sales and use tax return for the month in which the sale was made. No credit or refund is given for the $20 fee originally paid.

~~A facsimile of the authorized aircraft commercial use permit is reproduced at part 8130.9992.~~

Presented to the governor May 23, 1995

Signed by the governor May 25, 1995, 10:15 a.m.

CHAPTER 234—S.F.No. 845

An act relating to health; MinnesotaCare; expanding provisions of health care; establishing requirements for integrated service networks; modifying requirements for health plan companies; repealing the regulated all-payer option; modifying universal coverage and insurance reform provisions; revising the research and data initiatives; modifying eligibility for the MinnesotaCare program; creating the prescription drug purchasing authority; establishing a drug purchasing benefit program for senior citizens; extending the health care commission and regional coordinating boards; making technical changes; providing penalties; appropriating money; amending Minnesota Statutes 1994, sections 13.99, by adding a subdivision; 16A.724; 60A.02, by adding a subdivision; 60B.02; 60B.03, subdivision 2; 60G.01, subdivisions 2, 4, and 5; 62A.10, subdivisions 1 and 2; 62A.65, subdivisions 5 and 8; 62D.02, subdivision 8; 62D.042, subdivision 2; 62D.11, subdivision 1; 62D.181, subdivisions 2, 3, 6, and 9; 62E.05; 62E.141; 62H.04; 62H.08; 62J.017; 62J.04, subdivisions 1a and 3; 62J.05, subdivisions 2 and 9; 62J.06; 62J.09, subdivisions 1, 1a, 2, 6, 8, and by adding a subdivision; 62J.152, subdivision 5; 62J.17, subdivisions 4a, 6a, and by adding a subdivision; 62J.212; 62J.37; 62J.38; 62J.40; 62J.41, subdivisions 1 and 2; 62J.48; 62J.54; 62J.55; 62J.58; 62L.02, subdivisions 11, 16, 24, and 26; 62L.03, subdivisions 3, 4, and 5; 62L.09, subdivision 1; 62L.12, subdivision 2; 62L.17, by adding a subdivision; 62L.18, subdivision 2; 62M.07; 62M.09, subdivision 5; 62M.10, by adding a subdivision; 62N.02, by adding subdivisions; 62N.04; 62N.10, by adding a subdivision; 62N.11, subdivision 1; 62N.13; 62N.14, subdivision 3; 62N.25, subdivision 2; 62P.05, subdivision 4, and by adding a subdivision; 62Q.01, subdivisions 2, 3, 4, and by adding subdivisions; 62Q.03, subdivisions 1, 6, 7, 8, 9, 10, and by adding subdivisions; 62Q.07, subdivisions 1 and 2; 62Q.075, subdivision 4; 62Q.09, subdivision 3; 62Q.11, subdivision 2; 62Q.165; 62Q.17, subdivisions 2, 6, 8, and by adding a subdivision; 62Q.18; 62Q.19; 62Q.30; 62Q.32; 62Q.33, subdivisions 4 and 5; 62Q.41; 72A.20, by adding subdivisions; 72A.201, by adding a subdivision; 136A.1355, subdivisions 3 and 5; 136A.1356, subdivisions 3 and 4; 144.1464, subdivisions 2, 3, and 4; 144.147, subdivision 1; 144.1484, subdivision 1; 144.1486, subdivision 4; 144.1487, subdivision 1; 144.1488, subdivisions 1 and 4; 144.1489, subdivisions 1, 3, and 4; 144.1490; 144.1491, subdivision 2; 144.801, by adding a subdivision; 144.804, subdivision 1; 145.414; 148B.32, subdivision 1; 151.48; 214.16, subdivisions 2 and 3; 256.9354, subdivisions 1, 4, 5, and by adding a subdivision; 256.9355, subdivision 2; 256.9357, subdivisions 1, 2, and 3; 256.9358, subdivisions 3, 4, and by adding a subdivision; 256.9363, subdivision 5; 256B.037, subdivisions 1, 3, 4, and by adding subdivisions; 256B.04, by adding a subdivision; 256B.055, by adding a subdivision; 256B.057, by

adding subdivisions; 256B.0625, subdivision 30; 256B.69, subdivisions 2 and 4; 270.101, subdivision 1; 295.50, subdivisions 3, 4, and 10a; 295.53, subdivisions 1, 3, and 4; 295.55, subdivision 4; 295.57; and 295.582; Laws 1990, chapter 591, article 4, section 9; Laws 1993, chapter 224, article 4, section 40; Laws 1993, First Special Session chapter 1, article 8, section 30, subdivision 2; Laws 1994, chapter 625, article 5, sections 5, subdivision 1; 7; and 10, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 16B; 62J; 62L; 62N; 62Q; 62R; 137; 144; 256; 256B; and 295; repealing Minnesota Statutes 1994, sections 62J.045; 62J.07, subdivision 4; 62J.09, subdivision 1a; 62J.152, subdivision 6; 62J.19; 62J.30; 62J.31; 62J.32; 62J.33; 62J.34; 62J.35; 62J.41, subdivisions 3 and 4; 62J.44; 62J.45; 62J.65; 62L.08, subdivision 7a; 62N.34; 62P.01; 62P.02; 62P.03; 62P.07; 62P.09; 62P.11; 62P.13; 62P.15; 62P.17; 62P.19; 62P.21; 62P.23; 62P.25; 62P.27; 62P.29; 62P.31; 62P.33; 62Q.03, subdivisions 2, 3, 4, 5, and 11; 62Q.18, subdivisions 2, 3, 4, 5, 6, 8, and 9; 62Q.21; 62Q.27; 144.1488, subdivision 2; 148.236; and 256.9353, subdivisions 4 and 5; Laws 1993, chapter 247, article 1, sections 12, 13, 14, 15, 18, and 19; Minnesota Rules, part 4685.1700, subpart 1, item D.

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

ARTICLE 1

INTEGRATED SERVICE NETWORKS

Section 1. Minnesota Statutes 1994, section 60B.02, is amended to read:

60B.02 **PERSONS COVERED.**

The proceedings authorized by sections 60B.01 to 60B.61 may be applied to:

(1) All insurers who are doing, or have done, an insurance business in this state, and against whom claims arising from that business may exist now or in the future;

(2) All insurers who purport to do an insurance business in this state;

(3) All insurers who have insureds resident in this state;

(4) All other persons organized or in the process of organizing with the intent to do an insurance business in this state; and

(5) All nonprofit service plan corporations incorporated or operating under the nonprofit health service plan corporation act, any health plan incorporated under chapter 317A, all fraternal benefit societies operating under chapter 64B, except those associations enumerated in section 64B.38, ~~all assessment benefit associations operating under chapter 63,~~ all township mutual or other companies operating under chapter 67A, ~~and~~ all reciprocals or interinsurance exchanges operating under chapter 71A, and all integrated service networks operating under chapter 62N.

Sec. 2. Minnesota Statutes 1994, section 60B.03, subdivision 2, is amended to read:

Subd. 2. **COMMISSIONER.** "Commissioner" means the commissioner of commerce of the state of Minnesota and, in that commissioner's absence or disability, a deputy or other person duly designated to act in that commissioner's place. In the context of rehabilitation or liquidation of a health maintenance organization or integrated service network, "commissioner" means the commissioner of health of the state of Minnesota and, in that commissioner's absence or disability, a deputy or other person duly designated to act in that commissioner's place.

Sec. 3. Minnesota Statutes 1994, section 60G.01, subdivision 2, is amended to read:

Subd. 2. **COMMISSIONER.** "Commissioner" means the commissioner of commerce, except that "commissioner" means the commissioner of health for administrative supervision of health maintenance organizations and integrated service networks.

Sec. 4. Minnesota Statutes 1994, section 60G.01, subdivision 4, is amended to read:

Subd. 4. **DEPARTMENT.** "Department" means the department of commerce, except that "department" means the department of health for administrative supervision of health maintenance organizations and integrated service networks.

Sec. 5. Minnesota Statutes 1994, section 60G.01, subdivision 5, is amended to read:

Subd. 5. **INSURER.** "Insurer" means and includes every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuities as limited to:

(1) any insurer who is doing an insurer business, or has transacted insurance in this state, and against whom claims arising from that transaction may exist now or in the future;

(2) any fraternal benefit society which is subject to chapter 64B;

(3) nonprofit health service plan corporations subject to chapter 62C;

(4) cooperative life and casualty companies subject to sections 61A.39 to 61A.52; ~~and~~

(5) health maintenance organizations regulated under chapter 62D; and

(6) integrated service networks regulated under chapter 62N.

Sec. 6. Minnesota Statutes 1994, section 62D.181, subdivision 2, is amended to read:

Subd. 2. **ELIGIBLE INDIVIDUALS.** An individual is eligible for alternative coverage under this section if:

(1) the individual had individual health coverage through a health maintenance organization, integrated service network, or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization, integrated service network, or community integrated service network, and the individual has not obtained alternative coverage; or

(2) the individual had group health coverage through a health maintenance organization, integrated service network, or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization, integrated service network, or community integrated service network, and the individual has not obtained alternative coverage.

Sec. 7. Minnesota Statutes 1994, section 62D.181, subdivision 3, is amended to read:

Subd. 3. **APPLICATION AND ISSUANCE.** If a health maintenance organization, integrated service network, or community integrated service network will be liquidated, individuals eligible for alternative coverage under subdivision 2 may apply to the association to obtain alternative coverage. Upon receiving an application and evidence that the applicant was enrolled in the health maintenance organization, integrated service network, or community integrated service network at the time of an order for liquidation, the association shall issue policies to eligible individuals, without the limitation on preexisting conditions described in section 62E.14, subdivision 3.

Sec. 8. Minnesota Statutes 1994, section 62D.181, subdivision 6, is amended to read:

Subd. 6. **DURATION.** The duration of alternative coverage issued under this section is:

(1) for individuals eligible under subdivision 2, clause (1), 90 days; and

(2) for individuals eligible under subdivision 2, clause (2), 90 days or the length of time remaining in the group contract with the insolvent health maintenance organization, integrated service network, or community integrated service network, whichever is greater.

Sec. 9. Minnesota Statutes 1994, section 62D.181, subdivision 9, is amended to read:

Subd. 9. **COORDINATION OF POLICIES.** If an insolvent health maintenance organization, integrated service network, or community integrated service network has insolvency insurance coverage at the time of an order for liquidation, the association may coordinate the benefits of the policy issued under this section with those of the insolvency insurance policy available to the enrollees. The premium level for the combined association policy and the insolvency insurance policy may not exceed those described in subdivision 5.

Sec. 10. Minnesota Statutes 1994, section 62N.02, is amended by adding a subdivision to read:

Subd. 4b. **CREDENTIALING.** "Credentialing" means the process of collecting, verifying, and reviewing evidence that relates to a health care professional's qualifications to practice the health care profession as a provider within a specific integrated service network.

Sec. 11. Minnesota Statutes 1994, section 62N.02, is amended by adding a subdivision to read:

Subd. 4c. **CREDENTIALING STANDARDS.** An integrated service network may set credentialing standards for providers. A network may recredential providers on a recurring basis. If a network sets credentialing standards, the network must provide a written description of those standards upon request. An integrated service network may participate in a centralized credentialing program and must provide a written description of that program upon request.

Sec. 12. Minnesota Statutes 1994, section 62N.04, is amended to read:

62N.04 **REGULATION.**

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

Sec. 13. **[62N.071] DEFINITIONS.**

Subdivision 1. **APPLICABILITY.** The definitions in this section apply to sections 62N.071 to 62N.078. Unless otherwise specified, terms used in those sections have the meanings required to be used in preparation of the National Association of Insurance Commissioners (NAIC) annual statement blanks for health maintenance organizations.

Subd. 2. **ADMITTED ASSETS.** "Admitted assets" means admitted assets as defined under section 62D.044, including the deposit required under section 62N.074.

Subd. 3. **NET WORTH.** "Net worth" means admitted assets minus liabilities.

Subd. 4. **LIABILITIES.** "Liabilities" means a network's debts and other obligations, including estimates of the network's reported and unreported claims incurred for covered services and supplies provided to enrollees. Liabilities do not include those obligations that are subordinated in the same manner as preferred ownership claims under section 60B.44, subdivision 10, including promissory notes subordinated to all other liabilities of the integrated service network.

Subd. 5. **UNCOVERED EXPENDITURES.** "Uncovered expenditures" means the charges for health care services and supplies that are covered by an integrated service network for which an enrollee would also be liable if the network becomes insolvent. Uncovered expenditures includes charges for covered health care services and supplies received by enrollees from providers that are not employed by, under contract with, or otherwise affiliated with the network. Uncovered expenditures does not include amounts that enrollees would not have to pay due to the obligations being guaranteed, insured, or assumed by a person other than the network.

Subd. 6. **WORKING CAPITAL.** "Working capital" means current assets minus current liabilities.

Sec. 14. **[62N.072] NET WORTH REQUIREMENT.**

Subdivision 1. **INITIAL REQUIREMENT.** An integrated service network must, at time of licensure, have a minimum net worth of the greater of:

(1) $1,500,000; or

(2) 8-1/3 percent of the sum of all expenses expected to be incurred in the first full year of operation, less 90 percent of the expected reinsurance premiums for that period.

Subd. 2. **ONGOING REQUIREMENT.** After a network's initial year of operation, the network must maintain net worth of no less than $1,000,000 or 8-1/3 percent of the previous years' expenditures, whichever is greater.

Sec. 15. **[62N.073] DEPOSIT REQUIREMENT.**

Subdivision 1. **INITIAL DEPOSIT.** An integrated service network shall deposit, at time of licensure, a deposit consisting of cash and direct United States Treasury obligations in the total amount of not less than $300,000.

Subd. 2. **CUSTODIAL ACCOUNT.** The deposit must be held in a custodial or other controlled account under a written account agreement acceptable to the commissioner.

Subd. 3. **ONGOING DEPOSIT.** After the initial year of operation, the required amount of the deposit is the greater of

(1) $300,000; or

(2) 33-1/3 percent of the network's uncovered expenditures incurred in the previous calendar year.

Subd. 4. **USE OF DEPOSIT.** (a) In the event of any delinquency proceeding as defined in section 60B.03, the required minimum deposit shall be applied first to pay for or reimburse the commissioner for expenses incurred by the commissioner in performing the commissioner's duties in connection with the insol-

vency, including any legal, actuarial or accounting fees. The balance of the required minimum deposit, if any, shall be used to reimburse enrollees for uncovered expenditures, on a pro rata basis.

(b) If a deposit exceeds the required minimum deposit, the excess shall be applied first to uncovered expenditures and the balance, if any, to the commissioner's expenses.

(c) The deposit is not subject to garnishment or levy under any circumstances.

