planning for funds to provide services to elderly persons, including funds received under Title III of the Older Americans Act, Community Social Services Act, Title XX of the Social Security Act and the Local Public Health Act; and

(4) ensuring efficient services provision and nonduplication of funding.

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(c) The board or boards shall designate a public agency to serve as the lead agency. The lead agency receives and manages the project funds from the state and is responsible for the implementation of the local strategy. If selected as a project, the local long-term care coordinating team must semiannually evaluate the progress of the local long-term care strategy in meeting state measures of performance and results as established in the contract.

(d) Each member of the local coordinating team must indicate its endorsement of the local strategy. The local long-term care coordinating team may include in its membership other units of government which provide funding for services to the frail elderly. The team must cooperate with consumers and other public and private agencies, including nursing homes, in the geographic area in order to develop and offer a variety of cost-effective services to the elderly and their caregivers.

(e) The board or boards shall apply to be selected as a project. If the project is selected, the commissioner of human services shall contract with the lead agency for the project and shall provide additional administrative funds for implementing the provisions of the contract, within the appropriation available for this purpose.

(f) Projects shall be selected according to the following conditions.

No project may be selected unless it demonstrates that:

(i) the objectives of the local project will help to achieve the state's long-term care goals as defined in subdivision 1;

(ii) in the case of a project submitted jointly by several counties, all of the participating counties are contiguous;

(iii) there is a designated local lead agency that is empowered to make contracts with the state and local vendors on behalf of all participants;

(iv) the project proposal demonstrates that the local cooperating agencies have the ability to perform the project as described and that the implementation of the project has a reasonable chance of achieving its objectives;

(v) the project will serve an area that covers at least four counties or contains at least 2,500 persons who are 85 years of age or older, according to the projections of the state demographer or the census if the data is more recent; and

(vi) the local coordinating team documents efforts of cooperation with consumers and other agencies and organizations, both public and private, in planning for service delivery.

Sec. 64. Minnesota Statutes 1993 Supplement, section 295.50, subdivision 4, is amended to read:

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Subd. 4. **HEALTH CARE PROVIDER.** (a) "Health care provider" 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 plan company; or

(3) a licensed ambulance service.

(b) Health care provider does not include hospitals, nursing homes licensed under chapter 144A, pharmacies, and surgical centers.

Sec. 65. Minnesota Statutes 1993 Supplement, section 295.50, subdivision 12b, is amended to read:

Subd. 12b. **STAFF MODEL HEALTH CARRIER PLAN COMPANY.** "Staff model health carrier plan company" means a health carrier plan company as defined in section ~~62L.02, subdivision 4~~ 62Q.01, subdivision 4, which employs one or more types of health care provider to deliver health care services to the health carrier's plan company's enrollees.

Sec. 66. [317A.022] **ELECTION BY CERTAIN CHAPTER 318 ASSOCIATIONS.**

Subdivision 1. GENERAL. An association described in section 318.02, subdivision 5, may elect to cease to be an association subject to and governed by chapter 318 and to become subject to and governed by this chapter in the same manner and to the extent provided in this chapter as though it were a nonprofit corporation by complying with this section.

Subd. 2. AMENDED TITLE AND OTHER CONFORMING AMENDMENTS. The declaration of trust, as defined in section 318.02, subdivision 1, of the association must be amended to identify it as the "articles of an association electing to be treated as a nonprofit corporation." All references in this chapter to "articles" or "articles of incorporation" include the declaration of trust of an electing association. If the declaration of trust includes a provision prohibited by this chapter for inclusion in articles of incorporation, omits a provision required by this chapter to be included in articles of incorporation, or is inconsistent with this chapter, the electing association shall amend its declaration of trust to conform to the requirements of this chapter. The appropriate provisions of the association's declaration of trust or bylaws or chapter 318 control the manner of adoption of the amendments required by this subdivision.

Subd. 3. METHOD OF ELECTION. An election by an association under subdivision 2 must be made by resolution approved by the affirmative vote of the trustees of the association and by the affirmative vote of the members or

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other persons with voting rights in the association. The affirmative vote of both the trustees of the association and of the members or other persons with voting rights, if any, in the association must be of the same proportion that is required for an amendment of the declaration of trust of the association before the election, in each case upon proper notice that a purpose of the meeting is to consider an election by the association to cease to be an association subject to and governed by chapter 318 and to become and be a nonprofit corporation subject to and governed by this chapter. The resolution and the articles of the amendment of the declaration of trust must be filed with the secretary of state and are effective upon filing, or a later date as may be set forth in the filed resolution. Upon the effective date, without any other action or filing by or on behalf of the association, the association automatically is subject to this chapter in the same manner and to the same extent as though it had been formed as a nonprofit corporation pursuant to this chapter. Upon the effective date of the election, the association is not considered to be a new entity, but is considered to be a continuation of the same entity.

Subd. 4. EFFECTS OF ELECTION. Upon the effective date of an association's election under subdivision 3, and consistent with the continuation of the association under this chapter:

(1) the organization has the rights, privileges, immunities, powers, and is subject to the duties and liabilities, of a corporation formed under this chapter;

(2) all real or personal property, debts, including debts arising from a subscription for membership and interests belonging to the association, continue to be the real and personal property, and debts of the organization without further action;

(3) an interest in real estate possessed by the association does not revert to the grantor, or otherwise, nor is it in any way impaired by reason of the election, and the personal property of the association does not revert by reason of the election;

(4) except where the will or other instrument provides otherwise, a devise, bequest, gift, or grant contained in a will or other instrument, in a trust or otherwise, made before or after the election has become effective, to or for the association, inures to the organization;

(5) the debts, liabilities, and obligations of the association continue to be the debts, liabilities, and obligations of the organization, just as if the debts, liabilities, and obligations had been incurred or contracted by the organization after the election;

(6) existing claims or a pending action or proceeding by or against the association may be prosecuted to judgment as though the election had not been affected;

(7) the liabilities of the trustees, members, officers, directors, or similar

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groups or persons, however denominated, of the association, are not affected by the election;

(8) the rights of creditors or liens upon the property of the association are not impaired by the election;

(9) an electing association may merge with one or more nonprofit corporations in accordance with the applicable provisions of this chapter, and either the association or a nonprofit corporation may be the surviving entity in the merger; and

(10) the provisions of the bylaws of the association that are consistent with this chapter remain or become effective and provisions of the bylaws that are inconsistent with this chapter are not effective.

Sec. 67. Minnesota Statutes 1992, section 318.02, is amended by adding a subdivision to read:

Subd. 5. ELECTION TO BE GOVERNED BY CHAPTER 317A. An association may cease to be subject to or governed by this chapter by filing an election in the manner described in section 317A.022, to be subject to and governed by chapter 317A in the same manner and to the same extent provided in chapter 317A as though it were a nonprofit corporation if:

(1) it is not formed for a purpose involving pecuniary gain to its members, other than to members that are nonprofit organizations or subdivisions, units, or agencies of the United States or a state or local government; and

(2) it does not pay dividends or other pecuniary remuneration, directly or indirectly, to its members, other than to members that are nonprofit organizations or subdivisions, units, or agencies of the United States or a state or local government.

Sec. 68. **CHISAGO COUNTY HOSPITAL PROJECT.**

(a) Notwithstanding the provisions of Minnesota Statutes, section 144.551, subdivision 1, paragraph (a), a project to replace a hospital in Chisago county may be commenced if:

(1) the new hospital is located within ten miles of the current site;

(2) the project will result in a net reduction of licensed hospital beds; and

(3) all hospitals within ten miles of the project agree to the general location criteria, or if the hospitals do not agree by July 1, 1994, the commissioner of health approves the project through the process described in paragraph (b). The hospitals may notify the commissioner and request a mutually agreed upon extension of time not to extend beyond August 15, 1994, for submission of this project to the commissioner. The commissioner shall render a decision on the project within 60 days after submission by the parties. The commissioner's decision is the final administrative decision of the agency.

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(b) As expressly authorized under paragraph (a), the commissioner shall approve a project if it is determined that replacement of the existing hospital or hospitals will:

- (1) promote high quality care and services;
- (2) provide improved access to care;
- (3) not involve a substantial expansion of inpatient service capacity; and
- (4) benefit the region to be served by the new regional facility.

(c) Prior to making this determination, the commissioner shall solicit and review written comments from hospitals and community service agencies located within ten miles of the new hospital site and from the regional coordinating board.

(d) For the purposes of pursuing the process established under this section, Chisago health services and district memorial hospital may pursue discussions and work cooperatively with each other, and with another organization mutually agreed upon, to plan for a new hospital facility to serve the area presently served by the two hospitals.

#### Sec. 69. STUDY OF ANESTHESIA PRACTICES.

The commissioner of health shall study and report to the legislature by January 15, 1995, on anesthesia services provided in health care facilities of this state by nurse anesthetists and anesthesiologists. The study shall compare different third-party reimbursement practices and contractual and employment arrangements between health care facilities, nurse anesthetists, and anesthesiologists in terms of their effect on:

(1) patient outcomes in this state, including the incidence of mortality/morbidity as related to provider and practice methods in urban and rural settings as disclosed by a literature search of available retrospective or prospective studies;

(2) the cost of the service provided under each arrangement to health care facilities, third-party purchasers, and patients; and

(3) the effects on competition under each arrangement.

The report shall also include the commissioner's findings on the most appropriate methods to provide anesthesia services to ensure cost-effective delivery of quality anesthesia services.

#### Sec. 70. HOSPITAL STUDIES.

The commissioner of human services must review rebased hospital payment rates to determine whether hospitals with exceptionally high cost inpatient admissions are reimbursed at rates that are reasonable and adequate to meet the costs associated with each such high cost admission. The commissioner must

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report the results of this review, along with recommendations for any appropriate payment rate modifications.

The commissioners of health and human services shall also study the distribution and scope of specialized health care services for children, including the role of all children's hospitals in the context of health care reform. The commissioners shall submit a report, including recommendations, to the legislature and the governor by February 15, 1995.

Sec. 71. **HEALTH CARE ADMINISTRATION.** 1994 House File No. 3210, article 1, section 2, subdivision 3, if enacted, is amended to read:

Subd. 3. Health Care Administration

General

(37,766,000)            17,756,000

**MORATORIUM EXCEPTION PROPOSALS.** ~~Of this appropriation, \$110,000 is appropriated to the commissioner of human services for the fiscal year ending June 30, 1995, to pay the medical assistance costs associated with exceptions to the nursing home moratorium granted under Minnesota Statutes, section 144A.073. Notwithstanding section 144A.073, the inter-agency long-term care planning committee shall issue a request for proposals by June 6, 1994, and the commissioner of health shall make a final decision on project approvals by October 15, 1994.~~

**MANAGED CARE CARRYOVER.** Unexpended money appropriated for grants to counties for managed care administration in fiscal year 1994 does not cancel but is available in fiscal year 1995 for that purpose.

**HIGH COST INFANT AND YOUNG PEDIATRIC ADMISSIONS.** The appropriation to the aid to families with dependent children program in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 5, for the fiscal year ending June 30, 1994, is reduced by \$1,165,000. The appropriation to the medical assistance program is increased by \$1,165,000 for the fiscal

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year ending June 30, 1995, for the purpose of (1) exceptionally high cost inpatient admissions for infants under the age of one, and for children under the age of six receiving services in a hospital that receives payment under Minnesota Statutes, section 256.969, subdivision 9 or 9a; and (2) hospitals with a 20 percent or greater negative adjustment that exceeds \$1,000,000, as the adjustment is calculated under Minnesota Statutes, section 256.9695, subdivision 3.

**INFLATION ADJUSTMENTS.** The commissioner of finance shall include, as a budget change request in the 1996-1997 biennial detailed expenditure budget submitted to the legislature under Minnesota Statutes, section 16A.11, annual inflation adjustments in operating costs for: nursing services and home health aide services under Minnesota Statutes, section 256B.0625, subdivision 6a; nursing supervision of personal care services, under Minnesota Statutes, section 256B.0625, subdivision 19a; private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7; home and community-based services waiver for persons with mental retardation and related conditions under Minnesota Statutes, section 256B.501; home and community-based services waiver for the elderly under Minnesota Statutes, section 256B.0915; alternative care program under Minnesota Statutes, section 256B.0913; traumatic brain injury waiver under Minnesota Statutes, section 256B.093; adult residential program grants, under rule 12, under Minnesota Rules, parts 9535.2000 to 9535.3000; adult and family community support grants, under rules 14 and 78, under Minnesota Rules, parts 9535.1700 to 9535.1760.

#### **HOSPITAL TECHNOLOGY FAC-**

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**TOR.** For admissions occurring on or after April 1, 1994, through June 30, 1995, the hospital cost index shall be increased by 0.51 percent for technology. Notwithstanding the sunset provisions of this article, this increase shall become part of the base for the 1996-1997 biennium. For fiscal year 1995 only, the commissioner shall adjust rates paid to a health maintenance organization under medical assistance contract with the commissioner to reflect the hospital technology factor in this paragraph, and the adjustment must be made on an undiscounted basis.