Subd. 5. **ACTUAL DEPOSIT REQUIRED.** The deposit must be in the form specified in subdivision 1; a guarantee or letter of credit are not acceptable, in whole or in part, as substitutes.

Sec. 16. **[62N.074] WORKING CAPITAL.**

Subdivision 1. **REQUIREMENT.** An integrated service network must maintain a positive working capital at all times.

Subd. 2. **NOTICE REQUIRED.** If an integrated service network's working capital is no longer positive, or is likely to soon become no longer positive, the network shall immediately notify the commissioner.

Subd. 3. **PLAN OF CORRECTION.** If at any time an integrated service network's net worth, working capital, investments, deposits, or guarantees do not conform with the provisions of this chapter, the network shall promptly submit to the commissioner a written proposed plan of correction. The commissioner shall promptly approve, approve as modified, or reject the proposed plan. If a plan of correction has been approved by the commissioner, the network shall comply with it and shall cooperate fully with any activities the commissioner undertakes to monitor the network's compliance.

Subd. 4. **ACTION BY COMMISSIONER.** The commissioner may take any action permitted to the commissioner that the commissioner deems necessary or appropriate to protect the network or its enrollees if:

(1) the network fails to propose an approved plan of correction promptly;

(2) the network fails to comply with an approved plan of correction; or

(3) the commissioner determines that a deficiency in working capital cannot be corrected within a reasonable time.

Subd. 5. **OTHER REMEDIES.** This section does not limit the commissioner's power to use at any time other remedies available to the commissioner.

Sec. 17. **[62N.076] INVESTMENT RESTRICTIONS.**

Subdivision 1. **INVESTMENT POLICY.** An integrated service network shall have a written investment policy to govern investment of the network's

assets. The written policy must be reviewed and approved annually by the network's board of directors.

Subd. 2. **APPROVAL; INVESTMENTS.** A network shall not make loans or investments, unless authorized by its board of directors, or ratified by the board no later than the next regular board meeting.

Subd. 3. **PERMITTED INVESTMENT.** An integrated service network shall make investments only in securities or property designated by law as permitted for domestic life insurance companies; this restriction includes compliance with percentage limitations that apply to domestic life insurance companies. A network may, however, invest in real estate, including leasehold improvements, for the convenience and accommodation of its operations, including the home office, branch offices, medical facilities, and field operations, in excess of the percentage permitted for a domestic life insurance company, but not to exceed 25 percent of its total admitted assets.

Subd. 4. **CONFLICTS OF INTEREST.** An integrated service network shall not make loans to any of its directors or principal officers or make loans to or investments in any organization in which a director or principal officer has an interest.

Subd. 5. **PROOF OF COMPLIANCE.** An integrated service network shall annually file with the commissioner proof of compliance with this section in a form and on a date prescribed by the commissioner.

Sec. 18. **[62N.077] USE OF GUARANTEES.**

Subdivision 1. **GUARANTEE PERMITTED.** An integrated service network may, with the consent of the commissioner, satisfy up to 50 percent of its minimum net worth requirement by means of a guarantee provided by another organization.

Subd. 2. **SECURITY FOR GUARANTEE.** (a) If the guaranteeing organization is regulated for solvency by the commissioner of commerce or health, the guarantee must be treated as a liability for purposes of solvency regulation of the guaranteeing organization. If the guaranteeing organization becomes insolvent, a claim by the network on the guarantee must be at least of equal priority with claims of enrollees or other policy holders of the insolvent guaranteeing organization.

(b) If the guaranteeing organization is not regulated for solvency by the commissioner of commerce or health, the organization must maintain assets, except if, when calculated in combination with the assets described in section 62D.044, clause (17), the total of those assets and the real estate assets described in this subdivision do not exceed the total combined percent limitations allowable under this section and section 62D.044, clause (17), or except if permitted by the commissioner upon a finding that the percentage of the integrated service network's admitted assets is insufficient to provide convenient accommodation

of the network's business acceptable to the commissioner, with a market value at least equal to the amount of the guarantee, in a custodial or other controlled account on terms acceptable to the commissioner of health.

Subd. 3. **GOVERNMENTAL ENTITIES.** When a guaranteeing organization is a governmental entity, sections 62N.073 and 62N.076 do not apply. The commissioner may consider factors which provide evidence that the governmental entity is a financially reliable guaranteeing organization.

Sec. 19. **[62N.078] FINANCIAL REPORTING AND EXAMINATION.**

Subdivision 1. **FINANCIAL STATEMENTS.** An integrated service network shall file with the commissioner, annually on April 1, an audited financial statement. The financial statement must include the National Association of Insurance Commissioners (NAIC) annual statement blanks for health maintenance organizations, prepared in accordance with the NAIC annual statement instructions, and using the methods prescribed in the NAIC's accounting practices and procedures manual for health maintenance organizations. The financial statement must also include any other form or information prescribed by the commissioner.

Subd. 2. **QUARTERLY STATEMENTS.** An integrated service network shall file with the commissioner quarterly financial statements for the first three quarters of each year, on a date and form and in a manner prescribed by the commissioner.

Subd. 3. **OTHER INFORMATION.** An integrated service network shall comply promptly and fully with requests by the commissioner for other information that the commissioner deems necessary to monitor or assess the network's financial solvency.

Subd. 4. **FINANCIAL EXAMINATION.** The commissioner shall conduct a complete financial examination of each integrated service network at least once every three years, and more frequently if the commissioner deems it necessary. The examinations must be conducted according to the standards provided in the NAIC examiners handbook.

Sec. 20. Minnesota Statutes 1994, section 62N.10, is amended by adding a subdivision to read:

Subd. 7. **DATA SUBMISSION.** As a condition of licensure, an integrated service network shall comply fully with section 62J.38.

Sec. 21. Minnesota Statutes 1994, section 62N.11, subdivision 1, is amended to read:

Subdivision 1. **APPLICABILITY.** Every integrated service network enrollee residing in this state is entitled to evidence of coverage or contract. The integrated service network or its designated representative shall issue the evidence of coverage or contract. The commissioner shall adopt rules specifying the

requirements for contracts and evidence of coverage. "Evidence of coverage" means evidence that an enrollee is covered by a group contract issued to the group. The evidence of coverage must contain a description of provider locations, a list of the types of providers available, and information about the types of allied and midlevel practitioners and pharmacists that are available.

Sec. 22. Minnesota Statutes 1994, section 62N.13, is amended to read:

62N.13 **ENROLLEE COMPLAINT SYSTEM.**

Every integrated service network must establish and maintain an enrollee complaint system, ~~including an impartial arbitration provision~~ as required under section 62Q.105, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services. The integrated service network must inform enrollees that they may choose to use an alternative dispute resolution process. If an enrollee chooses to use an alternative dispute resolution process, the network must participate. The commissioner shall adopt rules specifying requirements relating to enrollee complaints.

Sec. 23. Minnesota Statutes 1994, section 62N.14, subdivision 3, is amended to read:

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 address, telephone number, and a brief description of the ~~state's office of consumer~~ information clearinghouse; and

(3) the telephone number of the department of health ~~or local ombudsperson~~.

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

Sec. 24. **[62N.15] PROVIDER REQUIREMENTS.**

Subdivision 1. **SERVICES.** An integrated service network may operate as a staff model as defined in section 295.50, subdivision 12b, or may contract with providers or provider organizations for the provision of services.

Subd. 2. **LOCATION.** (a) An integrated service network must ensure that primary care providers, including allied independent health providers as defined in section 62Q.095, subdivision 5, midlevel practitioners as defined in section 136A.1356, subdivision 1, are located at adequate locations within the service

area of the network. In determining whether locations are adequate, the integrated service network may consider the practice and referral patterns in each community served throughout the service area.

(b) Urgent and emergency care providers must be located within a distance of 30 miles or a travel time of 30 minutes from every enrollee.

Subd. 3. **NUMBERS.** An integrated service network must provide a sufficient number of providers to meet the projected needs of its enrollees, including special needs and high-risk enrollees, for all covered health care services.

Subd. 4. **TYPES.** An integrated service network must determine what types of providers are needed to deliver all appropriate and necessary health services to its enrollees. In determining which types of providers are necessary, networks shall use allied and midlevel practitioners and pharmacists within their respective scopes of practice.

Subd. 5. **CAPACITY.** An integrated service network shall monitor the capacity of the network to provide services to enrollees and take steps to increase capacity when parts of the network are not able to meet enrollee needs.

Subd. 6. **ACCESS.** (a) An integrated service network shall make available and accessible all covered health care services on a 24-hour per day, seven days per week basis. This requirement may be fulfilled through the use of:

(1) regularly scheduled appointments;

(2) after-hour clinics;

(3) use of a 24-hour answering service;

(4) backup coverage by another participating physician; or

(5) referrals to urgent care centers and to hospital emergency care.

(b) An integrated service network shall arrange for covered health care services, including referrals to specialty physicians, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines. An integrated service network shall have appointment scheduling guidelines based on the type of health care service.

(c) Nothing in this act shall be construed to require the creation or maintenance of abortion clinics or other abortion providers within any integrated service network; nor shall anything in this act be construed to authorize any agency to require the creation or maintenance of abortion clinics or abortion providers or to deny certification or any other benefit granted by this act to a health plan company based on the number of or the presence or absence of abortion clinics or other abortion providers in or affiliated with the health plan company.

Subd. 7. **CONTINUITY.** (a) An integrated service network shall provide

continuing care for enrollees in the event of contract termination between the integrated service network and any of its contracted providers or in the event of site closings involving a provider with more than one location of service.

(b) An integrated service network shall provide to its enrollees a written disclosure of the process by which continuity of care will be provided to all enrollees.

Subd. 8. **REVIEW.** The commissioner shall review each network's compliance with subdivisions 1 to 7. If the commissioner determines that a network is not meeting the requirements of this section, the commissioner may order the network to submit a plan of corrective action, and may order the network to comply with the provisions of that plan, as amended by the commissioner.

Sec. 25. **[62N.17] OUT-OF-NETWORK SERVICES.**

(a) An integrated service network shall provide coverage for all emergency services provided outside the network, when the care is immediately necessary or believed to be necessary to preserve life, prevent impairment of bodily functions, or to prevent placing the physical or mental health of the enrollee in jeopardy.

(b) An integrated service network shall include in its marketing materials a description of all limitations of coverage for out-of-network services, including when enrollees reside or travel outside the network's service area.

Sec. 26. **[62N.18] QUALITY IMPROVEMENT.**

Subdivision 1. **INTERNAL MEASURES.** Every integrated service network shall establish and maintain an internal quality improvement process. A network shall disclose these processes to enrollees, and to the commissioner upon request.

Subd. 2. **ENROLLEE SURVEYS.** (a) Every integrated service network shall, on at least a biennial basis, survey enrollee satisfaction with network performance and quality of care, and shall make survey results available to enrollees and potential enrollees. Integrated service networks shall also submit survey results to the information clearinghouse.

(b) Every integrated service network shall participate in the consumer survey efforts established under section 62J.451, subdivision 6b, to evaluate enrollee satisfaction, network performance, and quality of care. Participation in the consumer survey efforts of section 62J.451, subdivision 6b, shall satisfy paragraph (a) of this subdivision.

Subd. 3. **QUALITY IMPROVEMENT WORKPLANS.** (a) An integrated service network shall submit annual quality improvement workplans to the commissioner. A workplan must:

(1) identify the four most common enrollee complaints related to service

delivery and the four most common enrollee complaints related to administration;

(2) identify the specific measures that the network plans to take to address each of these complaint areas;

(3) provide an assessment of how these complaints affect health care outcomes; and

(4) identify the mechanisms that the network will use to communicate and implement the changes needed to address each of these complaints identified in clause (1).

(b) An integrated service network shall disclose in marketing materials the complaints identified in paragraph (a), and measures that will be taken by the network to address these complaints.

Sec. 27. Minnesota Statutes 1994, section 62N.25, subdivision 2, is amended to read:

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. A community integrated service network that phases in its net worth over a three-year period is not required to respond to requests for proposals under section 256B.0644 during the first 12 months of licensure. These community networks are not prohibited from responding to requests for proposals, however, if they choose to do so during that time period. After the initial 12 months of licensure, these community networks are required to respond to the requests for proposals as required under section 256B.0644.

Sec. 28. **[62N.40] CHEMICAL DEPENDENCY SERVICES.**

Each community integrated service network and integrated service network regulated under this chapter must ensure that chemically dependent individuals have access to cost-effective treatment options that address the specific needs of individuals. These include, but are not limited to, the need for: treatment that takes into account severity of illness and comorbidities; provision of a continuum of care, including treatment and rehabilitation programs licensed under Minnesota Rules, parts 9530.4100 to 9530.4410 and 9530.5000 to 9530.6500; the safety of the individual's domestic and community environment; gender appropriate and culturally appropriate programs; and access to appropriate social services.

Sec. 29. **REPEALER.**

Minnesota Statutes 1994, section 62N.34, is repealed.

ARTICLE 2

MODIFICATIONS OF REQUIREMENTS FOR HEALTH PLAN COMPANIES

Section 1. Minnesota Statutes 1994, section 62D.11, subdivision 1, is amended to read:

Subdivision 1. **ENROLLEE COMPLAINT SYSTEM.** Every health maintenance organization shall establish and maintain a complaint system ~~including an impartial arbitration provision~~, as required under section 62Q.105 to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services. "Provision of health services" includes, but is not limited to, questions of the scope of coverage, quality of care, and administrative operations. ~~Arbitration shall be subject to chapter 572, except (a) in the event that an enrollee elects to litigate a complaint prior to submission to arbitration, and (b) no medical malpractice damage claim shall be subject to arbitration unless agreed to by both parties subsequent to the event giving rise to the claim.~~ The health maintenance organization must inform enrollees that they may choose to use an alternative dispute resolution process. If an enrollee chooses to use an alternative dispute resolution process, the health maintenance organization must participate.

Sec. 2. Minnesota Statutes 1994, section 62Q.01, subdivision 2, is amended to read:

Subd. 2. **COMMISSIONER.** "Commissioner" means the commissioner of health for purposes of regulating health maintenance organizations, community integrated service networks, and integrated service networks, or the commissioner of commerce for purposes of regulating all other health plan companies. For all other purposes, "commissioner" means the commissioner of health.

Sec. 3. Minnesota Statutes 1994, section 62Q.01, is amended by adding a subdivision to read:

Subd. 2a. **ENROLLEE.** "Enrollee" means a natural person covered by a health plan and includes an insured, policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Sec. 4. Minnesota Statutes 1994, section 62Q.01, subdivision 3, is amended to read:

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; or an integrated service network~~; or an all-payer insurer as defined in section 62P.02~~.