**ICF/MR RECEIVERSHIP.** If an intermediate care facility for persons with mental retardation or related conditions that is in receivership under Minnesota Statutes, section 245A.12 or 245A.13, is sold to an unrelated organization: (1) the facility shall be considered a newly established facility for rate setting purposes notwithstanding any provisions to the contrary in section 256B.501, subdivision 11; and (2) the facility's historical basis for the physical plant, land, and land improvements for each facility must not exceed the prior owner's aggregate historical basis for these same assets for each facility. The allocation of the purchase price between land, land improvements, and physical plant shall be based on the real estate appraisal using the depreciated replacement cost method.

**NEW ICF/MR.** A newly constructed or newly established intermediate care facility for persons with mental retardation or related conditions that is developed and financed during the fiscal year ending June 30, 1995, shall not be subject to the equity requirements in Minnesota Statutes, section 256B.501, subdivision 11, paragraph (d), or Minnesota Rules, part 9553.0060, subpart 3,

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item F, provided that the provider's interest rate does not exceed the interest rate available through state agency tax-exempt financing.

**Sec. 72. REVISOR INSTRUCTION.**

The revisor of statutes shall change the term "health right" to "MinnesotaCare," "health right plan" to "MinnesotaCare program," and "MinnesotaCare plan" to "MinnesotaCare program," wherever these terms are used in Minnesota Statutes or Minnesota Rules.

**Sec. 73. CONTINGENT REPEALER FOR MINNESOTACARE.**

Notwithstanding section 645.34, the article 13, section 2, amendment to section 256.9354, subdivision 5, and the article 13, section 5, amendment to section 256.9358, subdivision 4, are repealed July 1, 1994, and the provisions are revived as they were before the amendments, if the 1994 Legislature passes and the governor signs into law a provision that establishes and provides money for a health care access reserve account to ensure adequate funding for the MinnesotaCare program through fiscal year 1996.

**Sec. 74. REPEALER.**

Minnesota Statutes 1992, section 256.362, subdivision 5; Minnesota Statutes 1993 Supplement, sections 62J.04, subdivision 8; 62N.07; 62N.075; 62N.08; 62N.085; and 62N.16, are repealed.

**Sec. 75. EFFECTIVE DATE.**

Sections 4, 15, 18, 20, 22, 24, 27 to 29, 31 to 35, 39 to 42, 45, 47 to 49, 51 to 55, 62, 64 to 68, and 71 to 74 are effective the day following final enactment. All other sections are effective July 1, 1994.

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**ARTICLE 9**

**ADMINISTRATIVE SIMPLIFICATION**

**Section 1. [62J.50] CITATION AND PURPOSE.**

Subdivision 1. CITATION. Sections 62J.50 to 62J.61 may be cited as the Minnesota health care administrative simplification act of 1994.

Subd. 2. PURPOSE. The legislature finds that significant savings throughout the health care industry can be accomplished by implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange. The legislature finds that initial steps have been taken at the national level by the federal health

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care financing administration in its implementation of nationally accepted electronic transaction sets for its medicare program. The legislature further recognizes the work done by the workgroup for electronic data interchange and the American national standards institute and its accredited standards committee X12, at the national level, and the Minnesota administrative uniformity committee, a statewide, voluntary, public-private group representing payers, hospitals, state programs, physicians, and other health care providers in their work toward administrative simplification in the health care industry.

Sec. 2. [62J.51] DEFINITIONS.

Subdivision 1. SCOPE. For purposes of sections 62J.50 to 62J.61, the following definitions apply.

Subd. 2. ANSI. "ANSI" means the American national standards institute.

Subd. 3. ASC X12 "ASC X12" means the American national standards institute committee X12.

Subd. 4. CATEGORY I INDUSTRY PARTICIPANTS. "Category I industry participants" means the following: group purchasers, providers, and other health care organizations doing business in Minnesota including public and private payers; hospitals; claims clearinghouses; third-party administrators; billing service bureaus; value added networks; self-insured plans and employers with more than 100 employees; clinic laboratories; durable medical equipment suppliers with a volume of at least 50,000 claims or encounters per year; and group practices with 20 or more physicians.

Subd. 5. CATEGORY II INDUSTRY PARTICIPANTS. "Category II industry participants" means all group purchasers and providers doing business in Minnesota not classified as category I industry participants.

Subd. 6. CLAIM PAYMENT/ADVICE TRANSACTION SET (ANSI ASC X12 835). "Claim payment/advice transaction set (ANSI ASC X12 835)" means the electronic transaction format developed and approved for implementation in October 1991, and used for electronic remittance advice and electronic funds transfer.

Subd. 7. CLAIM SUBMISSION TRANSACTION SET (ANSI ASC X12 837). "Claim submission transaction set (ANSI ASC X12 837)" means the electronic transaction format developed and approved for implementation in October 1992, and used to submit all health care claims information.

Subd. 8. EDI. "EDI" or "electronic data interchange" means the computer application to computer application exchange of information using nationally accepted standard formats.

Subd. 9. ELIGIBILITY TRANSACTION SET (ANSI ASC X12 270/271). "Eligibility transaction set (ANSI ASC X12 270/271)" means the transaction format developed and approved for implementation in February 1993, and used by providers to request and receive coverage information on the member or insured.

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Subd. 10. ENROLLMENT TRANSACTION SET (ANSI ASC X12 834). "Enrollment transaction set (ANSI ASC X12 834)" means the electronic transaction format developed and approved for implementation in February 1992, and used to transmit enrollment and benefit information from the employer to the payer for the purpose of enrolling in a benefit plan.

Subd. 11. GROUP PURCHASER. "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

Subd. 12. ISO. "ISO" means the international standardization organization.

Subd. 13. NCPDP. "NCPDP" means the national council for prescription drug programs, inc.

Subd. 14. NCPDP TELECOMMUNICATION STANDARD FORMAT 3.2. "NCPDP telecommunication standard format 3.2" means the recommended transaction sets for claims transactions adopted by the membership of NCPDP in 1992.

Subd. 15. NCPDP TAPE BILLING AND PAYMENT FORMAT 2.0. "NCPDP tape billing and payment format 2.0" means the recommended transaction standards for batch processing claims adopted by the membership of the NCPDP in 1993.

Subd. 16. PROVIDER. "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Subd. 17. UNIFORM BILLING FORM HCFA 1450. "Uniform billing form HCFA 1450" means the uniform billing form known as the HCFA 1450 or UB92, developed by the national uniform billing committee in 1992 and approved for implementation in October 1993.

Subd. 18. UNIFORM BILLING FORM HCFA 1500. "Uniform billing form HCFA 1500" means the 1990 version of the health insurance claim form, HCFA 1500, developed by the uniform claims form task force of the federal health care financing administration.

Subd. 19. UNIFORM DENTAL BILLING FORM. "Uniform dental billing form" means the 1990 uniform dental claim form developed by the American dental association.

Subd. 20. UNIFORM PHARMACY BILLING FORM. "Uniform pharmacy billing form" means the national council for prescription drug programs/universal claim form (NCPDP/UCF).

Subd. 21. WEDI. "WEDI" means the national workgroup for electronic data interchange report issued in October, 1993.

**Sec. 3. [62J.52] ESTABLISHMENT OF UNIFORM BILLING FORMS.**

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Subdivision 1. UNIFORM BILLING FORM HCFA 1450. (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, and institutionally owned or operated outpatient services rendered by providers in Minnesota, that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form HCFA 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the national uniform billing committee, as adopted and finalized by the Minnesota uniform billing committee.

(c) Services to be billed using the uniform billing form HCFA 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); and institutional owned or operated outpatient services such as hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, including infusion therapy, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, community mental health centers, and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

Subd. 2. UNIFORM BILLING FORM HCFA 1500. (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form HCFA 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1500 shall be in accordance with the manual developed by the administrative uniformity committee entitled standards for the use of the HCFA 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form HCFA 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional services, certi-

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fied registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, and other health care providers such as home health intravenous therapy providers, personal care attendants, day activity centers, waived services, hospice, and other home health services, and freestanding ambulatory surgical centers.

**Subd. 3. UNIFORM DENTAL BILLING FORM.** (a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the American dental association uniform dental billing form.

(b) The instructions and definitions for the use of the uniform dental billing form shall be in accordance with the manual developed by the administrative uniformity committee dated February 1994, and as amended or further defined by the commissioner.

**Subd. 4. UNIFORM PHARMACY BILLING FORM.** (a) On and after January 1, 1996, all pharmacy services provided by pharmacists in Minnesota that are not currently being billed using an equivalent electronic billing format shall be billed using the NCPDP/universal claim form, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform claim form shall be in accordance with instructions specified by the commissioner of health, except as provided in subdivision 5.

**Subd. 5. STATE AND FEDERAL HEALTH CARE PROGRAMS.** (a) Skilled nursing facilities and ICF-MR services billed to state and federal health care programs administered by the department of human services shall use the form designated by the department of human services.

(b) On and after July 1, 1996, state and federal health care programs administered by the department of human services shall accept the HCFA 1450 for community mental health center services and shall accept the HCFA 1500 for freestanding ambulatory surgical center services.

(c) State and federal health care programs administered by the department of human services shall be authorized to use the forms designated by the department of human services for pharmacy services and for child and teen checkup services.

(d) State and federal health care programs administered by the department of human services shall accept the form designated by the department of human services, and the HCFA 1500 for supplies, medical supplies or durable medical equipment. Health care providers may choose which form to submit.

**Sec. 4. [62J.53] ACCEPTANCE OF UNIFORM BILLING FORMS BY GROUP PURCHASERS.**

On and after January 1, 1996, all category I and II group purchasers in Min-

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nesota shall accept the uniform billing forms prescribed under section 62J.52 as the only nonelectronic billing forms used for payment processing purposes.

**Sec. 5. [62J.54] IDENTIFICATION AND IMPLEMENTATION OF UNIQUE IDENTIFIERS.**

**Subdivision 1. UNIQUE IDENTIFICATION NUMBER FOR HEALTH CARE PROVIDER ORGANIZATIONS.** (a) On and after January 1, 1996, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify health care provider organizations, except as provided in paragraph (d).

(b) Following the recommendation of the workgroup for electronic data interchange, the federal tax identification number assigned to each health care provider organization by the internal revenue service of the department of the treasury shall be used as the unique identification number for health care provider organizations.

(c) The unique health care provider organization identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The state and federal health care programs administered by the department of human services shall use the unique identification number assigned to health care providers for implementation of the medicaid management information system or the uniform provider identification number (UPIN) assigned by the health care financing administration.

**Subd. 2. UNIQUE IDENTIFICATION NUMBER FOR INDIVIDUAL HEALTH CARE PROVIDERS.** (a) On and after January 1, 1996, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify an individual health care provider, except as provided in paragraph (d).

(b) The uniform provider identification number (UPIN) assigned by the health care financing administration shall be used as the unique identification number for individual health care providers. Providers who do not currently have a UPIN number shall request one from the health care financing administration.

(c) The unique individual health care provider identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The state and federal health care programs administered by the department of human services shall use the unique identification number assigned to health care providers for implementation of the medicaid management information system or the uniform provider identification number (UPIN) assigned by the health care financing administration.

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**Subd. 3. UNIQUE IDENTIFICATION NUMBER FOR GROUP PURCHASERS.** (a) On and after January 1, 1996, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers.

(b) The federal tax identification number assigned to each group purchaser by the internal revenue service of the department of the treasury shall be used as the unique identification number for group purchasers. This paragraph applies until the codes described in paragraph (c) are available and feasible to use, as determined by the commissioner.

(c) A two-part code, consisting of 11 characters and modeled after the national association of insurance commissioners company code shall be assigned to each group purchaser and used as the unique identification number for group purchasers. The first six characters, or prefix, shall contain the numeric code, or company code, assigned by the national association of insurance commissioners. The last five characters, or suffix, which is optional, shall contain further codes that will enable group purchasers to further route electronic transaction in their internal systems.

(d) The unique group purchaser identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

**Subd. 4. UNIQUE PATIENT IDENTIFICATION NUMBER.** (a) On and after January 1, 1996, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (e).

(b) Except as provided in paragraph (d), following the recommendation of the workgroup for electronic data interchange, the social security number of the patient shall be used as the unique patient identification number.

(c) The unique patient identification number shall be used by group purchasers and health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The commissioner shall develop an alternate numbering system for patients who do not have or refuse to provide a social security number. This provision does not require that patients provide their social security numbers and does not require group purchasers or providers to demand that patients provide their social security numbers. Group purchasers and health care providers shall establish procedures to notify patients that they can elect not to have their social security number used as the unique patient identification number.

(e) The state and federal health care programs administered by the department of human services shall use the unique person master index (PMI) identification number assigned to clients participating in programs administered by the department of human services.

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**Sec. 6. [62J.55] PRIVACY OF UNIQUE IDENTIFIERS.**

(a) When the unique identifiers specified in section 62J.54 are used for data collection purposes, the identifiers must be encrypted, as required in section 62J.30, subdivision 6. Encryption must follow encryption standards set by the national bureau of standards and approved by the American national standards institute as ANSIX3. 92-1982/R 1987 to protect the confidentiality of the data. Social security numbers must not be maintained in unencrypted form in the database, and the data must never be released in a form that would allow for the identification of individuals. The encryption algorithm and hardware used must not use clipper chip technology.

(b) Providers and group purchasers shall treat medical records, including the social security number if it is used as a unique patient identifier, in accordance with section 144.335. The social security number may be disclosed by providers and group purchasers to the commissioner as necessary to allow performance of those duties set forth in section 144.05.

**Sec. 7. [62J.56] IMPLEMENTATION OF ELECTRONIC DATA INTERCHANGE STANDARDS.**

Subdivision 1. GENERAL PROVISIONS. (a) The legislature finds that there is a need to advance the use of electronic methods of data interchange among all health care participants in the state in order to achieve significant administrative cost savings. The legislature also finds that in order to advance the use of health care electronic data interchange in a cost-effective manner, the state needs to implement electronic data interchange standards that are nationally accepted, widely recognized, and available for immediate use. The legislature intends to set forth a plan for a systematic phase-in of uniform health care electronic data interchange standards in all segments of the health care industry.

(b) The commissioner of health, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, shall administer the implementation of and monitor compliance with, electronic data interchange standards of health care participants, according to the plan provided in this section.

(c) The commissioner may grant exemptions to category I and II industry participants from the requirements to implement some or all of the provisions in this section if the commissioner determines that the cost of compliance would place the organization in financial distress, or if the commissioner determines that appropriate technology is not available to the organization.

Subd. 2. IDENTIFICATION OF CORE TRANSACTION SETS. (a) All category I and II industry participants in Minnesota shall comply with the standards developed by the ANSI ASC X12 for the following core transaction sets, according to the implementation plan outlined for each transaction set.

(1) ANSI ASC X12 835 health care claim payment/advice transaction set.

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(2) ANSI ASC X12 837 health care claim transaction set.

(3) ANSI ASC X12 834 health care enrollment transaction set.

(4) ANSI ASC X12 270/271 health care eligibility transaction set.

(b) The commissioner, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, and in coordination with federal efforts, may approve the use of new ASC X12 standards, or new versions of existing standards, as they become available, or other nationally recognized standards, where appropriate ASC X12 standards are not available for use. These alternative standards may be used during a transition period while ASC X12 standards are developed.

Subd. 3. IMPLEMENTATION GUIDES. (a) The commissioner, with the advice of the Minnesota administrative uniformity committee, and the Minnesota Center for Health Care Electronic Data Interchange shall review and recommend the use of guides to implement the core transaction sets. Implementation guides must contain the background and technical information required to allow health care participants to implement the transaction set in the most cost-effective way.

(b) The commissioner shall promote the development of implementation guides among health care participants for those business transaction types for which implementation guides are not available, to allow providers and group purchasers to implement electronic data interchange. In promoting the development of these implementation guides, the commissioner shall review the work done by the American hospital association through the national uniform billing committee and its state representative organization; the American medical association through the uniform claim task force; the American dental association; the national council of prescription drug programs; and the workgroup for electronic data interchange.

**Sec. 8. [62J.57] MINNESOTA CENTER FOR HEALTH CARE ELECTRONIC DATA INTERCHANGE.**

(a) It is the intention of the legislature to support, to the extent of funds appropriated for that purpose, the creation of the Minnesota center for health care electronic data interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers, and government programs to advance the use of health care electronic data interchange in the state. The center shall attempt to obtain private sector funding to supplement legislative appropriations, and shall become self-supporting by the end of the second year.

(b) The Minnesota center for health care electronic data interchange shall facilitate the statewide implementation of electronic data interchange standards in the health care industry by:

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(1) Coordinating and ensuring the availability of quality electronic data interchange education and training in the state;

(2) Developing an extensive, cohesive health care electronic data interchange education curriculum;

(3) Developing a communications and marketing plan to publicize electronic data interchange education activities, and the products and services available to support the implementation of electronic data interchange in the state;

(4) Administering a resource center that will serve as a clearinghouse for information relative to electronic data interchange, including the development and maintenance of a health care constituents data base, health care directory and resource library, and a health care communications network through the use of electronic bulletin board services and other network communications applications; and

(5) Providing technical assistance in the development of implementation guides, and in other issues including legislative, legal, and confidentiality requirements.

#### Sec. 9. [62J.58] IMPLEMENTATION OF STANDARD TRANSACTION SETS.

Subdivision 1. CLAIMS PAYMENT. (a) By July 1, 1995, all category I industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version 3030) for electronic transfer of payment information.

(b) By July 1, 1996, all category II industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version 3030) for electronic submission of payment information to health care providers.

Subd. 2. CLAIMS SUBMISSION. Beginning July 1, 1995, all category I industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 837 health care claim transaction set (draft standard for trial use version 3030) for the electronic transfer of health care claim information. Category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, this transaction set, beginning July 1, 1996.

Subd. 3. ENROLLMENT INFORMATION. Beginning January 1, 1996, all category I industry participants, excluding pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 834 health care enrollment transaction set (draft standard for trial use version 3030) for the electronic transfer of enrollment and health benefit information. Category II industry partici-

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pants, except pharmacists, shall be able to accept or submit, as appropriate, this transaction set, beginning January 1, 1997.

Subd. 4. ELIGIBILITY INFORMATION. By January 1, 1996, all category I industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 270/271 health care eligibility transaction set (draft standard for trial use version 3030) for the electronic transfer of health benefit eligibility information. Category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, this transaction set, beginning January 1, 1997.

Subd. 5. APPLICABILITY. This section does not require a group purchaser, health care provider, or employer to use electronic data interchange or to have the capability to do so. This section applies only to the extent that a group purchaser, health care provider, or employer chooses to use electronic data interchange.

**Sec. 10. [62J.59] IMPLEMENTATION OF NCPDP TELECOMMUNICATIONS STANDARD FOR PHARMACY CLAIMS.**

(a) Beginning January 1, 1996, all category I and II pharmacists licensed in this state shall accept the NCPDP telecommunication standard format 3.2 or the NCPDP tape billing and payment format 2.0 for the electronic submission of claims as appropriate.

(b) Beginning January 1, 1996, all category I and category II group purchasers in this state shall use the NCPDP telecommunication standard format 3.2 or NCPDP tape billing and payment format 2.0 for electronic submission of payment information to pharmacists.

**Sec. 11. [62J.60] STANDARDS FOR THE MINNESOTA UNIFORM HEALTH CARE IDENTIFICATION CARD.**

Subdivision 1. MINNESOTA HEALTH CARE IDENTIFICATION CARD. All individuals with health care coverage shall be issued health care identification cards by group purchasers as of January 1, 1998. The health care identification cards shall comply with the standards prescribed in this section.

Subd. 2. GENERAL CHARACTERISTICS. (a) The Minnesota health care identification card must be a pre-printed card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional.

(b) The Minnesota health care identification card must have an essential information window in the front side with the following data elements left justified in the following top to bottom sequence: issuer name, issuer number, identification number, identification name. No optional data may be interspersed between these data elements. The window must be left justified.

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(c) Standardized labels are required next to human readable data elements. The card issuer may decide the location of the standardized label relative to the data element.

Subd. 3. HUMAN READABLE DATA ELEMENTS. (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota health care identification card:

(1) Issuer name or logo, which is the name or logo that identifies the card issuer. The issuer name or logo may be the card's front background. No standard label is required for this data element;

(2) Issuer number, which is the unique card issuer number consisting of a base number assigned by a registry process followed by a suffix number assigned by the card issuer. The use of this element is mandatory within one year of the establishment of a process for this identifier. The standardized label for this element is "Issuer";

(3) Identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

(4) Identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

(5) Account number(s), which is any other number, such as a group number, if required for part of the identification or claims process. The standardized label for this data element is "Account";

(6) Care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

(7) Service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health. The standard label for this data element is "Svc Type"; and

(8) Provider/clinic name, which is the name of the primary care clinic the cardholder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the cardholder.

(b) The following human readable data elements shall be present on the back side of the Minnesota health identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) Claims submission name(s) and address(es), which are the name(s) and

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address(es) of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) Telephone number(s) and name(s); which are the telephone number(s) and name(s) of the following contact(s) with a standardized label describing the service function as applicable;

(i) eligibility and benefit information;

(ii) utilization review;

(iii) pre-certification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the card for health maintenance organizations and integrated service networks:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) telephone number to call to appeal to the commissioner of health. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

**Subd. 4. MACHINE READABLE DATA CONTENT.** The Minnesota health care identification card may be machine readable or nonmachine readable. If the card is machine readable, the card must contain a magnetic stripe that conforms to ANSI and ISO standards for Tracks 1.

#### Sec. 12. [62J.61] RULEMAKING; IMPLEMENTATION.

The commissioner of health is exempt from rulemaking in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.59. The commissioner shall publish proposed rules in the State Register. Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish the final rules in the State Register 30 days before they are to take effect. The commissioner may use emergency and permanent rulemaking to implement the remainder of this article. The commissioner shall not adopt any rules requiring patients to provide their social security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter. The commissioner shall seek comments from the ethics and confidentiality committee of

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the Minnesota health data institute and the department of administration, public information policy analysis division, before adopting or publishing final rules relating to issues of patient privacy and medical records.

**Sec. 13. COMMISSIONER; CONTINUED SIMPLIFICATION.**

The commissioner of health shall continue to develop additional standard billing and administrative procedure simplification. These may include reduction or elimination of payer-required attachments to claims, standard formularies, standard format for direct patient billing, and increasing standardization of claims forms and EDI formats.

**Sec. 14. EVALUATIONS.**

Subdivision 1. UNIQUE EMPLOYER IDENTIFICATION NUMBER. The commissioner of health shall evaluate the need for the development and implementation of unique employer identification numbers to identify employers or entities that provide health care coverage.

Subd. 2. UNIQUE "ISSUER" IDENTIFICATION NUMBER. The commissioner of health shall evaluate the need for the development and implementation of unique identification numbers to identify issuers of health care identification cards.

**Sec. 15. EFFECTIVE DATE.**

Sections 1 to 14 are effective the day following final enactment.

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**ARTICLE 10**

**INSURANCE REFORM**

Section 1. Minnesota Statutes 1993 Supplement, section 43A.317, is amended by adding a subdivision to read:

Subd. 12. STATUS OF AGENTS. Notwithstanding section 60K.03, subdivision 5, and 72A.07, the program may use, and pay referral fees, commissions, or other compensation to, agents licensed as life and health agents under chapter 60K or licensed under section 62C.17, regardless of whether the agents are appointed to represent the particular health carriers, integrated service networks, or community integrated service networks that provide the coverage available through the program. When acting under this subdivision, an agent is not an agent of the health carrier, integrated service network, or community integrated service network, with respect to that transaction.

Sec. 2. Minnesota Statutes 1993 Supplement, section 60K.14, subdivision 7, is amended to read:

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Subd. 7. **DISCLOSURE OF COMMISSIONS.** 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 in writing 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. 3. Minnesota Statutes 1993 Supplement, section 62A.011, subdivision 3, is amended to read:

Subd. 3. **HEALTH PLAN.** "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

- (1) limited to disability or income protection coverage;
- (2) automobile medical payment coverage;
- (3) supplemental to liability insurance;
- (4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense-incurred basis;
- (5) credit accident and health insurance as defined in section 62B.02;
- (6) designed solely to provide dental or vision care;
- (7) blanket accident and sickness insurance as defined in section 62A.11;
- (8) accident-only coverage;
- (9) a long-term care policy as defined in section 62A.46;
- (10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended ~~through December 31, 1991~~;
- (11) workers' compensation insurance; or
- (12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan.

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Sec. 4. Minnesota Statutes 1992, section 62A.303, is amended to read:

**62A.303 PROHIBITION; SEVERING OF GROUPS.**

Section 62L.12, subdivisions 1, 2, 3, and 4, apply to all employer group health plans, as defined in section 62A.011, regardless of the size of the group.

**Sec. 5. [62A.306] USE OF GENDER PROHIBITED.**

Subdivision 1. APPLICABILITY. This section applies to all health plans as defined in section 62A.011 offered, sold, issued, or renewed, by a health carrier on or after January 1, 1995.

Subd. 2. PROHIBITION ON USE OF GENDER. No health plan described in subdivision 1 shall determine the premium rate or any other underwriting decision, including initial issuance, through a method that is in any way based upon the gender of any person covered or to be covered under the health plan. This subdivision prohibits use of marital status or generalized differences in expected costs between employees and spouses or between principal insureds and their spouses.

Sec. 6. Minnesota Statutes 1993 Supplement, section 62A.31, subdivision 1h, is amended to read:

**Subd. 1h. LIMITATIONS ON DENIALS, CONDITIONS, AND PRICING OF COVERAGE.** No issuer of Medicare supplement policies, including policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any Medicare supplement insurance policy form available for sale in this state, nor may it discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such insurance is submitted during the six-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B. This paragraph applies regardless of whether the individual has attained the age of 65 years. If an individual who is enrolled in Medicare Part B due to disability status is involuntarily disenrolled due to loss of disability status, the individual is eligible for the six-month enrollment period provided under this subdivision if the individual later becomes eligible for and enrolls again in Medicare Part B.

Sec. 7. Minnesota Statutes 1993 Supplement, section 62A.36, subdivision 1, is amended to read:

**Subdivision 1. LOSS RATIO STANDARDS.** (a) For purposes of this section, "Medicare supplement policy or certificate" has the meaning given in section 62A.31, subdivision 3, but also includes a policy, contract, or certificate issued under a contract under section 1833 or 1876 of the federal Social Security Act.

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ty Act, United States Code, title 42, section 1395 et seq. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

(1) at least 75 percent of the aggregate amount of premiums earned in the case of group policies, and

(2) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies, 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. An insurer shall demonstrate that the third year loss ratio is greater than or equal to the applicable percentage.