Sec. 5. Minnesota Statutes 1994, section 62Q.01, is amended by adding a subdivision to read:

Subd. 5. **MANAGED CARE ORGANIZATION.** "Managed care organization" means: (1) a health maintenance organization operating under chapter 62D; (2) a community integrated service network as defined under section 62N.02, subdivision 4a; (3) an integrated service network as defined under section 62N.02, subdivision 8; or (4) an insurance company licensed under chapter 60A, nonprofit health service plan corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

Sec. 6. Minnesota Statutes 1994, section 62Q.01, is amended by adding a subdivision to read:

Subd. 6. **MEDICARE-RELATED COVERAGE.** "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts) or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

Sec. 7. **[62Q.02] APPLICABILITY OF CHAPTER.**

(a) This chapter applies only to health plans, as defined in section 62Q.01, and not to other types of insurance issued or renewed by health plan companies, unless otherwise specified.

(b) This chapter applies to a health plan company only with respect to health plans, as defined in section 62Q.01, issued or renewed by the health plan company, unless otherwise specified.

(c) If a health plan company issues or renews health plans in other states, this chapter applies only to health plans issued or renewed in this state for Minnesota residents, or to cover a resident of the state, unless otherwise specified.

Sec. 8. Minnesota Statutes 1994, section 62Q.03, subdivision 1, is amended to read:

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.~~ The purpose of risk adjustment is to reduce the effects of risk selection on health insurance premiums by making monetary transfers from health plan companies that insure lower risk populations to health plan companies that insure higher risk populations. Risk adjustment is needed to: achieve a more equitable, efficient system of health care financing; remove current disincentives in the health care system to insure and ~~serve~~ provide adequate access for 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~~ risk status of those in a given insurance pool; and help ~~assure~~ maintain the viability of ~~all~~ health plan companies, ~~including community integrated service networks~~ by protecting them from the financial effects of enrolling a disproportionate number of high risk individuals. 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 subdivisions 2 and 3.~~ The risk adjustment system shall:

(1) possess a reasonable level of accuracy and administrative feasibility, be adaptable to changes as methods improve, incorporate safeguards against fraud and manipulation, and shall neither reward inefficiency nor penalize for verifiable improvements in health status;

(2) require participation by all health plan companies providing coverage in the individual, small group, and Medicare supplement markets;

(3) address unequal distribution of risk between health plan companies, but shall not address the financing of public programs or subsidies for low-income people; and

(4) be developed and implemented by the risk adjustment association with joint oversight by the commissioners of health and commerce.

Sec. 9. Minnesota Statutes 1994, section 62Q.03, is amended by adding a subdivision to read:

Subd. 5a. **PUBLIC PROGRAMS.** (a) A separate risk adjustment system must be developed for state-run public programs, including medical assistance, general assistance medical care, and MinnesotaCare. The system must be developed in accordance with the general risk adjustment methodologies described in this section, must include factors in addition to age and sex adjustment, and may include additional demographic factors, different targeted conditions, and/or different payment amounts for conditions. The risk adjustment system for public programs must attempt to reflect the special needs related to poverty, cultural, or language barriers and other needs of the public program population.

(b) The commissioners of health and human services shall jointly convene a public programs risk adjustment work group responsible for advising the commissioners in the design of the public programs risk adjustment system. The commissioner of health shall work with the risk adjustment association to ensure coordination between the risk adjustment systems for the public and private sec-

tors. The commissioner of human services shall seek any needed federal approvals necessary for the inclusion of the medical assistance program in the public program risk adjustment system.

(c) The public programs risk adjustment work group must be representative of the persons served by publicly paid health programs and providers and health plans that meet their needs. To the greatest extent possible, the appointing authorities shall attempt to select representatives that have historically served a significant number of persons in publicly paid health programs or the uninsured. Membership of the work group shall be as follows:

(1) one provider member appointed by the Minnesota Medical Association;

(2) two provider members appointed by the Minnesota Hospital Association, at least one of whom must represent a major disproportionate share hospital;

(3) five members appointed by the Minnesota Council of HMOs, one of whom must represent an HMO with fewer than 50,000 enrollees located outside the metropolitan area and one of whom must represent an HMO with at least 50 percent of total membership enrolled through a public program;

(4) two representatives of counties appointed by the Association of Minnesota Counties;

(5) three representatives of organizations representing the interests of families, children, childless adults, and elderly persons served by the various publicly paid health programs appointed by the governor;

(6) two representatives of persons with mental health, developmental or physical disabilities, chemical dependency, or chronic illness appointed by the governor; and

(7) three public members appointed by the governor, at least one of whom must represent a community health board. The risk adjustment association may appoint a representative, if a representative is not otherwise appointed by an appointing authority.

(d) The commissioners of health and human services, with the advice of the public programs risk adjustment work group, shall develop a work plan and time frame and shall coordinate their efforts with the private sector risk adjustment association's activities and other state initiatives related to public program managed care reimbursement. The commissioners of health and human services shall report to the health care commission and to the appropriate legislative committees on January 15, 1996, and on January 15, 1997, on any policy or legislative changes necessary to implement the public program risk adjustment system.

Sec. 10. Minnesota Statutes 1994, section 62Q.03, is amended by adding a subdivision to read:

Subd. 5b. **MEDICARE SUPPLEMENT MARKET.** A risk adjustment system may be developed for the Medicare supplement market. The Medicare supplement risk adjustment system may include a demographic component and may, but is not required to, include a condition-specific risk adjustment component.

Sec. 11. Minnesota Statutes 1994, section 62Q.03, subdivision 6, is amended to read:

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~~.~~, but is authorized to incorporate under chapter 317A.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association may operate under the approved plan of operation and shall be governed in accordance with this chapter and may operate in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation meets the requirements of filing articles of incorporation.

The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 14, 60A, 62A, and 62P. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. The board of directors and health carriers who are members of the association are exempt from sections 325D.49 to 325D.66 in the performance of their duties as directors and members of the association. The risk adjustment association is subject to the open meeting law.

Sec. 12. Minnesota Statutes 1994, section 62Q.03, subdivision 7, is amended to read:

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.~~ established to develop and implement a private sector risk adjustment system.

Subject to state oversight set forth in subdivision 10, the association shall:

(1) develop and implement comprehensive risk adjustment systems for individual, small group, and Medicare Supplement markets consistent with the provisions of this chapter;

(2) submit a plan for the development of the risk adjustment system which

identifies appropriate implementation dates consistent with the rating and underwriting restrictions of each market, recommends whether transfers attributable to risk adjustment should be required between the individual and small group markets, and makes other appropriate recommendations to the commissioners of health and commerce by November 5, 1995;

(3) develop a combination of a demographic risk adjustment system and payments for targeted conditions;

(4) test an ambulatory care groups (ACGs) and diagnostic cost groups (DCGs) system, and recommend whether such a methodology should be adopted;

(5) fund the development and testing of the risk adjustment system;

(6) recommend market conduct guidelines; and

(7) develop a plan for assessing members for the costs of administering the risk adjustment system.

Sec. 13. Minnesota Statutes 1994, section 62Q.03, subdivision 8, is amended to read:

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 of operation 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.

Sec. 14. Minnesota Statutes 1994, section 62Q.03, is amended by adding a subdivision to read:

Subd. 8a. **PLAN OF OPERATION.** The board shall submit a proposed plan of operation by August 15, 1995, to the commissioners of health and commerce for review. The commissioners of health and commerce shall have the authority to approve or reject the plan of operation.

Amendments to the plan of operation may be made by the commissioners or by the directors of the association, subject to the approval of the commissioners.

Sec. 15. Minnesota Statutes 1994, section 62Q.03, subdivision 9, is amended to read:

Subd. 9. **DATA COLLECTION AND DATA PRIVACY.** ~~The board of the association shall consider antitrust implications and establish procedures to assure that pricing and 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.~~ The association members shall not have access to unaggregated data on individuals or health plan companies. The association shall develop, as a part of the plan of operation, procedures for ensuring that data is collected by an appropriate entity. The commissioners of health and commerce shall have the authority to audit and examine data collected by the association for the purposes of the development and implementation of the risk adjustment system. Data on individuals obtained for the purposes of risk adjustment development, testing, and operation are designated as private data. Data not on individuals which is obtained for the purposes of development, testing, and operation of risk adjustment are designated as nonpublic data. Except for the proposed and approved plan of operation, the risk adjustment methodologies examined, the plan for testing, the plan of the risk adjustment system, minutes of meetings, and other general operating information are classified as public data. Nothing in this section is intended to prohibit the preparation of summary data under section 13.05, subdivision 7. The association, state agencies, and any contractors having access to this data shall maintain it in accordance with this classification. The commissioners of health and human services have the authority to collect data from health plan companies as needed for the purpose of developing a risk adjustment mechanism for public programs.

Sec. 16. Minnesota Statutes 1994, section 62Q.03, subdivision 10, is amended to read:

Subd. 10. ~~SUPERVISION~~ STATE OVERSIGHT OF RISK ADJUSTMENT ACTIVITIES. The association's activities shall be supervised by the commissioners of health and commerce. The commissioners shall provide specific oversight functions during the development and implementation phases of the risk adjustment system as follows:

(1) the commissioners shall approve or reject the association's plan for testing risk adjustment methods, the methods to be used, and any changes to those methods;

(2) the commissioners must have the right to attend and participate in all meetings of the association and its work groups or committees, except for meetings involving privileged communication between the association and its counsel as permitted under section 471.705, subdivision 1d, paragraph (e);

(3) the commissioners shall approve any consultants or administrators used by the association;

(4) the commissioners shall approve or reject the association's plan of operation; and

(5) the commissioners shall approve or reject the plan for the risk adjustment system described in subdivision 7, clause (2).

If the commissioners reject any of the plans identified in clauses (1), (4), and (5) of this subdivision, the directors shall submit for review an appropriate revised plan within 30 days.

Sec. 17. Minnesota Statutes 1994, section 62Q.03, is amended by adding a subdivision to read:

Subd. 12. **PARTICIPATION BY ALL HEALTH PLAN COMPANIES.** Upon its implementation, all health plan companies, as a condition of licensure, must participate in the risk adjustment system to be implemented under this section.

Sec. 18. Minnesota Statutes 1994, section 62Q.07, subdivision 1, is amended to read:

Subdivision 1. **ACTION PLANS REQUIRED.** (a) To increase public awareness and accountability of health plan companies, all health plan companies that issue or renew a health plan, as defined in section 62Q.01, 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. For purposes of this subdivision, "health plan" includes the coverages described in section 62A.011, subdivision 3, clause (10). 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.

Sec. 19. Minnesota Statutes 1994, section 62Q.07, subdivision 2, is amended to read:

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 company 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 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. 20. Minnesota Statutes 1994, section 62Q.09, subdivision 3, is amended to read:

Subd. 3. **ENFORCEMENT.** ~~Either~~ The ~~commissioner~~ commissioners of health ~~or~~ and commerce shall each periodically review contracts among health care providing entities and health plan companies to determine compliance with this section, with respect to health plan companies that the commissioners respectively regulate. Any provider may submit a contract to the relevant commissioner for review if the provider believes this section has been violated. Any provision of a contract found by the relevant commissioner to violate this sec-

tion is null and void, and the relevant commissioner may ~~seek~~ assess civil penalties against the health plan company in an amount not to exceed $25,000 for each such contract, using the enforcement procedures otherwise available to the commissioner involved.

Sec. 21. **[62Q.105] HEALTH PLAN COMPANY COMPLAINT PROCEDURE.**

Subdivision 1. **ESTABLISHMENT.** Each health plan company shall establish and make available to enrollees, by July 1, 1997, an informal complaint resolution process that meets the requirements of this section. A health plan company must make reasonable efforts to resolve enrollee complaints, and must inform complainants in writing of the company's decision within 30 days of receiving the complaint. The complaint resolution process must treat the complaint and information related to it as required under sections 72A.49 to 72A.505.

Subd. 2. **MEDICALLY URGENT COMPLAINTS.** Health plan companies shall make reasonable efforts to resolve medically urgent enrollee complaints within 72 hours of receiving the complaint.

Subd. 3. **APPEALS PROCESS.** Health plan companies shall establish and make available to enrollees an impartial appeals process. If a decision by a health plan company regarding a complaint is partially or wholly adverse to the complainant, the health plan company shall advise the complainant of the right to appeal through the impartial appeals process or to the commissioner.

Subd. 4. **ALTERNATIVE DISPUTE RESOLUTION.** Health plan companies shall make available to enrollees an alternative dispute resolution process, and shall participate in alternative dispute resolution at the request of an enrollee, as required under section 62Q.11. A health plan company may meet the requirements of subdivision 3 by providing an alternative dispute resolution process. If the health plan company chooses to provide alternative dispute resolution to meet the requirements of subdivision 3, the process shall be provided at no cost to the enrollee.

Subd. 5. **REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS.** Each managed care organization shall submit all health care quality related complaints to its quality review board or quality review organization for evaluation and possible action. The complaint resolution process for managed care organizations must clearly indicate the entity responsible for resolving complaints made by enrollees against hospitals, other health care facilities, and health care providers, that are owned by or under contract with the managed care organization.

Subd. 6. **RECORD KEEPING.** Health plan companies shall maintain records of all enrollee complaints and their resolutions. These records must be retained for five years, and must be made available to the appropriate commissioner upon request.

Subd. 7. **REPORTING.** Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that are not resolved within 30 days. A health plan company shall also make this information available to the public upon request.

Subd. 8. **NOTICE TO ENROLLEES.** Health plan companies shall provide a clear and complete description of their complaint resolution procedures to enrollees as part of their evidence of coverage or contract. The description must specifically inform enrollees:

(1) how to file a complaint with the health plan company;

(2) how to request an impartial appeal;

(3) that they have the right to request the use of alternative methods of dispute resolution; and

(4) that they have the right to litigate.

Sec. 22. **[62Q.1055] CHEMICAL DEPENDENCY.**

All health plan companies shall use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660, when assessing and placing enrollees for chemical dependency treatment.

Sec. 23. **[62Q.106] DISPUTE RESOLUTION BY COMMISSIONER.**

A complainant may at any time submit a complaint to the appropriate commissioner to investigate. After investigating a complaint, or reviewing a company's decision, the appropriate commissioner may order a remedy as authorized under section 62N.04, 62Q.30, chapter 45, 60A, or 62D.

Sec. 24. Minnesota Statutes 1994, section 62Q.11, subdivision 2, is amended to read:

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, and shall establish appropriate cost-sharing requirements for parties taking part in alternative dispute resolution.

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

Sec. 25. **[62Q.145] ABORTION AND SCOPE OF PRACTICE.**

Health plan company policies related to scope of practice for allied independent health providers as defined in section 62Q.095, subdivision 5, midlevel practitioners as defined in section 136A.1356, subdivision 1, and other nonphysician health care professionals must comply with the requirements governing the performance of abortions in section 145.412, subdivision 1.

Sec. 26. Minnesota Statutes 1994, section 62Q.19, is amended to read:

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);

(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 unit as defined in section 62D.02, subdivision 11, an Indian tribal government, an Indian health service unit, or community health board as defined in chapter 145A.

Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

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.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner. Applications must be accepted within two years after the effective date of the rules adopted by the commissioner to implement this section.

(b) Each application submitted must be accompanied by an application fee in an amount determined by the commissioner. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

Subd 2a. **DEFINITION OF HEALTH PLAN COMPANY.** For purposes of this section, "health plan company" does not include a health plan company as defined in section 62Q.01 with fewer than 50,000 enrollees, all of whose enrollees are covered under medical assistance, general assistance medical care, or MinnesotaCare.

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 services designated to be provided by 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~~ for these services. 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~~ in which the essential community provider is ~~certified to serve~~ located.

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~~ the same rate per unit of service as is paid to other health plan providers for the same or similar services.

Subd. 5a. **COOPERATION.** Each health plan company and essential community provider shall cooperate to facilitate the use of the essential community provider by the high risk and special needs populations. This includes cooperation on the submission and processing of claims, sharing of all pertinent records and data, including performance indicators and specific outcomes data, and the use of all dispute resolution methods as defined in section 62Q.11, subdivision 1.

Subd. 5b. **ENFORCEMENT.** For any violation of this section or any rule applicable to an essential community provider, the commissioner may suspend, modify, or revoke an essential community provider designation. The commissioner may also use the enforcement authority specified in section 62D.17.

Subd. 6. **TERMINATION.** The designation as an essential community provider ~~is terminated~~ terminates five years after it is granted, ~~and~~ or when universal coverage as defined under section 62Q.165 is achieved, whichever is later. Once the designation terminates, the former essential community provider has no rights or privileges beyond those of any other health care provider. The commissioner shall make a recommendation to the legislature on whether an essential community provider designation should be longer than five years.

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 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. The rules shall require health plan companies to comply with all provisions of section 62Q.14 with respect to enrollee use of essential community providers.

Sec. 27. **[62Q.43] GEOGRAPHIC ACCESS.**

Subdivision 1. **CLOSED-PANEL HEALTH PLAN.** For purposes of this section, "closed-panel health plan" means a health plan as defined in section 62Q.01 that requires an enrollee to receive all or a majority of primary care services from a specific clinic or physician designated by the enrollee that is within the health plan company's clinic or physician network.

Subd. 2. **ACCESS REQUIREMENT.** Every closed-panel health plan must allow enrollees who are full-time students under the age of 25 years to change their designated clinic or physician at least once per month, as long as the clinic or physician is part of the health plan company's statewide clinic or physician network. A health plan company shall not charge enrollees who choose this

option higher premiums or cost sharing than would otherwise apply to enrollees who do not choose this option. A health plan company may require enrollees to provide 15 days written notice of intent to change their designated clinic or physician.

Sec. 28. **[62Q.45] COVERAGE FOR OUT-OF-AREA PRIMARY CARE.**

Subdivision 1. **STUDY.** The commissioner of health shall develop methods to allow enrollees of managed care organizations to obtain primary care health services outside of the service area of their managed care organization, from health care providers who are employed by or under contract with another managed care organization. The commissioner shall make recommendations on: (1) whether this out-of-area primary care coverage should be available to students and/or other enrollees without additional premium charges or cost sharing; (2) methods to coordinate the services provided by different managed care organizations; (3) methods to manage the quality of care provided by different managed care organizations and monitor health care outcomes; (4) methods to reimburse managed care organizations for care provided to enrollees of other managed care organizations; and (5) other issues relevant to the design and administration of out-of-area primary care coverage. The commissioner shall present recommendations to the legislature by January 15, 1996.

Subd. 2. **DEFINITION.** For purposes of this section, "managed care organization" means: (1) a health maintenance organization operating under chapter 62D; (2) a community integrated service network as defined under section 62N.02, subdivision 4a; (3) an integrated service network as defined under section 62N.02, subdivision 8; or (4) an insurance company licensed under chapter 60A, nonprofit health service plan corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

Sec. 29. **[62Q.47] MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES.**

(a) All health plans, as defined in section 62Q.01, that provide coverage for mental health or chemical dependency services, must comply with the requirements of this section.

(b) 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.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical depen-

dency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

Sec. 30. Minnesota Statutes 1994, section 145.414, is amended to read:

145.414 **ABORTION NOT MANDATORY.**

(a) No person and no hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion for any reason.

(b) It is the policy of the state of Minnesota that no health plan company as defined under section 62Q.01, subdivision 4, or health care cooperative as defined under section 62R.04, subdivision 2, shall be required to provide or provide coverage for an abortion. No provision of this chapter; of chapter 62A, 62C, 62D, 62H, 62L, 62M, 62N, 62R, 64B, or of any other chapter; of Minnesota Rules; or of this act shall be construed as requiring a health plan company as defined under section 62Q.01, subdivision 4, or a health care cooperative as defined under section 62R.04, subdivision 2, to provide or provide coverage for an abortion.

(c) This section supersedes any provision of this act, or any act enacted prior to enactment of this act, that in any way limits or is inconsistent with this section. No provision of any act enacted subsequent to this act shall be construed as in any way limiting or being inconsistent with this section, unless the act amends this section or expressly provides that it is intended to limit or be inconsistent with this section.

Sec. 31. **SINGLE ENTRY POINT FOR COMPLAINTS.**

The commissioner of health shall establish a single entry point within the health department for consumer complaints about the quality and cost of health care services, whether these services are delivered by individual providers, health care facilities, or health plan companies. The commissioner shall present a work plan to the legislature by February 1, 1996.

Sec. 32. **CHEMICAL DEPENDENCY STANDARDS AND INCENTIVES.**

Subdivision 1. **STANDARDS.** As part of the department of human service's household survey of chemical dependency needs in Minnesota, the commissioner of human services shall study whether utilization standards pertaining to the number of chemical dependency treatment inpatient and outpatient referrals per 1,000 enrollees and lengths of stay are needed for the state to address chemical dependency treatment needs.

Subd. 2. **INCENTIVES SYSTEM.** The commissioners of human services and health shall develop recommendations for a financial or other incentive sys-

tem for health plan companies to meet the standards developed in subdivision 1. The commissioners shall report to the health care commission and appropriate legislative committees by January 15, 1997.

Sec. 33. **CONSTRUCTION.**

Nothing in this act shall be construed to expand existing law with respect to coverage of abortion.

Sec. 34. **STUDY OF HEALTH CARE DELIVERY.**

The Minnesota health care commission shall study the impact of managed care and other methods of health care delivery on the quality of life and care provided to terminally ill patients. The commission shall also study the impact of managed care and other methods of health care delivery on the quality of life and care provided to persons with chronic illness or disability. The commission shall hold hearings at various sites in Minnesota and take testimony from concerned citizens. The commission shall present a report on these issues to the legislature and the governor by December 15, 1996.

Sec. 35. **REPEALER; HMO ARBITRATION RULES.**

Minnesota Rules, part 4685.1700, subpart 1, item D, is repealed.

Sec. 36. **REPEALER.**

Minnesota Statutes 1994, sections 62Q.03, subdivisions 2, 3, 4, 5, and 11; 62Q.21; and 62Q.27, are repealed.

Sec. 37. **EFFECTIVE DATE.**

Sections 1, 31, and 36 are effective January 1, 1996.

Section 27 is effective July 1, 1995, and applies to closed-panel health plans offered, sold, issued, or renewed on or after that date.

Section 29 is effective August 1, 1995, and applies to health plans offered, issued, or renewed on or after that date.

ARTICLE 3

REGULATED ALL-PAYER OPTION

Section 1. Minnesota Statutes 1994, section 62J.017, is amended to read:

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. 2. Minnesota Statutes 1994, 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 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 February 15 of each year on the implementation of the growth limits. This annual report shall describe the differences between the projected increase in health care expenditures, 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, in consultation with the Minnesota health care commission, shall research and include in the annual report required in paragraph (a) for 1996, recommendations regarding the implementation of growth limits for health plan companies and providers. The commissioner shall:

(1) consider both spending and revenue approaches and report on the implementation of the interim limits as defined in sections 62J.041 and 62J.042;

(2) make recommendations regarding the enforcement mechanism and consider mechanisms to adjust future growth limits as well as mechanisms to establish financial penalties for noncompliance;

(3) address the feasibility of systemwide limits imposed on all integrated service networks; and

(4) make recommendations on the most effective way to implement growth limits on the fee-for-service system in the absence of a regulated all-payer system.

~~(b)~~ (c) The commissioner shall enforce limits on growth in spending ~~and revenues~~ for ~~integrated service networks and for the regulated all-payer option~~ health plan companies and revenues for providers. If the commissioner determines that artificial inflation or padding of costs or prices has occurred in anticipation of the implementation of growth limits, 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)~~ (d) The commissioner shall impose and enforce overall limits on growth in ~~revenues and~~ spending for ~~integrated service networks~~ health plan companies, with adjustments for changes in enrollment, benefits, severity, and risks. If ~~an integrated service network~~ a health plan company exceeds 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~~ impose financial penalties up to the amount exceeding the applicable growth limit.

~~(d) The commissioner shall set prices, utilization controls, and other requirements for the regulated all-payer 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 growth limits for a calendar year are exceeded, the commissioner may reduce reimbursement rates or otherwise recoup amounts exceeding the limit for all or part of the next calendar year. To the extent possible, the commissioner may reduce reimbursement rates or otherwise recoup amounts over the limit from individual providers who exceed the 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 systemwide 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. 3. Minnesota Statutes 1994, 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 option 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 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. 4. Minnesota Statutes 1994, section 62J.152, subdivision 5, is amended to read:

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

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

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

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

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

~~(5)~~ (4) by health care providers in making decisions about adding or replacing technology and the appropriate use of technology;

~~(6)~~ (5) by consumers in making decisions about treatment;

~~(7)~~ (6) by medical device manufacturers in developing and marketing new technologies; and

~~(8)~~ (7) as otherwise needed by health care providers, health care plans, consumers, and purchasers.

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

Sec. 5. Minnesota Statutes 1994, section 62Q.01, subdivision 4, is amended to read:

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; or

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

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

Sec. 6. Minnesota Statutes 1994, section 62Q.30, is amended to read:

62Q.30 **EXPEDITED FACT FINDING AND DISPUTE RESOLUTION PROCESS.**

The commissioner shall establish an expedited fact finding and dispute resolution process to assist enrollees of ~~integrated service networks and all-payer insurers~~ health plan companies 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~~ health coverage. 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~~ a health plan company that is the subject of repeated orders by the commissioner that suggests a pattern of inappropriate underutilization.

Sec. 7. Minnesota Statutes 1994, section 62Q.41, is amended to read:

62Q.41 **ANNUAL IMPLEMENTATION REPORT.**

(a) 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.

(b) As part of the report required in paragraph (a) due for 1996, the commissioner, in consultation with the health care commission, shall make recommendations on the design and development of an appropriate framework to apply regulations uniformly among all health plan companies and to ensure adequate oversight and consumer protection in the absence of a regulated all-payer system.

Sec. 8. Laws 1994, chapter 625, article 5, section 5, subdivision 1, is amended to read:

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.

Sec. 9. **INSTRUCTION TO REVISOR; RECODIFICATION OF INTERIM LIMITS.**

The revisor of statutes shall recode Minnesota Statutes, section 62P.04, as amended, as section 62J.041, and shall recode section 62P.05, as amended, as section 62J.042.

Sec. 10. **REPEALER.**

Minnesota Statutes 1994, sections 62J.152, subdivision 6; 62P.01; 62P.02; 62P.03; 62P.07; 62P.09; 62P.11; 62P.13; 62P.15; 62P.17; 62P.19; 62P.21; 62P.23; 62P.25; 62P.27; 62P.29; 62P.31; and 62P.33, are repealed.

ARTICLE 4

UNIVERSAL COVERAGE

Section 1. Minnesota Statutes 1994, section 62Q.165, is amended to read:

62Q.165 **UNIVERSAL COVERAGE.**

Subdivision 1. **DEFINITION.** 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;~~

~~(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~~. Universal coverage is achieved when:

(1) every Minnesotan has access to a full range of quality health care services;

(2) every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care; and

(3) every Minnesotan pays into the health care system according to that person's ability.

Subd. 2. **GOAL.** It is the goal of the state to make continuous progress toward reducing the number of Minnesotans who do not have health coverage so that by January 1, 2000, fewer than four percent of the state's population will be without health coverage. The goal will be achieved by improving access to private health coverage through insurance reforms and market reforms, by making health coverage more affordable for low-income Minnesotans through purchasing pools and state subsidies, and by reducing the cost of health coverage through cost containment programs and methods of ensuring that all Minnesotans are paying into the system according to their ability.

Subd. 3. **REPORT ON HEALTH CARE ACCESS.** (a) The health care commission shall annually report to the legislature regarding the extent to which the state is making progress toward the goal of universal coverage described in this section. As part of this report, the commission shall monitor the number of uninsured in the state. The annual report must be submitted no later than January 15 of each year in compliance with section 3.195.

(b) The annual report required under paragraph (a), due January 15, 1996, shall advise the legislature regarding possible additional steps in insurance reform that would be helpful in progressing toward universal coverage. The commission shall consider further initiatives involving group purchasing pools, narrowing premium variations, guaranteed issue and portability requirements, preexisting condition limitations, and other provisions that provide greater opportunities to obtain affordable health coverage. The commission shall consider the small employer reforms contained in the model laws recommended by the National Association of Insurance Commissioners and shall recommend whether these reforms should be adopted.

(c) The annual report due required under paragraph (a), required on January 15, 1996, shall advise the legislature regarding possible changes in the individual insurance market. The report shall consider initiatives regarding purchasing pools, including specific design details of a state-run or state-initiated purchasing pool for individuals, specific legislative reforms needed to encourage the formation of purchasing pools, and point-by-point consideration of the obstacles to enactment of these purchasing pools, including adverse selection. The report shall consider the creation of a standard and objective definition of eligibility for the comprehensive health association, and whether the enactment of such a definition could be coupled with guaranteed issuance for the remainder of the individual market. The report should include all other considerations of the commission as to the optimal reforms of the individual market.

(d) The health care commission shall in its annual report make recommendations regarding any steps toward achieving universal coverage that became feasible as a result of changes in federal law that remove barriers to state efforts to expand health care access.