All filings of rates and rating schedules shall demonstrate that 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 or certificate shall equal or exceed the appropriate loss ratio standards.

An application form for a Medicare supplement policy or certificate, as defined in this section, must prominently disclose the anticipated loss ratio and explain what it means.

(b) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the National Association of Insurance Commissioners Medicare Supplement Refund Calculating form, for each type of Medicare supplement benefit plan.

If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation must be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than

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the average rate of interest for 13-week treasury bills. A refund or credit against premiums due shall be made by September 30 following the experience year on which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy or certificate 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 policies or certificates in force less than three years.

As soon as practicable, but before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(1) a premium adjustment that is necessary to produce an expected loss ratio under the policy or certificate that will conform with minimum loss ratio standards for Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy or certificate other than the adjustments described herein shall be made with respect to a policy or certificate at any time other than on its renewal date or anniversary date;

(2) if an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits considered necessary to achieve the loss ratio required by this section;

(3) any appropriate riders, endorsements, or policy or certificate forms needed to accomplish the Medicare supplement insurance policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy or certificate forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(d) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of a refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner considered appropriate by the commissioner.

(e) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting docu-

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mentation have been filed with, and approved by, the commissioner according to the filing requirements and procedures prescribed by the commissioner.

Sec. 8. Minnesota Statutes 1993 Supplement, section 62A.65, subdivision 2, is amended to read:

Subd. 2. **GUARANTEED RENEWAL.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health 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 plan to the person. The premium rate upon renewal must also otherwise comply with this section. A health carrier must not refuse to renew an individual health plan may be subject to refusal to renew only under the conditions provided in chapter 62L for health benefit plans prior to enrollment in Medicare Parts A and B, except for nonpayment of premiums, fraud, or misrepresentation.

Sec. 9. Minnesota Statutes 1993 Supplement, section 62A.65, subdivision 3, is amended to read:

Subd. 3. **PREMIUM RATE RESTRICTIONS.** No individual health 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 health plan is as provided in section 62A.021. All rating and premium restrictions of chapter 62L apply to the individual market, unless clearly inapplicable to the individual market, following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) 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

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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. 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) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and

(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.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) The rates must 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 risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

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Sec. 10. Minnesota Statutes 1993 Supplement, section 62A.65, subdivision 4, is amended to read:

Subd. 4. **GENDER RATING PROHIBITED.** No individual health plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, ~~or~~ through a method that is in any way based upon the gender of any person covered or to be covered under the health plan. This subdivision prohibits the use of marital status or generalized differences in expected costs between principal insureds and their spouses.

Sec. 11. Minnesota Statutes 1993 Supplement, section 62A.65, subdivision 5, is amended to read:

Subd. 5. **PORTABILITY OF COVERAGE.** (a) No individual health 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 or exclusionary rider, unless the limitation or exclusion ~~would be~~ is permitted under ~~chapter 62L~~ this subdivision, 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~~ subjected to an 18-month preexisting condition limitation, unless the individual has maintained continuous coverage as defined in ~~chapter 62L~~ section 62L.02. The individual must not be subjected to an exclusionary rider. 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, of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02~~, at the time that the individual first is covered under an individual health plan by any health carrier. The individual must not be subjected to an exclusionary rider. Thereafter, the individual must not be subject to any preexisting condition limitation or exclusion or exclusionary rider 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 health plan to any individual previously covered under a group health ~~benefit~~ plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in ~~chapter 62L~~ section 62L.02. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan and must not contain any preexisting condition limitation or exclusion or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate

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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, and the premium rate must be less than that amount if necessary to otherwise comply with this section. An individual health plan offered under this paragraph to a person satisfies the health carrier's obligation to offer conversion coverage under section 62E.16, with respect to that person. Section 72A.20, subdivision 28, applies to this paragraph.

Sec. 12. Minnesota Statutes 1993 Supplement, section 62A.65, is amended by adding a subdivision to read:

**Subd. 8. CESSATION OF INDIVIDUAL BUSINESS.** Notwithstanding the provisions of subdivisions 1 to 7, a health carrier may elect to cease doing business in the individual market if it complies with the requirements of this subdivision. A health carrier electing to cease doing business in the individual 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 individual market or continue an existing product line, provided that a health carrier does not terminate, cancel, or fail to renew its current individual business or other product lines. A health carrier electing to cease doing business in the individual market shall provide 120 days' written notice to each policyholder covered by a health plan issued by the health carrier. A health carrier that ceases to write new business in the individual market shall continue to be governed by this section with respect to continuing individual business conducted by the carrier. A health carrier that ceases to do business in the individual market after July 1, 1994, is prohibited from writing new business in the individual market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the individual market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the individual market in that same service area. The right to cancel or refuse to renew an individual health plan under this subdivision does not apply to individual health plans originally issued prior to July 1, 1993, on a guaranteed renewable basis.

Sec. 13. Minnesota Statutes 1993 Supplement, section 62D.12, subdivision 17, is amended to read:

**Subd. 17. DISCLOSURE OF COMMISSIONS.** Any person receiving commissions for the sale of coverage or enrollment in a health plan, as defined in section 62A.011, offered by a health maintenance organization shall, before selling or offering to sell coverage or enrollment, disclose in writing 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.

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Sec. 14. Minnesota Statutes 1992, section 62E.141, is amended to read:

**62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.**

No employee, or dependent of an employee, of an employer ~~who~~ that offers a health ~~benefit~~ plan, under which the employee or dependent is eligible ~~to enroll under chapter 62L for coverage~~, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation or exclusion or exclusionary rider under the employer's health ~~benefit~~ plan. This section does not apply to persons enrolled in the comprehensive health association as of June 30, 1993. With respect to persons eligible to enroll in the health plan of an employer that has more than 29 current employees, as defined in section 62L.02, this section does not apply to persons enrolled in the comprehensive health association as of December 31, 1994.

Sec. 15. Minnesota Statutes 1992, section 62E.16, is amended to read:

**62E.16 POLICY CONVERSION RIGHTS.**

Every program of self-insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state, shall include, in addition to the provisions required by section 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions if the individual insured leaves the group regardless of the reason for leaving the group or if an employer member of a group ceases to remit payment so as to terminate coverage for its employees, or upon cancellation or termination of the coverage for the group except where uninterrupted and continuous group coverage is otherwise provided to the group. If the health maintenance organization has canceled coverage for the group because of a loss of providers in a service area, the health maintenance organization shall arrange for other health maintenance or indemnity conversion options that shall be offered to enrollees without the addition of underwriting restrictions. The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. The person may exercise this right to conversion within 30 days of leaving the group or within 30 days following receipt of due notice of cancellation or termination of coverage of the group or of the employer member of the group and upon payment of premiums from the date of termination or cancellation. Due notice of cancellation or termination of coverage for a group or of the employer member of the group shall be provided to each employee having coverage in the group by the insurer, self-insurer or health maintenance organization canceling or terminating the coverage except where reasonable evidence indicates that uninterrupted and continuous group coverage is otherwise provided to the group. Every employer having a policy of group accident and health insurance, group subscriber or contract of coverage by a health maintenance organization shall, upon request, provide the insurer or health maintenance organization a list of the names and ad-

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dresses of covered employees. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue coverage under the same or a different contract without the addition of underwriting restrictions until the individual would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived. An individual conversion contract issued by a health maintenance organization shall not be deemed to be an individual enrollment contract for the purposes of section 62D.10. An individual health plan offered under section 62A.65, subdivision 5, paragraph (b), to a person satisfies the health carrier's obligation to offer conversion coverage under this section with respect to that person.

Sec. 16. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 8, is amended to read:

Subd. 8. **COMMISSIONER.** "Commissioner" means the commissioner of commerce for health carriers subject to the jurisdiction of the department of commerce or the commissioner of health for health carriers subject to the jurisdiction of the department of health, or the relevant commissioner's designated representative. For purposes of sections 62L.13 to 62L.22, "commissioner" means the commissioner of commerce or that commissioner's designated representative.

Sec. 17. Minnesota Statutes 1992, section 62L.02, subdivision 9, is amended to read:

Subd. 9. **CONTINUOUS COVERAGE.** "Continuous coverage" means the maintenance of continuous and uninterrupted qualifying ~~prior coverage by an eligible employee or dependent.~~ An ~~eligible employee or dependent~~ individual is considered to have maintained continuous coverage if the individual requests enrollment in a ~~health benefit plan~~ qualifying coverage within 30 days of termination of the ~~qualifying prior coverage.~~

Sec. 18. Minnesota Statutes 1992, section 62L.02, is amended by adding a subdivision to read:

Subd. 9a. **CURRENT EMPLOYEE.** "Current employee" means an employee, as defined in this section, other than a retiree or handicapped former employee.

Sec. 19. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 11, is amended to read:

Subd. 11. **DEPENDENT.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 19 years, unmarried child under the age of 25 years who is a full-time student as defined in section 62A.301 ~~and financially dependent upon the eligible employee, or,~~ dependent child of any age who is handicapped and who meets the eligibility criteria in section 62A.14, sub-

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division 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child may include a child for whom the employee or the employee's spouse has been appointed legal guardian.

Sec. 20. Minnesota Statutes 1992, section 62L.02, subdivision 13, is amended to read:

Subd. 13. **ELIGIBLE EMPLOYEE.** "Eligible employee" means an individual employed by a small employer for at least 20 hours per week and employee who has satisfied all employer participation and eligibility requirements; including, but not limited to, the satisfactory completion of a probationary period of not less than 30 days but no more than 90 days. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include employees who work on a temporary, seasonal, or substitute basis.

Sec. 21. Minnesota Statutes 1992, section 62L.02, is amended by adding a subdivision to read:

Subd. 13a. **EMPLOYEE.** "Employee" means an individual employed for at least 20 hours per week and includes a sole proprietor or a partner of a partnership, if the sole proprietor or partner is included under a health benefit plan of the employer, but does not include individuals who work on a temporary, seasonal, or substitute basis. "Employee" also includes a retiree or a handicapped former employee required to be covered under sections 62A.147 and 62A.148.

Sec. 22. Minnesota Statutes 1992, section 62L.02, is amended by adding a subdivision to read:

Subd. 14a. **GUARANTEED ISSUE.** "Guaranteed issue" means that a health carrier shall not decline an application by a small employer for any health benefit plan offered by that health carrier and shall not decline to cover under a health benefit plan any eligible employee or eligible dependent, including persons who become eligible employees or eligible dependents after initial issuance of the health benefit plan, subject to the health carrier's right to impose preexisting condition limitations permitted under this chapter.

Sec. 23. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 15, is amended to read:

Subd. 15. **HEALTH BENEFIT PLAN.** "Health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a health carrier to a small employer for the coverage of medical and hospital benefits. Health benefit plan includes a small employer plan. Health benefit plan does not include coverage that is:

- (1) limited to disability or income protection coverage;

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- (2) automobile medical payment coverage;
- (3) supplemental to liability insurance;
- (4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense-incurred basis;
- (5) credit accident and health insurance as defined in section 62B.02;
- (6) designed solely to provide dental or vision care;
- (7) blanket accident and sickness insurance as defined in section 62A.11;
- (8) accident-only coverage;
- (9) a long-term care policy as defined in section 62A.46;
- (10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended ~~through December 31, 1991~~;
- (11) workers' compensation insurance; or
- (12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health benefit plan.

For the purpose of this chapter, a health benefit plan issued to eligible employees of a small employer who meets the participation requirements of section 62L.03, subdivision 3, is considered to have been issued to a small employer. A health benefit plan issued on behalf of a health carrier is considered to be issued by the health carrier.

Sec. 24. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 16, is amended to read:

Subd. 16. **HEALTH CARRIER.** "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; and a multiple employer welfare arrangement, as defined in United States Code, title 29, section 1002(40), as amended ~~through December 31, 1991~~. For purposes of sections 62L.01 to 62L.12, but not for purposes of sections 62L.13 to 62L.22, "health carrier" includes a community integrated service network or integrated service network licensed under chapter 62N. Any use of this definition in another chapter by reference does not include a community integrated service network or

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integrated service network, unless otherwise specified. For the purpose of this chapter, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one health carrier, except that any insurance company or health service plan corporation that is an affiliate of a health maintenance organization located in Minnesota, or any health maintenance organization located in Minnesota that is an affiliate of an insurance company or health service plan corporation, or any health maintenance organization that is an affiliate of another health maintenance organization in Minnesota, may treat the health maintenance organization as a separate health carrier.