(e) To the extent possible, the health care commission shall utilize existing information, including information collected by other state or federal agencies and organizations, to complete the studies and reports in this subdivision. State agencies and organizations shall provide information, technical and analytic support, and other assistance to the commission as possible, to ensure the timely and efficient completion of the studies and reports in this subdivision. Staff from the appropriate state agencies shall participate with the commission executive director no later than June 15 each year in initial planning and coordination for the annual reports and studies of this subdivision. Following this initial planning, the executive director shall report to the legislative oversight commission on health care access by July 1 each year on the initial study plan, and on any commission tasks or studies which may not be completed as scheduled due to such constraints as lack of sufficient available information or resources.

Sec. 2. Minnesota Statutes 1994, section 62Q.18, is amended to read:

62Q.18 ~~UNIVERSAL~~ PORTABILITY OF 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 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; and

(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:~~

~~(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, general assistance medical care under chapter 256D, or the MinnesotaCare program 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 program 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 and who qualify under the group's eligibility requirements:

(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 preexisting condition exclusion.

To the extent that this ~~paragraph~~ subdivision conflicts with chapter 62L, ~~with respect to small employers as defined in section 62L.02,~~ chapter 62L governs, regardless of whether the group sponsor is a small employer as defined in section 62L.02, except that for group health plans issued to groups that are not small employers, this subdivision's requirement that the individual have maintained continuous coverage applies. An individual who has maintained continuous coverage, but would be considered a late entrant under chapter 62L, may be

treated as a late entrant in the same manner under this subdivision as permitted under chapter 62L.

~~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 section 62Q.165 and Laws 1994, chapter 625, article 6, sections 5, 6, and 7. Subdivision 6 is not effective until an effective date is specified in 1995 legislation.~~

Sec. 3. **COORDINATION BETWEEN ACUTE AND LONG-TERM CARE.**

Subdivision 1. **GOAL.** The health care commission shall examine the relationship between the acute and long-term care systems in order to address fragmentation and cost shifting between these two systems.

Subd. 2. **PLAN.** The commission shall prepare a plan for a process to bring about greater coordination between acute and long-term care that would maximize quality, overcome cost shifting, and contain overall costs.

(a) The commission's plan shall identify:

(1) concepts, issues, perceived problems, or concerns to be addressed as part of a process to achieve greater coordination and improved outcomes in acute and long-term care;

(2) a suitable process for addressing the issues in clause (1), including adequate involvement of appropriate stakeholder groups, persons receiving long-term care, and the public; and

(3) recommendations for appropriate relationships, division of responsibilities, resources, and a timetable for the process of achieving greater coordination between acute and long-term care.

(b) The commission's plan shall address:

(1) the need for an appropriate framework for measuring and comparing potential costs and benefits of proposals to improve coordination between acute and long-term care;

(2) specific information needs and how the information will be developed or obtained;

(3) the role of the commission and any changes or modifications of the commission in assisting the process described in the plan; and

(4) the degree to which the process of coordinating acute and long-term care might be undertaken sequentially or incrementally, with descriptions of any recommended steps in the process.

(c) In developing the plan, the commission shall take testimony from interested persons, review findings of previous studies and reports, and consult with other state agencies and organizations, including, but not limited to:

(1) adults with disabilities, parents or guardians of children with disabilities, and groups representing children and adults with a variety of disabilities; and

(2) facility based and home and community-based long-term care providers.

(d) The commission's plan shall be reported to the legislature by January 15, 1996.

Sec. 4. **REPEALER; ADDITIONAL INSURANCE REFORMS.**

Minnesota Statutes 1994, section 62Q.18, subdivisions 2, 3, 4, 5, 6, 8, and 9, are repealed.

ARTICLE 5

DATA COLLECTION AND RESEARCH INITIATIVES

Section 1. Minnesota Statutes 1994, section 13.99, is amended by adding a subdivision to read:

Subd. 115. **HEALTH DATA INSTITUTE DATA.** Data created, collected, received, maintained, or disseminated by the Minnesota health data institute established under section 62J.451 are classified under section 62J.452; access to and disclosure of such data are governed by section 62J.452.

Sec. 2. Minnesota Statutes 1994, section 62J.04, subdivision 3, is amended to read:

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

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

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne counties, for purposes of fostering

the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve spending limits;

(3) provide technical assistance to regional coordinating boards;

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

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

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

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

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

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

~~(10)~~ (8) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs; and

~~(11) administer the data analysis unit; and~~

~~(12)~~ (9) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans.

Sec. 3. Minnesota Statutes 1994, section 62J.06, is amended to read:

62J.06 **IMMUNITY FROM LIABILITY.**

No member of the Minnesota health care commission established under section 62J.05, regional coordinating boards established under section 62J.09, or the health ~~planning~~ technology advisory committee established under section 62J.15, ~~data collection advisory committee established under section 62J.30, or practice parameter advisory committee established under section 62J.32~~ shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

Sec. 4. Minnesota Statutes 1994, section 62J.212, is amended to read:

62J.212 ~~COLLABORATION ON~~ **PUBLIC HEALTH GOALS.**

~~The commissioner may increase regional spending limits if public health goals for that region are achieved.~~ The commissioner shall establish specific public health goals including, but not limited to, increased delivery of prenatal care, improved birth outcomes, and expanded childhood immunizations. The commissioner shall consider the community public health goals and the input of the statewide advisory committee on community health in establishing the statewide goals.

Sec. 5. **[62J.2930] INFORMATION CLEARINGHOUSE.**

Subdivision 1. **ESTABLISHMENT.** The commissioner of health shall establish an information clearinghouse within the department of health to facilitate the ability of consumers, employers, providers, health plan companies, and others to obtain information on health reform activities in Minnesota. The commissioner shall make available through the clearinghouse updates on federal and state health reform activities, including information developed or collected by the department of health on cost containment or other research initiatives, the development of integrated service networks, and voluntary purchasing pools, action plans submitted by health plan companies, reports or recommendations of the health technology advisory committee and other entities on technology assessments, and reports or recommendations from other formal committees applicable to health reform activities. The clearinghouse shall also refer requestors to sources of further information or assistance. The clearinghouse is subject to chapter 13.

Subd. 2. **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.

Subd. 3. **CONSUMER INFORMATION.** The information clearinghouse or another entity designated by the commissioner shall provide consumer information to health plan company enrollees to:

(1) assist enrollees in understanding their rights;

(2) 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;

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

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

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

The information clearinghouse or other entity designated by the commissioner for the purposes of this subdivision shall not:

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

(3) 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.

Subd. 4. **COORDINATION.** To the extent possible, the commissioner shall coordinate the activities of the clearinghouse with the activities of the Minnesota health data institute.

Sec. 6. **[62J.301] RESEARCH AND DATA INITIATIVES.**

Subdivision 1. **DEFINITIONS.** For purposes of sections 62J.2930 to 62J.42, the following definitions apply:

(a) "Health outcomes data" means data used in research designed to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition, in order to determine the most appropriate and cost-effective means to prevent, diagnose, treat, or manage the condition, or in order to develop and test methods for reducing inappropriate or unnecessary variations in the type and frequency of interventions.

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

Subd. 2. **STATEMENT OF PURPOSE.** The commissioner of health shall

conduct data and research initiatives in order to monitor and improve the efficiency and effectiveness of health care in Minnesota.

Subd. 3. **GENERAL DUTIES.** The commissioner shall:

(1) collect and maintain data which enable population-based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;

(2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;

(3) collect and maintain data for the purposes of setting limits under section 62J.04, and measuring growth limit compliance;

(4) conduct applied research using existing and new data and promote applications based on existing research;

(5) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plan companies, as defined in section 62Q.01, subdivision 4;

(6) work closely with health plan companies and health care providers to promote improvements in health care efficiency and effectiveness; and

(7) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management.

Subd. 4. **INFORMATION TO BE COLLECTED.** (a) The data collected may include health outcomes data, patient functional status, and health status. The data collected may include information necessary to measure and make adjustments for differences in the severity of patient condition across different health care providers, and may include data obtained directly from the patient or from patient medical records, as provided in section 62J.321, subdivision 1.

(b) The commissioner may:

(1) collect the encounter level data required for the research and data initiatives of sections 62J.301 to 62J.42, using, to the greatest extent possible, standardized forms and procedures; and

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

(c) For purposes of estimating total health care spending and forecasting rates of growth in health care spending, the commissioner may collect from health care providers data on patient revenues and health care spending during a time period specified by the commissioner. The commissioner may also collect data on health care revenues and spending from group purchasers of health care.

Health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. Professional licensing boards and state agencies responsible for licensing, registering, or regulating providers and group purchasers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements.

Subd. 5. **NONLIMITING.** Nothing in this chapter shall be construed to limit the powers granted to the commissioner of health under chapter 62D, 62N, 144, or 144A.

Sec. 7. **[62J.311] ANALYSIS AND USE OF DATA.**

Subdivision 1. **DATA ANALYSIS.** The commissioner shall analyze the data collected to:

(1) assist the state in developing and refining its health policy in the areas of access, utilization, quality, and cost;

(2) assist the state in promoting efficiency and effectiveness in the financing and delivery of health services;

(3) monitor and track accessibility, utilization, quality, and cost of health care services within the state;

(4) evaluate the impact of health care reform activities;

(5) assist the state in its public health activities; and

(6) evaluate and determine the most appropriate methods for ongoing data collection.

Subd. 2. **CRITERIA FOR DATA AND RESEARCH INITIATIVES.** (a) Data and research initiatives by the commissioner, pursuant to sections 62J.301 to 62J.42, must:

(1) serve the needs of the general public, public sector health care programs, employers and other purchasers of health care, health care providers, including providers serving large numbers of people with low-income, and health plan companies as applicable;

(2) be based on scientifically sound and statistically valid methods;

(3) be statewide in scope, to the extent feasible, in order to benefit health care purchasers and providers in all parts of Minnesota and to ensure broad and representative health care data for research comparisons and applications;

(4) emphasize data that is useful, relevant, and nonredundant of existing data. The initiatives may duplicate existing private data collection activities, if necessary to ensure that the data collected will be in the public domain;

(5) be structured to minimize the administrative burden on health plan companies, health care providers, and the health care delivery system, and minimize any privacy impact on individuals; and

(6) promote continuous improvement in the efficiency and effectiveness of health care delivery.

(b) Data and research initiatives related to public sector health care programs must:

(1) assist the state's current health care financing and delivery programs to deliver and purchase health care in a manner that promotes improvements in health care efficiency and effectiveness;

(2) assist the state in its public health activities, including the analysis of disease prevalence and trends and the development of public health responses;

(3) assist the state in developing and refining its overall health policy, including policy related to health care costs, quality, and access; and

(4) provide data that allows the evaluation of state health care financing and delivery programs.

Sec. 8. **[62J.321] DATA COLLECTION AND PROCESSING PROCEDURES.**

Subdivision 1. **DATA COLLECTION.** (a) The commissioner shall collect data from health care providers, health plan companies, and individuals in the most cost-effective manner, which does not unduly burden them. The commissioner may require health care providers and health plan companies to collect and provide patient health records and claim files, and cooperate in other ways with the data collection process. The commissioner may also require health care providers and health plan companies to provide mailing lists of patients. Patient consent shall not be required for the release of data to the commissioner pursuant to sections 62J.301 to 62J.42 by any group purchaser, health plan company, health care provider; or agent, contractor, or association acting on behalf of a group purchaser or health care provider. Any group purchaser, health plan company, health care provider; or agent, contractor, or association acting on behalf of a group purchaser or health care provider, that releases data to the commissioner in good faith pursuant to sections 62J.301 to 62J.42 shall be immune from civil liability and criminal prosecution.

(b) When a group purchaser, health plan company, or health care provider submits patient identifying data, as defined in section 62J.451, to the commissioner pursuant to sections 62J.301 to 62J.42, and the data is submitted to the commissioner in electronic form, or through other electronic means including, but not limited to, the electronic data interchange system defined in section 62J.451, the group purchaser, health plan company, or health care provider shall submit the patient identifying data in encrypted form, using an encryption

method specified by the commissioner. Submission of encrypted data as provided in this paragraph satisfies the requirements of section 144.335, subdivision 3b.

(c) The commissioner shall require all health care providers, group purchasers, and state agencies to use a standard patient identifier and a standard identifier for providers and health plan companies when reporting data under this chapter. The commissioner must encrypt patient identifiers to prevent identification of individual patients and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consistent with chapter 13 and sections 62J.55 and 144.335. This encryption must ensure that any data released must be in a form that makes it impossible to identify individual patients.

Subd. 2. **FAILURE TO PROVIDE DATA.** The intentional failure to provide the data requested under this chapter is grounds for 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.

Subd. 3. **DATA COLLECTION AND REVIEW.** Data collection must continue for a sufficient time to permit: adequate analysis by researchers and appropriate providers, including providers who will be impacted by the data; feedback to providers; monitoring for changes in practice patterns; and the data and research criteria of section 62J.311, subdivision 2, to be fulfilled.

Subd. 4. **USE OF EXISTING DATA.** (a) The commissioner shall negotiate with private sector organizations currently collecting health care data of interest to the commissioner to obtain required data in a cost-effective manner and minimize administrative costs. The commissioner shall attempt to establish links between the health care data collected to fulfill sections 62J.301 to 62J.42 and existing private sector data and shall consider and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

(b) The commissioner shall use existing public sector data, such as those existing for medical assistance and Medicare, to the greatest extent possible. The commissioner shall establish links between existing public sector data and consider and implement methods to streamline public sector data collection in order to reduce public and private sector administrative costs.

Subd. 5. **DATA CLASSIFICATION.** (a) Data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 that identify individual patients or providers are private data on individuals. Data not on individuals are nonpublic data. 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, individual or group purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter.

(b) Raw unaggregated data collected from household and employer surveys used by the commissioner to monitor the number of uninsured individuals, reasons for lack of insurance coverage, and to evaluate the effectiveness of health care reform, are subject to the same data classifications as data collected pursuant to sections 62J.301 to 62J.42.

(c) Notwithstanding sections 13.03, subdivisions 6 to 8; 13.10, subdivisions 1 to 4; and 138.17, data received by the commissioner pursuant to sections 62J.301 to 62J.42, shall retain the classification designated under this section and shall not be disclosed other than pursuant to this section.

(d) Summary data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 may be disseminated under section 13.05, subdivision 7. For the purposes of this section, summary data includes nonpublic data not on individuals.

(e) Notwithstanding paragraph (a), the commissioner may publish nonpublic or private data collected pursuant to sections 62J.301 to 62J.42 on health care costs and spending, quality and outcomes, and utilization for health care institutions, individual health care professionals and groups of health care professionals, group purchasers, and integrated service networks, with a description of the methodology used for analysis. The commissioner may not make public any patient identifying information except as specified in law. The commissioner shall not reveal the name of an institution, group of professionals, individual health care professional, group purchaser, or integrated service network until after the institution, group of professionals, individual health care professional, group purchaser, or integrated service network has had 21 days to review the data and comment. The commissioner shall include comments received in the release of the data.

(f) A provider or group purchaser may contest whether the data meets the criteria of section 62J.311, subdivision 2, paragraph (a), clause (2), in accordance with a contested case proceeding as set forth in sections 14.57 to 14.62, subject to appeal in accordance with sections 14.63 to 14.68. To obtain a contested case hearing, the provider or group purchaser must make a written request to the commissioner before the end of the time period for review and comment. Within ten days of the assignment of an administrative law judge, the provider or group purchaser shall make a clear showing to the administrative law judge of probable success in a hearing on the issue of whether the data are accurate and valid and were collected based on the criteria of section 62J.311, subdivision 2, paragraph (a), clause (2). If the administrative law judge determines that the provider or group purchaser has made such a showing, the data

shall remain private or nonpublic during the contested case proceeding and appeal. If the administrative law judge determines that the provider or group purchaser has not made such a showing, the commissioner may publish the data immediately, with comments received in the release of the data. The contested case proceeding and subsequent appeal is not an exclusive remedy and any person may seek a remedy pursuant to section 13.08, subdivisions 1 to 4, or as otherwise authorized by law.

Subd. 6. **RULEMAKING.** The commissioner may adopt rules to implement sections 62J.301 to 62J.452.

Subd. 7. **FEDERAL AND OTHER GRANTS.** The commissioner may seek federal funding, and funding from private and other nonstate sources, for data and research initiatives.

Subd. 8. **CONTRACTS AND GRANTS.** To carry out the duties assigned in sections 62J.301 to 62J.42, the commissioner may contract with or provide grants to private sector entities. Any contract or grant must require the private sector entity to maintain the data which it receives according to the statutory provisions applicable to the data.

Sec. 9. **[62J.322] PROVIDER INFORMATION PILOT STUDY.**

The commissioner 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:

(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: (i) statistical validity of the data; (ii) public need for the data; (iii) estimated expense of collecting and reporting the data; and (iv) usefulness of the data to identify barriers and opportunities to improve quality care provision within health plan companies.

Sec. 10. Minnesota Statutes 1994, section 62J.37, is amended to read:

62J.37 **COST CONTAINMENT DATA FROM INTEGRATED SERVICE NETWORKS.**

The commissioner shall require integrated service networks operating under section 62N.06, subdivision 1, to submit data on health care spending and revenue for calendar year ~~1994~~ 1996 by ~~February 15, 1995~~ April 1, 1997. Each ~~February 15~~ April 1 thereafter, integrated service networks shall submit to the commissioner data on health care spending and revenue for the preceding calendar year. The data must be provided in the form specified by the commissioner. To the extent that an integrated service network is operated by a group purchaser under section 62N.06, subdivision 2, the integrated service network is exempt from this section and the group purchaser must provide data on the integrated service network under section 62J.38.

Sec. 11. Minnesota Statutes 1994, section 62J.38, is amended to read:

62J.38 **COST CONTAINMENT 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~~ each calendar year ~~1993 and successive calendar years~~. Group purchasers shall submit data for the 1993 calendar year by 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~~ may be pro-

vided separately for the following categories or for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency ~~and out-of-area care~~, pharmacy services and ~~prescription drugs~~ other nondurable medical goods, mental health ~~services~~, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs.

(c) The commissioner may collect information on:

(1) premiums, benefit levels, managed care procedures, and other features of health plan companies;

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

(3) information on health care services not provided through health plan companies, including information on prices, costs, expenditures, and utilization.

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

Sec. 12. Minnesota Statutes 1994, section 62J.40, is amended to read:

62J.40 **COST CONTAINMENT DATA FROM STATE AGENCIES AND OTHER GOVERNMENTAL UNITS.**

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

(b) For purposes of estimating total health care spending as provided in section 62J.301, subdivision 4, clause (c), all local governmental units shall provide expenditure data to the commissioner. The commissioner shall consult with representatives of the affected local government units in establishing definitions, reporting formats, and reporting time frames. As much as possible, the data shall be collected in a manner that ensures that the data collected is consistent with data collected from the private sector and minimizes the reporting burden to local government.

Sec. 13. Minnesota Statutes 1994, section 62J.41, subdivision 1, is amended to read:

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

(1) the total number of patients served;

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

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

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

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

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

(7) revenue from research activities;

(8) revenue from educational activities;

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

(10) revenue from donations; and

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

The commissioner may, by rule, modify the data submission categories listed above if the commissioner determines that this will reduce the reporting burden on providers without having a significant negative effect on necessary data collection efforts.

Sec. 14. Minnesota Statutes 1994, section 62J.41, subdivision 2, is amended to read:

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 April 1, 1994. Health care providers shall submit data for the 1994 calendar year by April 1, 1995, and each 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 provid-

ers, 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~~ commissioners of health and revenue shall have the authority to share data collected pursuant to this section.

Sec. 15. **[62J.451] MINNESOTA HEALTH DATA INSTITUTE.**

Subdivision 1. **STATEMENT OF PURPOSE.** It is the intention of the legislature to create a partnership between the public and the private sectors for the coordination of efforts related to the collection, analysis, and dissemination of cost, access, quality, utilization, and other performance data, to the extent administratively efficient and effective.

The Minnesota health data institute shall be a partnership between the commissioner of health and a board of directors representing group purchasers, health care providers, and consumers.

Subd. 2. **DEFINITIONS.** For purposes of this section and section 62J.452, the following definitions apply.

(a) "Analysis" means the identification of selected data elements, a description of the methodology used to select or analyze those data elements, and any other commentary, conclusions, or other descriptive material that the health data institute determines is appropriately included, all of which is undertaken by the health data institute for one or more of the purposes or objectives set forth in subdivisions 1 and 3, or by other authorized researchers pursuant to section 62J.452, subdivision 6.

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

(c) "Contractor" means an agent, association, or other individual or entity that has entered into an agreement with an industry participant, as defined in section 62J.452, subdivision 2, paragraph (i), to act on behalf of that industry participant for purposes of fulfilling the data collection and reporting activities established under this chapter.

(d) "Database" means a compilation of selected data elements by the health data institute for the purpose of conducting an analysis or facilitating an analysis by another party.

(e) "Electronic data interchange system" or "EDI system" means the electronic data system developed, implemented, maintained, or operated by the health data institute, as permitted by subdivisions 3, clause (2), and 5, according to standards adopted by the health data institute.

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

(g) "Group purchaser" has the definition provided in section 62J.03, subdivision 6.

(h) "Health data institute" means the public-private partnership between the commissioner of health and the board of directors established under this section.

(i) "Health plan company" has the definition provided in section 62Q.01, subdivision 4.

(j) "Industry participant" means any group purchaser, employers with employee health benefit plans, regardless of the manner in which benefits are provided or paid for under the plan, provider, or state agency or political subdivision, with the exception of professional licensing boards or law enforcement agencies.

(k) "Industry participant identifying data" means any data that identifies a specific industry participant directly, or which identifies characteristics which reasonably could uniquely identify such specific industry participant circumstantially. For purposes of this definition, an industry participant is not "directly identified" by the use of a unique identification number, provided that the number is coded or encrypted through a reliable system that can reasonably assure that such numbers cannot be traced back by an unauthorized person to determine the identity of an industry participant with a particular number.

(l) "Patient" is an individual as defined in section 13.02, subdivision 8, except that "patient" does not include any industry participant acting as an industry participant rather than as a consumer of health care services or coverage.

(m) "Patient identifying data" means data that identifies a patient directly, or which identifies characteristics which reasonably could uniquely identify such specific patients circumstantially. For purposes of this definition, a patient is not "directly identified" by the use of a unique identification number, provided that the number is coded or encrypted through a reliable system that can reasonably assure that such numbers cannot be traced back by an unauthorized person to determine the identity of a patient with a particular number.

(n) "Performance" means the degree to which a health plan company, provider organization, or other entity delivers quality, cost-effective services compared to other similar entities, or to a given level of care set as a goal to be attained.

(o) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

(p) "Roster data" with regard to the enrollee of a health plan company or group purchaser means an enrollee's name, address, telephone number, date of birth, gender, and enrollment status under a group purchaser's health plan. "Roster data" with regard to a patient of a provider means the patient's name,

address, telephone number, date of birth, gender, and date or dates treated, including, if applicable, the date of admission and the date of discharge.

Subd. 3. **OBJECTIVES OF THE HEALTH DATA INSTITUTE.** (a) The health data institute shall:

(1) develop a data collection plan that provides coordination for public and private sector data collection efforts related to the performance measurement and improvement of the health care delivery system;

(2) establish an electronic data interchange system that may be used by the public and private sectors to exchange health care data in a cost-efficient manner;

(3) develop a mechanism to collect, analyze, and disseminate information for comparing the cost and quality of health care delivery system components, including health plan companies and provider organizations;

(4) develop policies and procedures to protect the privacy of individual-identifiable data, and to assure appropriate access to and disclosure of information specific to individual health plan companies and provider organizations collected pursuant to this section; and

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

(b) In carrying out its responsibilities, the health data institute may contract with private sector organizations currently collecting data on specific health-related areas of interest to the health data institute, in order to achieve maximum efficiency and cost-effectiveness. The health data institute may establish links between the data collected and maintained by the health data institute and private sector data through the health data institute's electronic data interchange system, and may implement methods to streamline data collection in order to reduce public and private sector administrative costs. The health data institute may use or establish links with public sector data, such as that existing for medical assistance and Medicare, to the extent permitted by state and federal law. The health data institute may also recommend methods to streamline public sector data collection in order to reduce public and private sector administrative costs.

(c) Any contract with a private sector entity must require the private sector entity to maintain the data collected according to the applicable data privacy provisions, as provided in section 62J.452.

Subd. 4. **DATA COLLECTION PLAN.** (a) The health data institute shall develop a plan that:

(1) identifies the health care data needs of consumers, group purchasers,

providers, and the state regarding the performance of health care delivery system components including health plan companies and provider organizations;

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

(3) identifies the data needed for the health data institute to carry out the duties assigned in this section. The plan must take into consideration existing data sources and data sources that can easily be made uniform for links to other data sets.

(b) This plan shall be updated on an annual basis.

Subd. 5. **HEALTH CARE ELECTRONIC DATA INTERCHANGE SYSTEM.** (a) The health data institute shall establish an electronic data interchange system that electronically transmits, collects, archives, and provides users of data with the data necessary for their specific interests, in order to promote a high quality, cost-effective, consumer-responsive health care system. This public-private information system shall be developed to make health care claims processing and financial settlement transactions more efficient and to provide an efficient, unobtrusive method for meeting the shared electronic data interchange needs of consumers, group purchasers, providers, and the state.

(b) The health data institute shall operate the Minnesota center for health care electronic data interchange established in section 62J.57, and shall integrate the goals, objectives, and activities of the center with those of the health data institute's electronic data interchange system.

Subd. 6. **PERFORMANCE MEASUREMENT INFORMATION.** (a) The health data institute shall develop and implement a performance measurement plan to analyze and disseminate health care data to address the needs of consumers, group purchasers, providers, and the state for performance measurement at various levels of the health care system in the state. The plan shall include a mechanism to:

(1) provide comparative information to consumers, purchasers, and policymakers for use in performance assessment of health care system components, including health plan companies and provider organizations;

(2) complement and enhance, but not replace, existing internal performance improvement efforts of health care providers and plans; and

(3) reduce unnecessary administrative costs in the health care system by eliminating duplication in the collection of data for both evaluation and improvement efforts.

(b) Performance measurement at the provider organization level may be conducted on a condition-specific basis. Criteria for selecting conditions for measurement may include:

(1) relevance to consumers and purchasers;

(2) prevalence of conditions;

(3) costs related to diagnosis and treatment;

(4) demonstrated efficacy of treatments;

(5) evidence of variability in management;

(6) existence of risk adjustment methodologies to control for patient and other risk factors contributing to variation in cost and quality;

(7) existence of practice guidelines related to the condition; and

(8) relevance of the condition to public health goals.

(c) Performance measurement on a condition-specific basis may consider multiple dimensions of performance, including, but not limited to:

(1) accessibility;

(2) appropriateness;

(3) effectiveness, including clinical outcomes, patient satisfaction, and functional status; and

(4) efficiency.

(d) Collection of data for condition-specific performance measurement may be conducted at the patient level. Encounter-level data collected for this purpose may include unique identifiers for patients, providers, payers, and employers in order to link episodes of care across care settings and over time. The health data institute must encrypt patient identifiers to prevent identification of individual patients and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consistent with chapter 13 and sections 62J.452 and 144.335.

Subd. 6a. **HEALTH PLAN COMPANY PERFORMANCE MEASUREMENT.** As part of the performance measurement plan specified in subdivision 6, the health data institute shall develop a mechanism to assess the performance of health plan companies, and to disseminate this information through reports and other means to consumers, purchasers, policymakers, and other interested parties, consistent with the data policies specified in section 62J.452.

Subd. 6b. **CONSUMER SURVEYS.** (a) The health data institute shall develop and implement a mechanism for collecting comparative data on consumer perceptions of the health care system, including consumer satisfaction, through adoption of a standard consumer survey. 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 health data institute, in consultation with the health care commission, shall determine a mechanism for the inclusion of the uninsured. This consumer survey may be conducted every two years. A focused survey may be conducted on the off years. Health plan companies and group purchasers shall provide to the health data institute roster data as defined in subdivision 2, including the names, addresses, and telephone numbers of enrollees and former enrollees and other data necessary for the completion of this survey. This roster data provided by the health plan companies and group purchasers is classified as provided under section 62J.452. The health 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 performance reports specified in subdivision 6a, and in other reports developed and disseminated by the health data institute and the commissioner. The raw, unaggregated data is classified as provided under section 62J.452, and may be made available by the health data institute to the extent permitted under section 62J.452. The health data institute shall provide raw, unaggregated data to the commissioner. 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 health 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 health 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, 1996.

Subd. 6c. **PROVIDER ORGANIZATION PERFORMANCE MEASUREMENT.** As part of the performance measurement plan specified in subdivision 6, the health data institute shall develop a mechanism to assess the performance of hospitals and other provider organizations, and to disseminate this information to consumers, purchasers, policymakers, and other interested parties, consistent with the data policies specified in section 62J.452. Data to be collected may include structural characteristics including staff-mix and nurse-patient ratios. In selecting additional data for collection, the health data institute may 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.

Subd. 7. **DISSEMINATION OF REPORTS; OTHER INFORMATION.** (a) The health data institute shall establish a mechanism for the dissemination of reports and other information to consumers, group purchasers, health plan companies, providers, and the state. When applicable, the health data institute shall coordinate its dissemination of information responsibilities with those of the commissioner, to the extent administratively efficient and effective.