Sec. 25. Minnesota Statutes 1992, section 62L.02, subdivision 17, is amended to read:

Subd. 17. **HEALTH PLAN.** "Health plan" means a health benefit plan issued by a health carrier, ~~except that it may be issued:~~

(1) ~~to a small employer;~~

(2) ~~to an employer who does not satisfy the definition of a small employer as defined under subdivision 26; or~~

(3) ~~to an individual purchasing an individual or conversion policy of health care coverage issued by a health carrier as defined in section 62A.011 and includes individual and group coverage regardless of the size of the group, unless otherwise specified.~~

Sec. 26. Minnesota Statutes 1993 Supplement, 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 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 health 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 an individual is not a late entrant if the individual elects coverage under the health benefit plan rather than accepting continuation coverage required for which the individual is eligible under state or federal law with respect to the individual's previous qualifying coverage;~~

(2) the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget

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Reconciliation Act of 1985, Public Law Number 99-272, as amended, and any state continuation laws applicable to the employer or health 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 former spouse or 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. 27. Minnesota Statutes 1992, section 62L.02, subdivision 24, is amended to read:

Subd. 24. **QUALIFYING PRIOR COVERAGE OR QUALIFYING EXISTING COVERAGE.** "~~Qualifying prior coverage~~" or "~~qualifying existing coverage~~" means health benefits or health coverage provided under:

(1) a health plan, as defined in this section;

(2) Medicare;

(3) medical assistance under chapter 256B;

(4) general assistance medical care under chapter 256D;

(5) MCHA;

(6) a self-insured health plan;

(7) the ~~health right~~ MinnesotaCare plan program established under section 256.9352, when the plan includes inpatient hospital services as provided in section 256.9353;

(8) a plan provided under section 43A.316, 43A.317, or 471.617; or

(9) a plan similar to any of the above plans provided in this state or in another state as determined by the commissioner.

Sec. 28. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 26, is amended to read:

Subd. 26. **SMALL EMPLOYER.** (a) "Small employer" means a person, firm, corporation, partnership, association, or other entity actively engaged in

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business ~~who~~, including a political subdivision of the state, that, on at least 50 percent of its working days during the preceding ~~calendar year~~ 12 months, employed no fewer than two nor more than 29 eligible, or after June 30, 1995, more than 49, current employees, the majority of whom were employed in this state. 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. If an employer has only one eligible employee who has not waived coverage, the sale of a health plan to or for that eligible employee is not a sale to a small employer and is not subject to this chapter and may be treated as the sale of an individual health plan. 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 current employees. Entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer for purposes of determining the number of eligible current 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.

(b) 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 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, or after June 30, 1995, more than 49, current employees, even though the association provides coverage to 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~~ employers after July 1, 1993, the existing association must comply with all requirements of this chapter. Existing associations must register with the commissioner of commerce prior to July 1, 1993. With respect to small employers having not fewer than 30 nor more than 49 current employees, the July 1, 1993 date in this paragraph becomes July 1, 1995, and the reference to "after" that date becomes "on or after."

(c) If an employer has employees covered under a trust ~~established~~ specified 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, or employees whose health coverage is determined by a collective bargaining agreement and, as a result of the collective bargaining agreement, is purchased separately from the health plan provided to other employees, those employees are excluded in determining whether the employer qualifies as a small employer. Those employees are considered to be a separate small employer if they constitute a group that would qualify as a small employer in the absence of the employees who are not subject to the collective bargaining agreement.

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Sec. 29. Minnesota Statutes 1992, section 62L.03, subdivision 1, is amended to read:

Subdivision 1. **GUARANTEED ISSUE AND REISSUE.** Every health carrier shall, as a condition of authority to transact business in this state in the small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans, on a guaranteed issue basis, to any small employer that meets the participation and contribution requirements of subdivision 3, as provided in this chapter. This requirement does not apply to a health benefit plan designed for a small employer to comply with a collective bargaining agreement, provided that the health benefit plan otherwise complies with this chapter and is not offered to other small employers, except for other small employers that need it for the same reason. Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers. A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

Sec. 30. Minnesota Statutes 1993 Supplement, section 62L.03, subdivision 3, is amended to read:

Subd. 3. **MINIMUM PARTICIPATION AND CONTRIBUTION.** (a) A 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 on a guaranteed issue basis 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~~ **must** 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: (1) coverage under another group health plan; (2) coverage under Medicare parts A and B; or (3) coverage under MCHA permitted under section 62E.141.

(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~~ health plans, or a health benefit plan which, ~~except for guaranteed issue~~, must fully comply with this chapter. A health carrier that provides ~~group coverage~~ a health benefit plan 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 ~~an individual coverage~~ health plan, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers ~~coverage~~ the individual health plan, on a guaranteed issue basis, to all other employees of the same employer.

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(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. 31. Minnesota Statutes 1993 Supplement, 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~~ section, "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, or any~~ exclusionary rider. 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 about employees, and dependents of 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, but exclusionary riders must not be used. 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, but must not be subject to any exclusionary rider or exclusion. ~~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. 32. Minnesota Statutes 1993 Supplement, section 62L.03, subdivision 5, is amended to read:

Subd. 5. **CANCELLATIONS AND FAILURES TO RENEW.** (a) No health carrier shall cancel, decline to issue, or fail to renew a health benefit plan as a result of the claim experience or health status of the persons covered or to be covered by the health benefit plan. A health carrier may cancel or fail to renew a health benefit plan:

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(1) for nonpayment of the required premium;

(2) for fraud or misrepresentation by the small employer, or, with respect to coverage of an individual eligible employee or dependent, fraud or misrepresentation by the eligible employee or dependent, with respect to eligibility for coverage or any other material fact;

(3) if eligible employee participation during the preceding calendar year declines to less than 75 percent, subject to the waiver of coverage provision in subdivision 3;

(4) if the employer fails to comply with the minimum contribution percentage ~~legally~~ required by the health carrier under subdivision 3;

(5) if the health carrier ceases to do business in the small employer market under section 62L.09; ~~or~~

(6) if a failure to renew is based upon the health carrier's decision to discontinue the health benefit plan form previously issued to the small employer, but only if the health carrier permits each small employer covered under the prior form to switch to its choice of any other health benefit plan offered by the health carrier, without any underwriting restrictions that would not have been permitted for renewal purposes; or

(7) for any other reasons or grounds expressly permitted by the respective licensing laws and regulations governing a health carrier, including, but not limited to, service area restrictions imposed on health maintenance organizations under section 62D.03, subdivision 4, paragraph (m), to the extent that these grounds are not expressly inconsistent with this chapter.

(b) A health carrier need not renew a health benefit plan, and shall not renew a small employer plan, if an employer ceases to qualify as a small employer as defined in section 62L.02. If a health benefit plan, other than a small employer plan, provides terms of renewal that do not exclude an employer that is no longer a small employer, the health benefit plan may be renewed according to its own terms. If a health carrier issues or renews a health plan to an employer that is no longer a small employer, without interruption of coverage, the health plan is subject to section 60A.082.

Sec. 33. Minnesota Statutes 1992, section 62L.03, subdivision 6, is amended to read:

Subd. 6. **MCHA ENROLLEES.** Health carriers shall offer coverage to any eligible employee or dependent enrolled in MCHA at the time of the health carrier's issuance or renewal of a health benefit plan to a small employer. The health benefit plan must require that the employer permit MCHA enrollees to enroll in the small employer's health benefit plan as of the first date of renewal of a health benefit plan occurring on or after July 1, 1993, and as of each date of renewal after that, or, in the case of a new group, as of the initial effective date

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of the health benefit plan and as of each date of renewal after that. Unless otherwise permitted by this chapter, health carriers must not impose any underwriting restrictions, including any preexisting condition limitations or exclusions, on any eligible employee or dependent previously enrolled in MCHA and transferred to a health benefit plan so long as continuous coverage is maintained, provided that the health carrier may impose any unexpired portion of a preexisting condition limitation under the person's MCHA coverage. An MCHA enrollee is not a late entrant, so long as the enrollee has maintained continuous coverage.

Sec. 34. Minnesota Statutes 1993 Supplement, section 62L.04, subdivision 1, is amended to read:

Subdivision 1. **APPLICABILITY OF CHAPTER REQUIREMENTS.** (a) Beginning July 1, 1993, health carriers participating in the small employer market must offer and make available on a guaranteed issue basis any health benefit plan that they offer, including both of the small employer plans provided in section 62L.05, to all small employers ~~who~~ that 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.

(b) 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 and contribution 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.

(c) With respect to small employers having no fewer than 30 nor more than 49 current employees, all dates in this subdivision become July 1, 1995, and any reference to "after" a date becomes "on or after" July 1, 1995.

Sec. 35. Minnesota Statutes 1992, section 62L.05, subdivision 1, is amended to read:

Subdivision 1. **TWO SMALL EMPLOYER PLANS.** Each health carrier in the small employer market must make available, on a guaranteed issue basis, to any small employer that satisfies the contribution and participation requirements of section 62L.03, subdivision 3, both of the small employer plans described in subdivisions 2 and 3. Under subdivisions 2 and 3, coinsurance and deductibles do not apply to child health supervision services and prenatal ser-

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vices, as defined by section 62A.047. The maximum out-of-pocket costs for covered services must be \$3,000 per individual and \$6,000 per family per year. The maximum lifetime benefit must be \$500,000. ~~The out-of-pocket cost limits and the deductible amounts provided in subdivision 2 must be adjusted on July 1 every two years, based upon changes in the consumer price index, as of the end of the previous calendar year, as determined by the commissioner of commerce. Adjustments must be in increments of \$50 and must not be made unless at least that amount of adjustment is required.~~

Sec. 36. Minnesota Statutes 1992, section 62L.05, subdivision 5, is amended to read:

Subd. 5. **PLAN VARIATIONS.** (a) No health carrier shall offer to a small employer a health benefit plan that differs from the two small employer plans described in subdivisions 1 to 4, unless the health benefit plan complies with all provisions of chapters 62A, 62C, 62D, 62E, 62H, 62N, and 64B that otherwise apply to the health carrier, except as expressly permitted by paragraph (b).

(b) As an exception to paragraph (a), a health benefit plan is deemed to be a small employer plan and to be in compliance with paragraph (a) if it differs from one of the two small employer plans described in subdivisions 1 to 4 only by providing benefits in addition to those described in subdivision 4, provided that the health ~~care~~ benefit plan has an actuarial value that exceeds the actuarial value of the benefits described in subdivision 4 by no more than two percent. "Benefits in addition" means additional units of a benefit listed in subdivision 4 or one or more benefits not listed in subdivision 4.

Sec. 37. Minnesota Statutes 1992, section 62L.05, subdivision 8, is amended to read:

Subd. 8. **CONTINUATION COVERAGE.** Small employer plans must include the continuation of coverage provisions required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law Number 99-272, as amended ~~through December 31, 1991~~, and by state law.

Sec. 38. Minnesota Statutes 1992, section 62L.06, is amended to read:

**62L.06 DISCLOSURE OF UNDERWRITING RATING PRACTICES.**

When offering or renewing a health benefit plan, health carriers shall disclose in all solicitation and sales materials:

- (1) the case characteristics and other rating factors used to determine initial and renewal rates;
- (2) the extent to which premium rates for a small employer are established or adjusted based upon actual or expected variation in claim experience;
- (3) provisions concerning the health carrier's right to change premium rates and the factors other than claim experience that affect changes in premium rates;

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(4) provisions relating to renewability of coverage;

(5) the use and effect of any preexisting condition provisions, if permitted;  
**and**

(6) the application of any provider network limitations and their effect on eligibility for benefits; **and**

(7) the ability of small employers to insure eligible employees and dependents currently receiving coverage from the comprehensive health association through health benefit plans.

Sec. 39. Minnesota Statutes 1992, section 62L.07, subdivision 2, is amended to read:

Subd. 2. **WAIVERS.** Health benefit plans must require that small employers offering a health benefit plan maintain written documentation ~~of a waiver of coverage by an eligible employee or dependent and provide the documentation indicating that each eligible employee was informed of the availability of coverage through the employer and of a waiver of coverage by the eligible employee.~~ This documentation must be provided to the health carrier upon reasonable request.

Sec. 40. Minnesota Statutes 1992, section 62L.08, subdivision 2, is amended to read:

Subd. 2. **GENERAL PREMIUM VARIATIONS.** Beginning July 1, 1993, each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, industry of the employer, and duration of coverage from the date of issue. For purposes of this subdivision, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined to be actuarially valid and approved by the commissioner. Variations permitted under this subdivision must not be based upon age or applied differently at different ages. This subdivision does not prohibit use of a constant percentage adjustment for factors permitted to be used under this subdivision.

Sec. 41. Minnesota Statutes 1993 Supplement, section 62L.08, subdivision 4, is amended to read:

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 metro-

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politan 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 or more additional geographic ~~region~~ regions and a one or more separate index ~~rate~~ rates for premiums for employees working and 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. 42. Minnesota Statutes 1992, section 62L.08, subdivision 5, is amended to read:

Subd. 5. **GENDER-BASED RATES PROHIBITED.** Beginning July 1, 1993, no health carrier may determine premium rates through a method that is in any way based upon the gender of eligible employees or dependents. Rates must not in any way reflect marital status or generalized differences in expected costs between employees and spouses.

Sec. 43. Minnesota Statutes 1992, section 62L.08, subdivision 6, is amended to read:

Subd. 6. **RATE CELLS PERMITTED.** Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based on the number of adults and children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect marital status or differences in expected costs between employees and spouses.

Sec. 44. Minnesota Statutes 1992, section 62L.08, subdivision 7, is amended to read:

Subd. 7. **INDEX AND PREMIUM RATE DEVELOPMENT.** (a) In developing its index rates and premiums, a health carrier may take into account only the following factors:

- (1) actuarially valid differences in benefit designs of health benefit plans;

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(2) actuarially valid differences in the rating factors permitted in subdivisions 2 and 3;

(3) actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4.

(b) All premium variations permitted under this section must be based upon actuarially valid differences in expected cost to the health carrier of providing coverage. The variation must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All premium variations are subject to approval by the commissioner.