(b) The health data institute may require those requesting data from its databases to contribute toward the cost of data collection through the payments of fees.

(c) The health data institute shall not allow a group purchaser or health care provider to use or have access to the electronic data interchange system or to access data under section 62J.452, subdivision 6 or 7, unless the group purchaser or health care provider cooperates with the data collection efforts of the health data institute by submitting or making available through the EDI system or other means all data requested by the health data institute. The health data institute shall prohibit group purchasers and health care providers from transferring, providing, or sharing data obtained from the health data institute under section 62J.452, subdivision 6 or 7, with a group purchaser or health care provider that does not cooperate with the data collection efforts of the health data institute.

Subd. 8. **ANNUAL REPORT.** (a) The health data institute shall submit to the chairs of the senate joint crime prevention and judiciary subcommittee on privacy, the house of representatives judiciary committee, the legislative commission on health care access, the commissioner, and the governor a report on the activities of the health data institute by February 1 of each year beginning February 1, 1996. The report shall include:

(1) a description of the data initiatives undertaken by the health data insti-

tute, including a statement of the purpose and a summary of the results of the initiative;

(2) a description of the steps taken by the health data institute to comply with the confidentiality requirements of this section and other applicable laws, and of the health data institute's internal policies and operating procedures relating to data privacy and confidentiality; and

(3) a description of the actions taken by the health data institute to ensure that the EDI system being established pursuant to section 62J.451, subdivision 3, clause (2), and subdivision 5, protects the confidentiality requirements of this section and other applicable laws.

(b) If the health data institute amends or adopts an internal policy or operating procedure relating to data privacy and confidentiality, it shall submit copies of such policy or procedure within 30 days of its adoption to the public officials identified in this subdivision.

Subd. 9. **BOARD OF DIRECTORS.** The health data institute is governed by a 20-member board of directors consisting of the following members:

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

(2) four representatives of health carriers, two appointed by the Minnesota council of health maintenance organizations, one appointed by Blue Cross and Blue Shield of Minnesota, and one appointed by the Insurance Federation of Minnesota;

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

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

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

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

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

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

Subd. 10. **TERMS; COMPENSATION; REMOVAL; AND VACANCIES.** The board is governed by section 15.0575.

Subd. 11. **STATUTORY GOVERNANCE.** The health data institute is subject to chapter 13 and section 471.705 but is not otherwise subject to laws governing state agencies except as specifically provided in this chapter.

Subd. 12. **STAFF.** The board may hire an executive director. The executive director and other health data institute staff are not state employees but are covered by section 3.736. The executive director and other health data institute staff may participate in the following plans for employees in the unclassified service until January 1, 1996: the state retirement plan, the state deferred compensation plan, and the health, dental, and life insurance plans. The attorney general shall provide legal services to the board.

Subd. 13. **FEDERAL AND OTHER GRANTS.** The health data institute may seek federal funding, and funding from private and other nonstate sources for the initiative required by the board.

Subd. 14. **CONTRACTS.** To carry out the duties assigned in this section, the health data institute may contract with private sector entities. Any contract must require the private sector entity to maintain the data which it receives according to the statutory provisions applicable to the data and any other applicable provision specified in section 62J.452.

Subd. 15. **NONLIMITING.** Nothing in this section shall be construed to limit the powers granted to the commissioner of health in chapter 62D, 62N, 144, or 144A.

Subd. 16. **CLARIFICATION OF INTENT.** This section is intended to provide the health data institute with primary responsibility for establishing a data collection plan, establishing an electronic data interchange system, measuring performance at the provider organization and health plan company levels, collecting condition-specific data, developing and administering consumer surveys, and performing other duties specifically assigned in this section. The commissioner of health may perform these duties only if the commissioner determines that these duties will not be performed by the health data institute.

Sec. 16. **[62J.452] PROTECTION OF PRIVACY AND CONFIDENTIALITY OF HEALTH CARE DATA.**

Subdivision 1. **STATEMENT OF PURPOSE.** The health data institute shall adopt data collection, analysis, and dissemination policies that reflect the importance of protecting the right of privacy of patients in their health care data in connection with each data initiative that the health data institute intends to undertake.

Subd. 2. **DATA CLASSIFICATIONS.** (a) Data collected, obtained, received, or created by the health data institute shall be private or nonpublic, as

applicable, unless given a different classification in this subdivision. Data classified as private or nonpublic under this subdivision may be released or disclosed only as permitted under this subdivision and under the other subdivisions referenced in this subdivision. For purposes of this section, data that identify individual patients or industry participants are private data on individuals or nonpublic data, as appropriate. Data not on individuals are nonpublic data. Notwithstanding sections 13.03, subdivisions 6 to 8; 13.10, subdivisions 1 to 4; and 138.17, data received by the health data institute shall retain the classification designated under this chapter and shall not be disclosed other than pursuant to this chapter. Nothing in this subdivision prevents patients from gaining access to their health record information pursuant to section 144.335.

(b) When industry participants, as defined in section 62J.451, are required by statute to provide, either directly or through a contractor, as defined in section 62J.451, subdivision 2, paragraph (c), patient identifying data to the commissioner pursuant to this chapter or to the health data institute pursuant to section 62J.451, the industry participant or its contractor shall be able to provide the data with or without patient consent, and may not be held liable for doing so.

(c) When an industry participant submits patient identifying data to the health data institute, and the data is submitted to the health data institute in electronic form, or through other electronic means including, but not limited to, the electronic data interchange system defined in section 62J.451, the industry participant shall submit the patient identifying data in encrypted form, using an encryption method supplied or specified by the health data institute. Submission of encrypted data as provided in this paragraph satisfies the requirements of section 144.335, subdivision 3b.

(d) Patient identifying data may be disclosed only as permitted under subdivision 3.

(e) Industry participant identifying data which is not patient identifying data may be disclosed only by being made public in an analysis as permitted under subdivisions 4 and 5 or through access to an approved researcher, industry participant, or contractor as permitted under subdivision 6 or 7.

(f) Data that is not patient identifying data and not industry participant identifying data is public data.

(g) Data that describes the finances, governance, internal operations, policies, or operating procedures of the health data institute, and that does not identify patients or industry participants or identifies them only in connection with their involvement with the health data institute, is public data.

Subd. 3. **PATIENT IDENTIFYING DATA.** (a) The health data institute must not make public any analysis that contains patient identifying data.

(b) The health data institute may disclose patient identifying data only as follows:

(1) to research organizations that meet the requirements set forth in subdivision 6, paragraph (a), but only to the extent that such disclosure is also permitted by section 144.335, subdivision 3a, paragraph (a); or

(2) to a contractor of, or vendor of services to the health data institute for the purposes of conducting a survey or analysis, provided that such contractor or vendor agrees to comply with all data privacy requirements applicable to the health data institute, and to destroy or return to the health data institute all copies of patient identifying data in the possession of such contractor or vendor upon completion of the contract.

Subd. 4. **ANALYSIS TO BE MADE PUBLIC BY THE HEALTH DATA INSTITUTE.** (a) Notwithstanding the classification under subdivision 2 or other provision of state law of data included or used in an analysis, the health data institute may make public data in an analysis pursuant to this subdivision and subdivision 5. Such analysis may include industry participant identifying data but must not include patient identifying data. In making its determination as to whether to make an analysis or the data used in the analysis public, the health data institute shall consider and determine, in accordance with policies and criteria developed by the health data institute, that the data and analysis are sufficiently accurate, complete, reliable, valid, and as appropriate, case-mixed and severity adjusted, and statistically and clinically significant.

(b) Prior to making an analysis public, the health data institute must provide to any industry participant identified in the analysis an opportunity to use the fair hearing procedure established under subdivision 5.

(c) Accompanying an analysis made public by the health data institute, the health data institute shall also make public descriptions of the database used in the analysis, the methods of adjusting for case mix and severity, and assuring accuracy, completeness, reliability, and statistical and clinical significance, as appropriate, and appropriate uses of the analysis and related analytical data, including precautionary statements regarding the limitations of the analysis and related analytical data.

Subd. 5. **FAIR HEARING PROCEDURE PRIOR TO MAKING AN ANALYSIS PUBLIC.** (a) The health data institute may not make public an analysis that identifies an industry participant unless the health data institute first complies with this subdivision. A draft of the portion of the analysis that identifies an industry participant must be furnished upon an industry participant's request to that industry participant prior to making that portion of the analysis public. Such draft analysis is private or nonpublic, as applicable. The industry participants so identified have the right to a hearing, at which the industry participants or their contractors, as defined in section 62J.451, subdivision 2, paragraph (c), may object to or seek modification of the analysis. The cost of the hearing shall be borne by the industry participant requesting the hearing.

(b) The health data institute shall establish the hearing procedure in writing. The hearing procedure shall include the following:

(1) the provision of reasonable notice of the health data institute's intention to make such analysis public;

(2) an opportunity for the identified industry participants to submit written statements to the health data institute board of directors or its designate, to be represented by a contractor, as defined in section 62J.451, subdivision 2, paragraph (c), or other individual or entity acting on behalf of and chosen by the industry participant for this purpose, and to append a statement to such analysis to be included with it when and if the analysis is made public; and

(3) access by the identified industry participants to industry participant identifying data, but only as permitted by subdivision 6 or 7.

(c) The health data institute shall make the hearing procedure available in advance to industry participants which are identified in an analysis. The written hearing procedure is public data. The following data related to a hearing is public:

(1) the parties involved;

(2) the dates of the hearing; and

(3) a general description of the issue and the results of the hearing; all other data relating to the hearing is private or nonpublic.

Subd. 6. **ACCESS BY APPROVED RESEARCHERS TO DATA THAT IDENTIFIES INDUSTRY PARTICIPANTS BUT DOES NOT IDENTIFY PATIENTS.** (a) The health data institute shall provide access to industry participant identifying data, but not patient identifying data, once those data are in analyzable form, upon request to research organizations or individuals that:

(1) have as explicit goals research purposes that promote individual or public health and the release of research results to the public as determined by the health data institute according to standards it adopts for evaluating such goals;

(2) enforce strict and explicit policies which protect the confidentiality and integrity of data as determined by the health data institute according to standards it adopts for evaluating such policies;

(3) agree not to make public, redisclose, or transfer the data to any other individual or organization, except as permitted under paragraph (b);

(4) demonstrate a research purpose for the data that can be accomplished only if the data are provided in a form that identifies specific industry participants as determined by the health data institute according to standards it adopts for evaluating such research purposes; and

(5) agree to disclose analysis in a public forum or publication only pursuant to subdivisions 4 and 5 and other applicable statutes and the health data institute's operating rules governing the making of an analysis public by the health data institute.

(b) Contractors of entities that have access under paragraph (a) may also have access to industry participant identifying data, provided that the contract requires the contractor to comply with the confidentiality requirements set forth in this section and under any other statute applicable to the entity.

Subd. 7. **ACCESS BY INDUSTRY PARTICIPANTS TO DATA THAT IDENTIFIES INDUSTRY PARTICIPANTS BUT DOES NOT IDENTIFY PATIENTS.** (a) The health data institute may provide, to an industry participant, data that identifies that industry participant or other industry participants, to the extent permitted under this subdivision. An employer or an employer purchasing group may receive data relating to care provided to patients for which that employer acts as the payer. A health plan company may receive data relating to care provided to enrollees of that health plan company. A provider may receive data relating to care provided to patients of that provider.

(b) An industry participant may receive data that identifies that industry participant or other industry participants and that relates to care purchased or provided by industry participants other than the industry participant seeking the data. These data must be provided by the health data institute only with appropriate authorization from all industry participants identified.

(c) The health data institute must not provide access to any data under this subdivision that is patient identifying data as defined in section 62J.451, subdivision 2, paragraph (m), even if providing that data would otherwise be allowed under this subdivision.

(d) To receive data under this subdivision, an industry participant must cooperate with the health data institute as provided under section 62J.451, subdivision 7, paragraph (c).

(e) Contractors of entities that have access under paragraph (b) may have access to industry participant identifying data, provided that the contract requires the contractor to comply with the confidentiality requirements set forth in this section and under any other statute applicable to the entity.

Subd. 8. **STATUS OF DATA ON THE ELECTRONIC DATA INTERCHANGE SYSTEM.** (a) Data created or generated by or in the custody of an industry participant, and transferred electronically by that industry participant to another industry participant using the EDI system developed, implemented, maintained, or operated by the health data institute, as permitted by section 62J.451, subdivision 3, clause (2), and subdivision 5, is not subject to this section or to chapter 13 except as provided below.

(b) Data created or generated by or in the custody of an industry participant is subject to the privacy protections applicable to the data, including, but not limited to, chapter 13 with respect to state agencies and political subdivisions, the Minnesota insurance fair information reporting act with respect to industry participants subject to it, and section 144.335, with respect to providers and other industry participants subject to such section.

Subd. 9. **AUTHORIZATION OF STATE AGENCIES AND POLITICAL SUBDIVISIONS TO PROVIDE DATA.** (a) Notwithstanding any limitation in chapter 13 or section 62J.321, subdivision 5, regarding the disclosure of not public data, all state agencies and political subdivisions, including, but not limited to, municipalities, counties, and hospital districts may provide not public data relating to health care costs, quality, or outcomes to the health data institute for the purposes set forth in section 62J.451.

(b) Data provided by the commissioner pursuant to paragraph (a) of this subdivision may not include patient identifying data as defined in section 62J.451, subdivision 2, paragraph (m). For data provided by the commissioner of health pursuant to paragraph (a), the health data institute and anyone receiving the data from the health data institute, is prohibited from unencrypting or attempting to link the data with other patient identifying data sources.

(c) Any data provided to the health data institute pursuant to paragraph (a) shall retain the same classification that it had with the state agency or political subdivision that provided it. The authorization in this subdivision is subject to any federal law restricting or prohibiting such disclosure of the data described above.

(d) Notwithstanding any limitation in chapter 13 or sections 62J.451 and 62J.452 regarding the disclosure of nonpublic and private data, the health data institute may provide nonpublic and private data to any state agency that is a member of the board of the health data institute. Any such data provided to a state agency shall retain nonpublic or private classification, as applicable.

Subd. 10. **CIVIL REMEDIES.** Violation of any of the confidentiality requirements set forth in subdivision 3; 4, paragraph (a); 6; or 7, by the health data institute, its board members, employees and contractors, any industry participant, or by any other person shall be subject to section 13.08, including, but not limited to, the immunities set forth in section 13.08, subdivisions 5 and 6. The health data institute shall not be liable for exercising its discretion in a manner that is not an abuse of discretion with respect to matters under its discretion by this section or section 62J.451. The health data institute shall not be liable for the actions of persons not under the direction and control of the health data institute, where it has performed its responsibilities to protect data privacy by complying with the requirements of this section and other applicable laws with regard to the disclosure of data. The remedies set forth in this section do not preclude any person from pursuing any other remedies authorized by law.