Sec. 45. Minnesota Statutes 1992, section 62L.08, is amended by adding a subdivision to read:

Subd. 7a. PARTIAL EXEMPTION; POLITICAL SUBDIVISIONS. (a) Health coverage provided by a political subdivision of the state to its employees, officers, retirees, and their dependents, by participation in group purchasing of health plan coverage by or through an association of political subdivisions or by or through an educational cooperative service unit created under section 123.58 or by participating in a joint self-insurance pool authorized under section 471.617, subdivision 2, is subject to this subdivision. Coverage that is subject to this subdivision may have separate index rates and separate premium rates, based upon data specific to the association, educational cooperative service unit, or pool, so long as the rates, including the rating bands, otherwise comply with this chapter. The association, educational cooperative service unit, or pool is not required to offer the small employer plans described in section 62L.05 and is not required to comply with this chapter for employers that are not small employers or that are not eligible for coverage through the association, educational cooperative service unit, or pool. A health carrier that offers a health plan only under this subdivision need not offer that health plan to other small employers on a guaranteed issue basis.

(b) An association, educational cooperative service unit, or pool described in paragraph (a) may elect to be treated under paragraph (a) by filing a notice of the election with the commissioner of commerce no later than January 1, 1995. The election remains in effect for three years and applies to all health coverage provided to members of the group. It may be renewed for subsequent three-year periods. An entity eligible for treatment under paragraph (a) that forms after January 1, 1995, must make the election prior to provision of coverage, and the election remains in effect until January 1, 1998, or if filed after that date, until the next regular renewal date.

Sec. 46. Minnesota Statutes 1993 Supplement, 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

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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. 47. Minnesota Statutes 1992, section 62L.12, is amended to read:

**62L.12 PROHIBITED PRACTICES.**

Subdivision 1. **PROHIBITION ON ISSUANCE OF INDIVIDUAL POLICIES.** A health carrier operating in the small employer market shall not knowingly offer, issue, or renew an individual ~~policy, subscriber contract, or certificate~~ health plan to an eligible employee ~~or dependent~~ of a small employer that meets the minimum participation and contribution requirements ~~defined in~~ under section 62L.03, subdivision 3, except as authorized under subdivision 2.

Subd. 2. **EXCEPTIONS.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees and dependents.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees and dependents as required.

(e) A health carrier may sell, issue, or renew individual ~~coverage~~ health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group ~~coverage~~ health plan or due to the person's need for health care services not covered under the employer's ~~group policy~~ group health plan.

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(f) A health carrier may sell, issue, or renew an individual ~~policy, with the prior consent of the commissioner,~~ health plan, if the individual has elected to buy the individual ~~coverage~~ health plan not as part of a general plan to substitute individual ~~coverage~~ health plans for a group ~~coverage~~ health plan nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

(h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.31 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et. seq., as amended.

(i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

Subd. 3. **AGENT'S LICENSURE.** An agent licensed under chapter ~~60A~~ 60K or section 62C.17 who knowingly and willfully breaks apart a small group for the purpose of selling individual ~~policies~~ health plans to eligible employees and dependents of a small employer that meets the participation and contribution requirements of section 62L.03, subdivision 3, is guilty of an unfair trade practice and subject to disciplinary action, including the revocation or suspension of license, under section ~~60A.17, subdivision 6,~~ 60K.11 or 62C.17. The action must be by order and subject to the notice, hearing, and appeal procedures specified in section ~~60A.17, subdivision 6~~ 60K.11. The action of the commissioner is subject to judicial review as provided under chapter 14.

Subd. 4. **EMPLOYER PROHIBITION.** A small employer shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another health carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.

Subd. 5. **SALE OF OTHER PRODUCTS.** A health carrier shall not condition the offer, sale, issuance, or renewal of a health benefit plan on the purchase

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by a small employer of other insurance products offered by the health carrier or a subsidiary or affiliate of the health carrier, including, but not limited to, life, disability, property, and general liability insurance. This prohibition does not apply to insurance products offered as a supplement to a health maintenance organization plan, including, but not limited to, supplemental benefit plans under section 62D.05, subdivision 6.

Sec. 48. Minnesota Statutes 1992, section 62L.21, subdivision 2, is amended to read:

Subd. 2. **ADJUSTMENT OF PREMIUM RATES.** The board of directors shall establish operating rules to allocate adjustments to the reinsurance premium charge of no more than minus 25 percent of the monthly reinsurance premium for health carriers that can demonstrate administrative efficiencies and cost-effective handling of equivalent risks. The adjustment must be made ~~annually on a retrospective basis~~ monthly, unless the board provides for a different interval in its operating rules. The operating rules must establish objective and measurable criteria which must be met by a health carrier in order to be eligible for an adjustment. These criteria must include consideration of efficiency attributable to case management, but not consideration of such factors as provider discounts.

Sec. 49. **REPEALER.**

(a) Minnesota Statutes 1992, sections 62E.51, 62E.52, 62E.53, 62E.531, 62E.54, and 62E.55 are repealed.

(b) Minnesota Statutes 1992, section 62A.02, subdivision 5, is repealed.

Sec. 50. **REVISOR INSTRUCTIONS.**

(a) The revisor of statutes shall change the name of the private employers insurance program established in Minnesota Statutes, section 43A.317 to the Minnesota employees insurance program, and the private employers insurance trust fund to the Minnesota employees insurance trust fund, wherever either term occurs in Minnesota Statutes or Minnesota Rules.

(b) The revisor of statutes shall renumber Minnesota Statutes 1992, section 62L.23, as section 62L.08, subdivision 11, and shall change all references to that section in Minnesota Statutes or Minnesota Rules accordingly.

Sec. 51. **EFFECTIVE DATES.**

Sections 1, 3, 4, 6, 8, 10, 16 to 27, 29, 30, 32, 34 to 37, 40 to 45, and 47 to 50 are effective the day following final enactment. Sections 2, 12, 13, 33, 38, and 39 are effective July 1, 1994. Sections 5, 7, 9, 11, 14, 15, 28, 31, and 46 are effective January 1, 1995.

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## ARTICLE 11

## HEALTH CARE COOPERATIVES

Section 1. **[62R.01] STATEMENT OF LEGISLATIVE PURPOSE AND INTENT.**

The legislature finds that the goals of containing health care costs, improving the quality of health care, and increasing the access of Minnesota citizens to health care services reflected under chapters 62J and 62N may be further enhanced through the promotion of health care cooperatives. The legislature further finds that locally based and controlled efforts among health care providers, local businesses, units of local government, and health care consumers, can promote the attainment of the legislature's goals of health care reform, and takes notice of the long history of successful operations of cooperative organizations in this state. Therefore, in order to encourage cooperative efforts which are consistent with the goals of health care reform, including efforts among health care providers as sellers of health care services and efforts of consumers as buyers of health care services and health plan coverage, and to encourage the formation of and increase the competition among health plans in Minnesota, the legislature enacts the Minnesota health care cooperative act.

Sec. 2. **[62R.02] CITATION.**

This chapter may be cited as the "Minnesota health care cooperative act."

Sec. 3. **[62R.03] APPLICABILITY OF OTHER LAWS.**

Subdivision 1. MINNESOTA COOPERATIVE LAW. A health care cooperative is subject to chapter 308A unless otherwise provided in this chapter. After incorporation, a health care cooperative shall enjoy the powers and privileges and shall be subject to the duties and liabilities of other cooperatives organized under chapter 308A, to the extent applicable and except as limited or enlarged by this chapter. If any provision of this chapter conflicts with a provision of chapter 308A, the provision of this chapter takes precedence.

Subd. 2. HEALTH PLAN LICENSURE AND OPERATION. A health care network cooperative must be licensed as a health maintenance organization licensed under chapter 62D, a nonprofit health service plan corporation licensed under chapter 62C, or a community integrated service network or an integrated service network licensed under chapter 62N, at the election of the health care network cooperative. The health care network cooperative shall be subject to the duties and liabilities of health plans licensed pursuant to the chapter under which the cooperative elects to be licensed, to the extent applicable and except as limited or enlarged by this chapter. If any provision of any chapter under which the cooperative elects to be licensed conflicts with the provisions of this chapter, the provisions of this chapter take precedence. A health care network cooperative, upon licensure as provided in this subdivision, is a contributing member of the Minnesota comprehensive health association, on the same basis as other entities having the same licensure.

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Subd. 3. HEALTH PROVIDER COOPERATIVES. A health provider cooperative shall not be considered a mutual insurance company under chapter 60A, a health maintenance organization under chapter 62D, a nonprofit health services corporation under chapter 62C, or a community integrated service network or an integrated service network under chapter 62N. A health provider network shall not be considered to violate any limitations on the corporate practice of medicine. Health care service contracts under section 62R.06 shall not be considered to violate section 62J.23.

**Sec. 4. [62R.04] DEFINITIONS.**

Subdivision 1. SCOPE. For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. HEALTH CARE COOPERATIVE. "Health care cooperative" means a health care network cooperative or a health provider cooperative.

Subd. 3. HEALTH CARE NETWORK COOPERATIVE. "Health care network cooperative" means a corporation organized under this chapter and licensed in accordance with section 62R.03, subdivision 2. A health care network cooperative shall not have more than 50,000 enrollees, unless exceeding the enrollment limit is necessary to comply with guaranteed issue or guaranteed renewal requirements of chapter 62L or section 62A.65.

Subd. 4. HEALTH PROVIDER COOPERATIVE. "Health provider cooperative" means a corporation organized under this chapter and operated on a cooperative plan to market health care services to purchasers of those services.

Subd. 5. COMMISSIONER. Unless otherwise specified, "commissioner" means the commissioner of health for a health care network cooperative licensed under chapter 62D or 62N and the commissioner of commerce for a health care network cooperative licensed under chapter 62C.

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

Subd. 7. HEALTH CARE PROVIDING ENTITY. "Health care providing entity" means a participating entity that provides health care to enrollees of a health care cooperative.

**Sec. 5. [62R.05] POWERS.**

In addition to the powers enumerated under section 308A.201, a health care cooperative shall have all of the powers granted a nonprofit corporation under section 317A.161, except to the extent expressly inconsistent with the provisions of chapter 308A.

**Sec. 6. [62R.06] HEALTH CARE SERVICE CONTRACTS.**

Subdivision 1. PROVIDER CONTRACTS. A health provider cooperative

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and its licensed members may execute marketing and service contracts requiring the provider members to provide some or all of their health care services through the provider cooperative to the enrollees, members, subscribers, or insureds, of a health care network cooperative, community integrated service network, integrated service network, nonprofit health service plan, health maintenance organization, accident and health insurance company, or any other purchaser, including the state of Minnesota and its agencies, instruments, or units of local government. Each purchasing entity is authorized to execute contracts for the purchase of health care services from a health provider cooperative in accordance with this section. Any contract between a provider cooperative and a purchaser must provide for payment by the purchaser to the health provider cooperative on a substantially capitated or similar risk-sharing basis. Each contract between a provider cooperative and a purchaser shall be filed by the provider network cooperative with the commissioner of health and is subject to the provisions of section 62D.19.

Subd. 2. NO NETWORK LIMITATION. A health care network cooperative may contract with any health provider cooperative and may contract with any other licensed health care provider to provide health care services for its enrollees.

Subd. 3. RESTRAINT OF TRADE. Subject to section 62R.08, a health care provider cooperative is not a combination in restraint of trade, and any contracts or agreements between a health care provider cooperative and its members regarding the price the cooperative will charge to purchasers of its services, or regarding the prices the members will charge to the cooperative, or regarding the allocation of gains or losses among the members, or regarding the delivery, quality, allocation, or location of services to be provided, are not contracts that unreasonably restrain trade.

**Sec. 7. [62R.07] RELICENSURE.**

(a) A health care network cooperative licensed under chapter 62C or 62D may relinquish that license and be granted a new license as a community integrated service network or an integrated service network under chapter 62N in accordance with this section, provided that the cooperative meets all requirements for licensure as a network under chapter 62N, to the extent not expressly inconsistent with the provisions of chapter 308A.

(b) The relicensure shall be effective at the time specified in the plan of relicensure, which must not be earlier than the date upon which the previous license is surrendered.

(c) Upon the relicensure of the cooperative as a community integrated service network or an integrated service network:

(1) all existing group and individual enrollee benefit contracts in force on the effective date of the relicensure shall continue in effect and with the same terms and conditions, notwithstanding the cooperative's new licensure as a net-

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work, until the date of each contract's next renewal or amendment, but no later than one year from the date of the relicensure. At this time, each benefit contract then in force must be amended to comply with all statutory and regulatory requirements for network benefit contracts as of that date; and

(2) all contracts between the cooperative and any health care providing entity, including a health care provider cooperative, in force on the effective date of relicensure shall remain in effect under the cooperative's new licensure as a network until the date of the next renewal or amendment of that contract, but no later than one year from the date of relicensure.

(d) Except as otherwise provided in this section, nothing in the relicensure of a health care network cooperative shall in any way affect its corporate existence or any of its contracts, rights, privileges, immunities, powers or franchises, debts, duties or other obligations or liabilities.

#### Sec. 8. [62R.08] PROHIBITED PRACTICES.

(a) It shall be unlawful for any person, company, or corporation, or any agent, officer, or employee thereof, to coerce or require any person to agree, either in writing or orally, not to join or become or remain a member of, any health care provider cooperative, as a condition of securing or retaining a contract for health care services with the person, firm, or corporation.

(b) It shall be unlawful for any person, company, or corporation, or any combination of persons, companies, or corporations, or any agents, officers, or employees thereof, to engage in any acts of coercion, intimidation, or boycott of, or any refusal to deal with, any health care providing entity arising from that entity's actual or potential participation in a health care network cooperative or health care provider cooperative.

(c) It shall be unlawful for any health care network cooperative, other than a health care network cooperative operating on an employed, staff model basis, to require that its participating providers provide health care services exclusively to or through the health care network cooperative. It shall be unlawful for any health care provider cooperative to require that its members provide health care services exclusively to or through the health care provider cooperative.

(d) It shall be unlawful for any health care provider cooperative to engage in any acts of coercion, intimidation, or boycott of, or any concerted refusal to deal with, any health plan company seeking to contract with the cooperative on a competitive, reasonable, and nonexclusive basis.

(e) The prohibitions in this section are in addition to any conduct that violates sections 325D.49 to 325D.66.

(f) This section shall be enforced in accordance with sections 325D.56 to 325D.65.

Sec. 9. Minnesota Statutes 1992, section 308A.005, is amended by adding a subdivision to read:

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Subd. 8a. HEALTH CARE COOPERATIVE. "Health care cooperative" has the meaning given in section 62R.04, subdivision 2.

**Sec. 10. [308A.503] HEALTH CARE COOPERATIVE MEMBERS.**

Subdivision 1. HEALTH CARE NETWORK COOPERATIVE. For a health care network cooperative, the policyholder is the member provided that if the policyholder is an individual enrollee, the individual enrollee is the member, and if the policyholder is an employer or other group type, entity, or association, the group policyholder is the member.

Subd. 2. HEALTH PROVIDER COOPERATIVE. For a health provider cooperative, the licensed health care provider, professional corporation, partnership, hospital, or other licensed provider is the member, as provided in the articles or bylaws.

Subd. 3. STATE AND HOSPITAL MEMBERS AUTHORIZED. The state, or any agency, instrumentality, or political subdivision of the state, may be a member of a health care cooperative. Any governmental hospital authorized, organized or operated under chapters 158, 250, 376, or 397 or under sections 246A.10 to 246A.27, 412.221, 447.05 to 447.13, or 471.50, or under any special law authorizing or establishing a hospital or hospital district, may be a member of a health care provider cooperative.

Sec. 11. Minnesota Statutes 1992, section 308A.635, is amended by adding a subdivision to read:

Subd. 5a. HEALTH CARE COOPERATIVE. Notwithstanding the provisions of this section, the requirements and procedures for membership voting for a health care cooperative shall be as provided in the bylaws.

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**ARTICLE 12**

**RURAL HEALTH INITIATIVES**

Section 1. Minnesota Statutes 1993 Supplement, section 62N.23, is amended to read:

**62N.23 TECHNICAL ASSISTANCE; LOANS.**

(a) The commissioner shall provide technical assistance to parties interested in establishing or operating a community integrated service network or 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 community integrated service networks or integrated service networks in all regions of Minnesota. The commissioner shall advertise these

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seminars in local and regional newspapers, and attendance at these seminars shall be free.

The commissioner shall write a guide to establishing and operating a community integrated service network or an integrated service network. The guide must provide basic instructions for parties wishing to establish a community integrated service network or 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 a community integrated service network or 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.~~ shall grant loans for organizational and start-up expenses to entities forming community integrated service networks or integrated service networks, or to networks less than one year old, to the extent of any appropriation for that purpose. The commissioner shall allocate the available funds among applicants based upon the following criteria, as evaluated by the commissioner within the commissioner's discretion:

(1) the applicant's need for the loan;

(2) the likelihood that the loan will foster the formation or growth of a network; and

(3) the likelihood of repayment.

The commissioner shall determine any necessary application deadlines and forms and is exempt from rulemaking in doing so.

Sec. 2. Minnesota Statutes 1993 Supplement, section 144.1464, is amended to read:

**144.1464 SUMMER HEALTH CARE INTERNS.**

Subdivision 1. **SUMMER INTERNSHIPS.** The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants to hospitals and clinics to establish a secondary and post-secondary summer health care intern program. The purpose of the program is to expose interested ~~high school~~ secondary and post-secondary pupils to various careers within the health care profession.

Subd. 2. **CRITERIA.** (a) The commissioner, through the organization under contract, shall award grants to hospitals and clinics that agree to:

New language is indicated by underline, deletions by ~~strikeout~~.

(1) provide secondary and post-secondary summer health care interns with formal exposure to the health care profession;

(2) provide an orientation for the secondary and post-secondary summer health care interns;

(3) pay one-half the costs of employing a the secondary and post-secondary 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 secondary and post-secondary pupils for a minimum of six weeks and a maximum of 12 weeks.

(b) In order to be eligible to be hired as a secondary 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

(3) provide the facility with a letter of recommendation from a health occupations or science educator.

(c) In order to be eligible to be hired as a post-secondary summer health care intern by a hospital or clinic, a pupil must:

(1) intend to complete a two-year or four-year degree program and be planning on enrolling in or be enrolled in that degree program;

(2) be from a school district or attend an educational institution in proximity to the facility; and

(3) provide the facility with a letter of recommendation from a health occupations or science educator.

(d) Hospitals and clinics awarded grants may employ pupils as secondary and post-secondary 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.

Subd. 3. **GRANTS.** The commissioner, through the organization under contract, shall award separate 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~~ secondary and post-secondary pupils in a hospital or clinic during the course of the program. No more than five pupils may be selected from any ~~one high school~~ secondary or post-secondary institution 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.

New language is indicated by underline, deletions by ~~strikeout~~.

Subd. 4. **CONTRACT.** The commissioner shall contract with a statewide, nonprofit organization representing facilities at which secondary and post-secondary 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. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective July 1, 1994.

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**ARTICLE 13**

**FINANCING**

Section 1. Minnesota Statutes 1993 Supplement, section 256.9352, subdivision 3, is amended to read:

Subd. 3. **FINANCIAL MANAGEMENT.** (a) The commissioner shall manage spending for the ~~health right plan~~ MinnesotaCare program 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 ways and means committee and the senate finance committee, and the legislative commission on health care access, the commissioner shall make adjustments as 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~~ MinnesotaCare program; 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~~ MinnesotaCare program. 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.

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.

New language is indicated by underline, deletions by ~~strikeout~~.

By February 1, ~~1994~~ 1995, 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~~ taxes imposed under section 295.52 and the ~~one percent HMO~~ gross premiums tax imposed under section 60A.15, subdivision 1, paragraph (c), for the ~~1996-1997~~ biennium fiscal year 1997. ~~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.~~

(b) Notwithstanding paragraph (a), the commissioner shall proceed with the enrollment of single adults and households without children in accordance with section 256.9354, subdivision 5, paragraph (a), even if the expenditures do not remain within the limits of available revenues through fiscal year 1997 to allow the departments of human services and health to develop the plan required under paragraph (a).

Sec. 2. Minnesota Statutes 1993 Supplement, section 256.9354, subdivision 5, is amended to read:

Subd. 5. **ADDITION OF SINGLE ADULTS AND HOUSEHOLDS WITH NO CHILDREN.** (a) Beginning ~~July~~ October 1, 1994, "eligible persons" means shall include all families and individuals and households with no children who have gross family incomes that are equal to or less than 125 percent of the federal poverty guidelines and who are not eligible for medical assistance without a spenddown under chapter 256B.

(b) Beginning October 1, 1995, "eligible persons" means all individuals and families who are not eligible for medical assistance without a spenddown under chapter 256B.

(c) These persons All eligible persons under paragraphs (a) and (b) are eligible for coverage through the MinnesotaCare ~~plan~~ program but must pay a premium as determined under sections 256.9357 and 256.9358. Individuals and families whose income is greater than the limits established under section 256.9358 may not enroll in the MinnesotaCare ~~plan~~ program.

Sec. 3. Minnesota Statutes 1992, section 256.9355, is amended by adding a subdivision to read:

Subd. 4. APPLICATION PROCESSING. The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the department of human services. This requirement shall be suspended for four months following the dates in which single adults and families without children become eligible for the program.

New language is indicated by underline, deletions by ~~strikeout~~.



Sec. 4. Minnesota Statutes 1993 Supplement, section 256.9356, subdivision 3, is amended to read:

Subd. 3. **ADMINISTRATION AND COMMISSIONER'S DUTIES.** Premiums are dedicated to the commissioner for 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 MinnesotaCare for failure to pay required premiums. Premiums are calculated on a calendar month basis and may be paid on a monthly, 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 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. Persons disenrolled for nonpayment may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

Sec. 5. Minnesota Statutes 1992, section 256.9358, subdivision 4, is amended to read:

Subd. 4. **INELIGIBILITY.** ~~An individual or family~~ Families with children whose gross monthly income is above the amount specified in subdivision 3 ~~is~~ are not eligible for the plan. Beginning October 1, 1994, an individual or households with no children whose gross monthly income is greater than \$767 for a single individual and \$1,025 for a married couple without children are ineligible for the plan. Beginning October 1, 1995, an individual or families whose gross monthly income is above the amount specified in subdivision 3 are not eligible for the plan.

Sec. 6. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

Subd. 2a. DELIVERED OUTSIDE OF MINNESOTA. "Delivered outside of Minnesota" means property which the seller delivers to a common carrier for delivery outside Minnesota, places in the United States mail or parcel post directed to the purchaser outside Minnesota, or delivers to the purchaser outside Minnesota by means of the seller's own delivery vehicles, and which is not later returned to a point within Minnesota, except in the course of interstate commerce.

Sec. 7. Minnesota Statutes 1993 Supplement, section 295.50, subdivision 3, is amended to read:

Subd. 3. **GROSS REVENUES.** "Gross revenues" are total amounts received in money or otherwise by:

New language is indicated by underline, deletions by ~~strikeout~~.

- (1) a resident hospital for patient services;
- (2) a resident surgical center for patient services;
- (3) a nonresident hospital for patient services provided to patients domiciled in Minnesota;
- (4) a nonresident surgical center for patient services provided to patients domiciled in Minnesota;
- (5) a resident health care provider, other than a staff model health carrier, for patient services;
- (6) a nonresident health care provider for patient services provided to an individual domiciled in Minnesota;
- (7) a wholesale drug distributor for sale or distribution of ~~prescription legend~~ drugs that are delivered: (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 legend~~ drugs are delivered to another wholesale drug distributor who sells legend drugs exclusively at wholesale. ~~Prescription Legend~~ drugs do not include nutritional products as defined in Minnesota Rules, part 9505.0325;
- (8) a staff model health ~~carrier~~ plan company as gross premiums for enrollees, copayments, deductibles, coinsurance, and fees for patient services covered under its contracts with groups and enrollees;
- (9) a resident pharmacy for medical supplies, appliances, and equipment; and
- (10) a nonresident pharmacy for medical supplies, appliances, and equipment.

Sec. 8. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

Subd. 6a. HOSPICE CARE SERVICES. "Hospice care services" are services:

- (1) as defined in Minnesota Rules, part 9505.0297; and
- (2) provided at a recipient's residence, if the recipient does not live in a hospital, nursing facility as defined in section 62A.46, subdivision 3, or intermediate care facility for persons with mental retardation as defined in section 256B.055, subdivision 12, paragraph (d).

Sec. 9. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

New language is indicated by underline, deletions by ~~strikeout~~.

Subd. 15. LEGEND DRUG. "Legend drug" means a legend drug as defined in section 151.01, subdivision 17.

Sec. 10. Minnesota Statutes 1993 Supplement, section 295.52, subdivision 5, is amended to read:

Subd. 5. VOLUNTEER AMBULANCE SERVICES. Licensed Volunteer 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. For purposes of this requirement, "volunteer ambulance service" means an ambulance service in which all of the individuals whose primary responsibility is direct patient care meet the definition of volunteer under section 144.8091, subdivision 2. The ambulance service may employ administrative and support staff, and remain eligible for this exemption, if the primary responsibility of these staff is not direct patient care.

Sec. 11. Minnesota Statutes 1993 Supplement, 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 for services provided under the Medicare program, including payments received from the government, and organizations governed by sections 1833 and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, and enrollee deductibles, coinsurance, and 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 home health care services;

(4) payments received from hospitals or surgical centers for goods and services 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 on which liability for tax is imposed under 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~~ legend drugs, other than nutritional products, to a wholesale drug distributor reduced by reimbursements received for ~~prescription~~ legend 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;

New language is indicated by underline, deletions by ~~strikeout~~.

(8) payments received for providing services under the MinnesotaCare program including payments received directly from the government or from a pre-paid plan and enrollee deductibles, coinsurance, and copayments;

(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;

(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;

(16) payments received for hospice care services;

(17) payments received by a resident health care provider or the wholly owned subsidiary of a resident health care provider for medical supplies, appliances and equipment delivered outside of Minnesota;

(18) payments received for services provided by community supervised living facilities for persons with mental retardation or related conditions licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;

(19) payments received by a post-secondary educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants. Fee for service payments and payments for extended coverage are taxable; and

(20) payments received for services provided by: residential care homes licensed under chapter 144B; board and lodging establishments providing only custodial services, that are licensed under chapter 157 and registered under section 157.031 to provide supportive services or health supervision services; and assisted living programs, congregate housing programs, and other senior housing options.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 12. Minnesota Statutes 1993 Supplement, section 295.53, subdivision 2, is amended to read:

Subd. 2. **DEDUCTIONS FOR STAFF MODEL HEALTH CARRIERS PLAN COMPANY.** In addition to the exemptions allowed under subdivision 1, a staff model health carrier plan company 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 plan company for services on which liability for the tax is imposed under section 295.52;

(2) amounts added to reserves, if total reserves do not exceed 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 plan companies;

(3) assessments for the comprehensive health insurance plan under section 62E.11; and

(4) amounts spent for administration 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).

Sec. 13. Minnesota Statutes 1993 Supplement, section 295.53, subdivision 5, is amended to read:

Subd. 5. **DEDUCTIONS FOR PHARMACIES.** (a) Pharmacies may deduct from their gross revenues subject to tax payments for medical supplies, appliances, and devices that are exempt under subdivision 1, except payments under subdivision 1, clauses (3), (6), (9), (11), and (14).

(b) Resident pharmacies may deduct from their gross revenues subject to tax payments received for medical supplies, appliances, and equipment delivered outside of Minnesota.

Sec. 14. Minnesota Statutes 1993 Supplement, section 295.54, is amended to read:

**295.54 CREDIT FOR TAXES PAID TO ANOTHER STATE.**

Subdivision 1. TAXES PAID TO ANOTHER STATE. A resident hospital, resident surgical center, pharmacy, 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.

New language is indicated by underline, deletions by ~~strikeout~~.

Subd. 2. PHARMACY CREDIT. A resident pharmacy may claim a quarterly credit against the total amount of tax the pharmacy owes during that quarter under section 295.52, subdivision 1b, as provided in this subdivision. The credit shall equal two percent of the amount paid by the pharmacy to a wholesale drug distributor subject to tax under section 295.52, subdivision 3, for legend drugs delivered by the pharmacy outside of Minnesota. If the amount of the credit exceeds the tax liability of the pharmacy under section 295.52, subdivision 1b, the commissioner shall provide the pharmacy with a refund equal to the excess amount.

Sec. 15. Minnesota Statutes 1992, section 295.55, subdivision 2, is amended to read:

**Subd. 2. ESTIMATED TAX; HOSPITALS; SURGICAL CENTERS.** (a) Each hospital or surgical center must make estimated payments of the taxes for the calendar year in monthly installments to the commissioner within ten days after the end of the month.

(b) Estimated tax payments are not required of hospitals or surgical centers if the tax for the calendar year is less than \$500 or if ~~the~~ a hospital has been allowed a grant under section 144.1484, subdivision 2, for the year.

(c) Underpayment of estimated installments bear interest at the rate specified in section 270.75, from the due date of the payment until paid or until the due date of the annual return at the rate specified in section 270.75. An underpayment of an estimated installment is the difference between the amount paid and the lesser of (1) 90 percent of one-twelfth of the tax for the calendar year or (2) the tax for the actual gross revenues received during the month.

Sec. 16. Minnesota Statutes 1992, section 295.55, subdivision 3, is amended to read:

**Subd. 3. ESTIMATED TAX; OTHER TAXPAYERS.** (a) Each taxpayer, other than a hospital or surgical center, must make estimated payments of the taxes for the calendar year in quarterly installments to the commissioner by April 15, July 15, October 15, and January 15 of the following calendar year.

(b) Estimated tax payments are not required if the tax for the calendar year is less than \$500.

(c) Underpayment of estimated installments bear interest at the rate specified in section 270.75, from the due date of the payment until paid or until the due date of the annual return at the rate specified in section 270.75. An underpayment of an estimated installment is the difference between the amount paid and the lesser of (1) 90 percent of one-quarter of the tax for the calendar year or (2) the tax for the actual gross revenues received during the quarter.

Sec. 17. Minnesota Statutes 1993 Supplement, section 295.58, is amended to read:

New language is indicated by underline, deletions by ~~strikeout~~.

**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, community integrated service networks, integrated service networks, and nonprofit health service plan 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. There is annually appropriated from the health care access fund to the commissioner of revenue the amount necessary to make any refunds required under section 295.54.

Sec. 18. Minnesota Statutes 1993 Supplement, section 295.582, is amended to read:

**295.582 AUTHORITY.**

(a) A hospital, surgical center, pharmacy, or health care provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor, may transfer additional expense generated by section 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 plus two percent of~~ 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 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, or 62H, 65A, 65B, 79, or 79A, or under section 471.61 or 471.617, must pay the transferred expense in addition to any payments due under existing ~~or future~~ contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. A third-party purchaser of health care services includes, but is not limited to, a health carrier, integrated service network, or community integrated service network that pays for health care services on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures patients for health care services. A third-party purchaser shall comply with this section regardless of whether the third-party purchaser is a for-profit, not-for-profit, or nonprofit entity. A wholesale drug distributor may transfer additional expense generated by section 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay the additional expense. Nothing in this ~~subdivision~~ section limits the ability of a hospital, surgical center, pharmacy, wholesale drug distributor, or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

(b) Each third-party purchaser regulated under any chapter cited in paragraph (a) shall include with its annual renewal for certification of authority or licensure documentation indicating compliance with paragraph (a). If the commissioner responsible for regulating the third-party purchaser finds at any time

New language is indicated by underline, deletions by ~~strikeout~~.

that the third-party purchaser has not complied with paragraph (a) the commissioner may by order fine or censure the third-party purchaser or revoke or suspend the certificate of authority or license of the third-party purchaser to do business in this state. The third-party purchaser may appeal the commissioner's order through a contested case hearing in accordance with chapter 14.

Sec. 19. Laws 1992, chapter 549, article 9, section 22, is amended to read:

Sec. 22. **GROSS RECEIPTS TAX; EFFECTIVE DATE.**

Sections 1 and 16 to 21 are effective the day following final enactment. Section 4 is effective for taxable years beginning after December 31, 1992. Section 7, subdivision 1, is effective for gross revenues generated by services performed and goods sold after December 31, 1992. Section 7, subdivisions 2 to 4, are effective for gross revenues generated by services performed and goods sold after December 31, 1993. Section 8 is effective for hospitals and surgical centers for gross revenues generated by services performed and goods sold after December 31, 1992, except the exclusion under subdivision 1, clause (6) applies to payments for prescription drug purchases made after December 31, 1993. Section 8 is effective for health care providers for gross revenues generated by services performed and goods sold after December 31, 1993, except the exclusion under subdivision 1, clause (6) applies to payments for prescription drug purchases made after December 31, 1993. Sections 14 and 15 are effective July 1, 1992.

Sec. 20. **STATEMENT OF INTENT.**

The amendment in section 19 clarifies an effective date in the 1992 legislation enacting the gross receipts tax on hospitals and health care providers. This legislation imposed a gross receipts tax on hospitals effective January 1, 1993, and on health care providers and wholesale drug distributors effective January 1, 1994. To avoid double taxation or pyramiding of the tax burden, hospitals and health care providers were allowed an exclusion for amounts paid to wholesale drug distributors for prescription drugs. These amounts would already be taxed to the wholesale drug distributors. The section creating this exclusion did not contain an effective date. As a result, under Minnesota Statutes, section 645.02, the law may permit hospitals to deduct these amounts for prescription drugs purchased during 1993, even though no tax was imposed on the wholesale drug distributor and no double taxation or pyramiding of the tax could occur. Section 19 clarifies that the exclusion applies only after the wholesale drug distributor tax goes into effect.

Sec. 21. **EFFECTIVE DATE.**

Sections 1, 2, 5, 12, 15 to 17, 19, and 20 are effective the day following final enactment.

Sections 3 and 4 are effective July 1, 1994.

Sections 6 to 11, 13, 14, and 18 are retroactively effective from January 1, 1994.

New language is indicated by underline, deletions by ~~strikeout~~.



**ARTICLE 14**  
**APPROPRIATIONS**

**Section 1. APPROPRIATIONS; SUMMARY.**

Except as otherwise provided in this act, the sums set forth in the columns designated "fiscal year 1994" and "fiscal year 1995" are appropriated from the general fund, or other named fund, to the agencies for the purposes specified in this act and are added to or subtracted from the appropriations for the fiscal years ending June 30, 1994, and June 30, 1995, in Laws 1993, chapter 345, or another named law.

**SUMMARY BY FUND**

**APPROPRIATIONS**

	1994	1995
General Fund	-0-	\$4,844,000
Health Care Access Fund	( 10,828,000)	( 17,562,000)
State Government Special Revenue	-0-	99,000
<b>Subdivision 1. DEPARTMENT OF HUMAN SERVICES</b>		
Health Care Access Fund	(8,974,000)	(14,436,000)

Of this appropriation, \$150,000 the second year is for administration of the MinnesotaCare program. The appropriation for the MinnesotaCare subsidized health care plan is reduced by \$8,974,000 in the first year and \$14,586,000 in the second year.

**Subd. 2. DEPARTMENT OF EMPLOYEE RELATIONS**

Health Care Access Fund	(1,854,000)	(6,125,000)
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This reduction is to the appropriation in Laws 1993, chapter 345, article 14, section 9, due to a negotiation of a third-party carrier contract for Minnesota employers insurance program.

**Subd. 3. DEPARTMENT OF HEALTH**

State Government Special Revenue	-0-	99,000
Health Care Access Fund	-0-	2,999,000

Of this appropriation, \$100,000 is for the purpose of making a grant to the school of medicine at the Duluth campus of the University of Minnesota for planning to meet the increasing need for rural family physicians.

Of this appropriation, \$150,000 shall be transferred to the general fund and appropriated from the general fund to the commissioner of human services for a consumer satisfaction survey. Any federal matching money received through the medical assistance program is appropriated to the commissioner for this purpose. The commissioner of human services shall contract with the commissioner of health to conduct the consumer satisfaction survey.

Of this appropriation, \$8,000 in fiscal year 1995 is appropriated to the commissioner of health to fund a rural ambulance demonstration project. The purpose of the project is to reduce the ambulance response times in the Rail Prairie and Scandia Valley townships. The commissioner of health shall grant the funds to the ambulance license holder for this area contingent on receiving a written statement from the license holder, describing the methods to be used to implement the demonstration projects.

Unexpended money appropriated for summer health care interns for fiscal year 1994 does not cancel and shall be available for that purpose in fiscal year 1995.

At the request of the Minnesota Health Care Commission, the commissioners of revenue, finance, health, human services, commerce, and employee relations shall provide assistance with research, policy analysis, modeling, cost and revenue projections, actuarial anal-

ysis, and other technical support for the financing study required under article 6, section 7. Under the direction of the commission, money from this appropriation may be transferred by the commissioner of health to other state agencies to cover the costs of technical support provided to the commission.

Money appropriated before fiscal year 1995 to the commissioner of health for the administrative functions in connection with the data institute may be used by the data institute for the administration of the consumer satisfaction survey to the extent that there are matching financial contributions from the private sector.

Subd. 4. LEGISLATIVE AUDITOR

General Fund	-0-	65,000
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This appropriation is in addition to the appropriation in Laws 1993, chapter 192, section 2, subdivision 5, for the purpose of conducting a single payer study.

Subd. 5. ATTORNEY GENERAL

General Fund	-0-	200,000
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This appropriation is in addition to the appropriation in Laws 1993, chapter 192, section 11, subdivision 4. The attorney general shall work cooperatively with the commissioner of health in an effort to increase Minnesota's Medicare reimbursement rate.\* (Subdivision 5 was vetoed by the governor.)

Sec. 2. TRANSFERS

Notwithstanding Laws 1993, chapter 345, article 14, section 10, the commissioner of finance shall transfer \$3,963,000 in fiscal year 1994 and \$11,101,000 in fiscal year 1995 from the health care access fund to the general fund.\* (The governor vetoed the preceding material beginning "Sec." and ending "general fund.")

Of this amount transferred in fiscal year 1995, \$4,579,000 is appropriated to the commissioner of human services for general assistance medical care grants.

Presented to the governor May 6, 1994

Signed by the governor May 10, 1994, 6:35 p.m.

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### CHAPTER 626—S.F.No. 180

*An act proposing an amendment to the Minnesota Constitution, article X, section 8; authorizing off-track betting on horse racing; requiring a report to the legislature.*

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

#### Section 1. CONSTITUTIONAL AMENDMENT.

An amendment to the Minnesota Constitution, article X, section 8, is proposed to the people. If the amendment is adopted, the section will read as follows:

Sec. 8. The legislature may authorize ~~on-track~~ pari-mutuel betting on horse racing in a manner prescribed by law.

#### Sec. 2. SUBMISSION TO VOTERS.

The proposed amendment must be submitted to the people at the 1994 general election. The question submitted shall be:

“Shall the Minnesota Constitution be amended to permit off-track wagering on horse racing in a manner prescribed by law?”

Yes .....  
No .....”

#### Sec. 3. REPORT TO LEGISLATURE.

If the constitutional amendment proposed in section 1 is approved by the people at the 1994 general election, the director of pari-mutuel racing shall submit a report to the legislature containing the director's recommendations on legislation to authorize and regulate off-track pari-mutuel betting on horse racing. The report must contain draft legislation that embodies the director's recommendations. The draft legislation must provide that:

(1) off-track pari-mutuel betting be conducted primarily to support on-track horse racing and not supplant it;

New language is indicated by underline, deletions by ~~strikeout~~.