Subd. 11. **PENALTIES.** (a) Any person who willfully violates the confidentiality requirements set forth in subdivision 3; 4, paragraph (a); 6; or 7, shall be guilty of a misdemeanor.

(b) Any person who willfully violates the confidentiality requirements of subdivision 3, 4, 6, 7, 8, or 9, by willfully disclosing patient or industry participant identifying data for compensation or remuneration of any kind or for the purpose of damaging the reputation of any patient or industry participant or any other malicious purpose, shall be guilty of a gross misdemeanor.

Subd. 12. **DISCOVERABILITY OF HEALTH DATA INSTITUTE DATA.** (a) Data created, collected, received, maintained, or disseminated by the health data institute shall not be subject to discovery or introduction into evidence in any civil or criminal action. Data created, collected, received, maintained, or disseminated by the health data institute that is otherwise available from original sources is subject to discovery from those sources and may be introduced into evidence in civil or criminal actions in accordance with and subject to applicable laws and rules of evidence and civil or criminal procedure, as applicable.

(b) Information related to submission of data to the health data institute by industry participants or contractors of industry participants is not discoverable from the health data institute, the industry participants, the contractors, or any other person or entity, in any civil or criminal action. Discovery requests prohibited under this paragraph include, but are not limited to, document requests or interrogatories that ask for "all data provided to the Minnesota health data institute."

Sec. 17. Minnesota Statutes 1994, section 62J.54, is amended to read:

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~~ 1998, 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~~ 1998, 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.

Subd. 3. **UNIQUE IDENTIFICATION NUMBER FOR GROUP PURCHASERS.** (a) On and after January 1, ~~1996~~ 1998, 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~~ 1998, 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.

Sec. 18. Minnesota Statutes 1994, section 62J.55, is amended to read:

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~~ 62J.321, subdivision ~~6~~ 1. 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. 19. Minnesota Statutes 1994, section 62J.58, is amended to read:

62J.58 **IMPLEMENTATION OF STANDARD TRANSACTION SETS.**

Subdivision 1. **CLAIMS PAYMENT.** ~~(a) By July 1, 1995~~ Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, 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,~~ and all category II industry participants, except phar-

macists, 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~~ Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II 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~~ Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II 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 participants, 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~~ Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II 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. 20. Minnesota Statutes 1994, section 214.16, subdivision 2, is amended to read:

Subd. 2. **BOARD COOPERATION REQUIRED.** The board shall assist the commissioner of health ~~and the data analysis unit~~ in data collection activities required under Laws 1992, chapter 549, article 7, and shall assist the commissioner of revenue in activities related to collection of the health care provider tax required under Laws 1992, chapter 549, article 9. Upon the request

of the commissioner~~, the data analysis unit,~~ or the commissioner of revenue, the board shall make available names and addresses of current licensees and provide other information or assistance as needed.

Sec. 21. Minnesota Statutes 1994, section 214.16, subdivision 3, is amended to read:

Subd. 3. **GROUNDS FOR DISCIPLINARY ACTION.** The board shall take disciplinary action, which may include license revocation, against a regulated person for:

(1) intentional failure to provide the commissioner of health ~~or the data analysis unit established under section 62J.30~~ with the data required under chapter 62J;

(2) intentional failure to provide the commissioner of revenue with data on gross revenue and other information required for the commissioner to implement sections 295.50 to 295.58; and

(3) intentional failure to pay the health care provider tax required under section 295.52.

Sec. 22. **RULES.**

Notwithstanding Minnesota Statutes, section 14.05, subdivision 1, Minnesota Rules, chapters 4650, 4651, and 4652, shall continue in effect under the authority granted in Minnesota Statutes, section 62J.321, subdivision 6.

Sec. 23. **INSTRUCTION TO REVISOR.**

(a) The revisor of statutes is instructed to change the term "data institute" or "institute", where applicable, to "health data institute" in the 1996 edition of Minnesota Statutes and Minnesota Rules.

(b) The revisor of statutes is instructed to change any statutory reference to the information clearinghouse from Minnesota Statutes, section 62J.33 or 62J.33, subdivision 2, to 62J.2930, in the 1996 edition of Minnesota Statutes and Minnesota Rules.

Sec. 24. **REPEALER.**

Minnesota Statutes 1994, sections 62J.30; 62J.31; 62J.32; 62J.33; 62J.34; 62J.35; 62J.41, subdivisions 3 and 4; 62J.44; and 62J.45, are repealed.

ARTICLE 6

MINNESOTACARE PROGRAM, PRESCRIPTION DRUG COVERAGE, AND THE HEALTH CARE REFORM WAIVER

Section 1. **[62J.66] DEFINITIONS.**

Subdivision 1. **APPLICABILITY.** For purposes of section 62J.66 and 62J.68, the following definitions apply.

Subd. 2. **DISCOUNTED PRICE.** The "discounted price" means the lesser of the average wholesale price for a prescription drug minus 20 percent or the usual and customary retail price, including any dispensing fee, minus five percent.

Subd. 3. **ELIGIBLE SENIOR.** "Eligible senior" means a senior citizen eligible for the senior drug discount program under section 62J.68, subdivision 3.

Subd. 4. **SENIOR CITIZEN.** "Senior citizen" means a resident of Minnesota who is age 65 or older.

Subd. 5. **SENIOR DRUG DISCOUNT PROGRAM.** "Senior drug discount program" means the program established in section 62J.68.

Subd. 6. **PARTICIPATING DRUG MANUFACTURER.** "Participating drug manufacturer" means any manufacturer who agrees to voluntarily participate in the senior drug discount program.

Subd. 7. **PARTICIPATING CLAIMS PROCESSING COMPANIES.** "Participating claims processing companies" means entities, including, but not limited to, pharmacy benefit management companies, that are awarded a contract by the department of administration to provide on-line services to process payments to participating pharmacies.

Subd. 8. **AVERAGE MANUFACTURER PRICE.** "Average manufacturer price" has the meaning assigned to the term by the Secretary of Health and Human Services for purposes of the federal drug rebate program established under the Omnibus Budget Reconciliation Act of 1990 and section 1927 of the Social Security Act.

Sec. 2. **[62J.68] SENIOR DRUG DISCOUNT PROGRAM.**

Subdivision 1. **ESTABLISHMENT AND ADMINISTRATION.** (a) The commissioner of administration shall award a contract or contracts to claims processing companies to process payments to participating pharmacies. The contract must include:

(1) provisions for participating manufacturers to provide discount payments, through participating claims processing companies, equal to four percent of the average manufacturer price; and

(2) quality assurance and verification procedures and authority to conduct audits of pharmacy claims as necessary to ensure that pharmacy reimbursement payments are appropriate and justified.

(b) The commissioner of administration may establish an expert panel to assist in the development of the request for proposal for awarding the contract or contracts to process payments for the senior drug discount program.

Subd. 2. **PARTICIPATING MANUFACTURERS.** Participating manufacturers agree to:

(1) pay participating pharmacies through the claims processor an amount equal to four percent of the average manufacturer price;

(2) process discount payments through participating claims processing companies according to the timelines used under the medical assistance program;

(3) pay administrative fees established under subdivision 7.

Subd. 3. **PARTICIPATING PHARMACIES.** Participating pharmacies agree to:

(1) provide eligible seniors the discounted price established by the senior drug discount program;

(2) accept payments from participating claims processing companies equal to four percent of the average manufacturer price; and

(3) not charge eligible seniors a dispensing fee greater than $3.

Subd. 4. **ENROLLMENT.** The commissioner of human services shall determine eligibility as specified in subdivision 5 and enroll senior citizens in the senior drug discount program. The commissioner may use volunteers to assist in eligibility and enrollment duties. The commissioner of human services shall post the eligibility of the enrollees to the Medicaid Management Information System (MMIS) where it can be assessed by participating pharmacies through the department's eligibility verification system and point-of-sale system upon presentation of the enrollee's Minnesota health care programs card.

Subd. 5. **ELIGIBILITY.** (a) Senior citizens are eligible for the program if:

(1) their household income does not exceed 200 percent of the federal poverty guidelines;

(2) they are enrolled in Medicare Part A and Part B;

(3) they do not have coverage for prescription drugs under a health plan, as defined in section 62Q.01, subdivision 3;

(4) they do not have coverage for prescription drugs under a Medicare supplement plan, 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 1976 of the federal Social Social Security Act, United States Code, title 42, section 1395, et seq., as amended, or coverage for prescription drugs under medical assistance under chapter 256B, general assistance medical care under chapter 256D, MinnesotaCare, or the qualified medical beneficiaries program;

(5) they meet the residency requirements established under section 256.9359; and

(6) they do not have coverage for prescription drugs under medical assistance, general assistance medical care, MinnesotaCare, or the qualified Medicare beneficiary program.

(b) The commissioner of human services shall provide each eligible senior with a Minnesota health care programs card indicating enrollment in the senior drug discount program. Eligible seniors must present this card to the participating pharmacy in order to receive the discounted price.

Subd. 6. **ENROLLMENT FEE.** The commissioner of human services may establish an annual enrollment fee of $5 for purposes of administering the senior drug discount program. The fees shall be deposited in a special revenue account for the purpose of administration of enrollment to the senior drug discount program. This account shall be exempt from paying statewide and agency indirect costs as required under section 16A.127.

Subd. 7. **ADMINISTRATIVE FEE.** The commissioner of administration may authorize a claims processing contractor to charge a fixed claims processing fee not to exceed ten cents for each prescription drug provided to participating seniors under this section. In the event the commissioner authorizes a claims processing fee, one-half of the fee must be paid by the participating manufacturer and one-half by the participating pharmacy.

Subd. 8. **DISEASE MANAGEMENT FOR DRUG THERAPY.** The commissioner of human services may establish a disease management program for drug therapy for eligible senior citizens. The commissioner may seek grants and donations from drug manufacturers, drug wholesalers, and other nonstate entities to establish and administer this disease management program.

Subd. 9. **SENIOR DRUG DISCOUNT PROGRAM EVALUATION.** The commissioners of human services and health, in consultation with the commissioner of administration, shall study the efficiency and effectiveness of the senior drug discount program. The commissioners shall examine methods of encouraging participation by drug manufacturers and pharmacies in the program and any program modifications necessary to effectively serve eligible senior citizens. The commissioners shall present a progress report on the program to the legislature by January 15, 1996, and recommendations for program changes to the legislature by January 15, 1997.

Sec. 3. Minnesota Statutes 1994, section 256.9352, subdivision 3, is amended to read:

Subd. 3. **FINANCIAL MANAGEMENT.** (a) The commissioner shall manage spending for the 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~~ biennium and for the following ~~two fiscal years~~ biennium. The estimated expenditure, including minimum reserve requirements, 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, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of finance makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner ~~may~~ shall 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 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 MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner ~~may~~ shall 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.

By February 1, 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 taxes imposed under section 295.52 and the gross premiums tax imposed under section 60A.15, subdivision 1, paragraph (e), for fiscal year 1997.

~~(b)~~ (c) Notwithstanding ~~paragraph (a)~~ paragraphs (a) and (b), 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)~~ (b).

Sec. 4. Minnesota Statutes 1994, section 256.9353, subdivision 1, is amended to read:

Subdivision 1. **COVERED HEALTH SERVICES.** "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than preventive services, orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, ~~hospice care services,~~ nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

Sec. 5. Minnesota Statutes 1994, 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 spenddown. 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 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~~ and they may not reenroll until 12 calendar

months have elapsed. 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.

(d) Any enrollee or family member of an enrollee who has previously been permanently disenrolled from MinnesotaCare for not applying for and cooperating with medical assistance shall be eligible to reenroll if 12 calendar months have elapsed since the date of disenrollment.

Sec. 6. Minnesota Statutes 1994, section 256.9354, subdivision 1, is amended to read:

Subdivision 1. **CHILDREN; EXPANSION AND CONTINUATION OF ELIGIBILITY.** (a) **CHILDREN.** Prior to October 1, 1992, "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~~ 185 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 program 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 program under the eligibility criteria in subdivisions 2 to 5 remain eligible for the MinnesotaCare program, 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 program 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. 7. Minnesota Statutes 1994, 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 or 4a shall continue to be enrolled pursuant to ~~subdivision 1~~ those subdivisions. 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.

Sec. 8. Minnesota Statutes 1994, section 256.9354, is amended by adding a subdivision to read:

Subd. 4a. **CHILDREN WITH LOWER INCOMES.** Beginning July 1, 1993, the definition of "eligible persons" is expanded to include 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. The commissioner shall exclude all earned income of dependent children who:

(1) are full-time or part-time students;

(2) are employed for less than 37.5 hours per week; and

(3) earn less than $10,000 a year in total from all sources of employment, when calculating gross family incomes for applicants who would otherwise be eligible under this subdivision.

Sec. 9. Minnesota Statutes 1994, section 256.9354, subdivision 5, is amended to read:

Subd. 5. **ADDITION OF SINGLE ADULTS AND HOUSEHOLDS WITH NO CHILDREN.** (a) Beginning October 1, 1994, the definition of "eligible persons" ~~shall~~ is expanded to include all 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.~~ After October 1, 1995, the commissioner of human services may expand the definition of "eligible persons" to include all individuals and households with no children who have gross family incomes that are equal to or less than 135 percent of federal poverty guidelines and are not eligible for medical assistance without a spenddown under chapter 256B. This expansion may occur only if the financial management requirements of section 256.9352, subdivision 3, can be met.

(c) The commissioners of health and human services, in consultation with the legislative commission on health care access, shall make preliminary recommendations to the legislature by October 1, 1995, and final recommendations to the legislature by February 1, 1996, on whether a further expansion of the definition of "eligible persons" to include all individuals and households with no children who have gross family incomes that are equal to or less than 150 percent of federal poverty guidelines and are not eligible for medical assistance without a spenddown under chapter 256B would be allowed under the financial management constraints outlined in section 256.9352, subdivision 3.

~~(c)~~ (d) All eligible persons under paragraphs (a) and (b) are eligible for coverage through the MinnesotaCare 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 program.

Sec. 10. Minnesota Statutes 1994, section 256.9355, subdivision 2, is amended to read:

Subd. 2. **COMMISSIONER'S DUTIES.** The commissioner shall use individuals' social security numbers as identifiers for purposes of administering the plan and conduct data matches to verify income. Applicants shall submit evidence of family income, earned and unearned, including the most recent income tax return, wage slips, or other documentation that is necessary to verify income eligibility. The commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the department of revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

Sec. 11. Minnesota Statutes 1994, section 256.9357, subdivision 1, is amended to read:

Subdivision 1. **GENERAL REQUIREMENTS.** ~~Families and individuals are eligible for subsidized premium payments based on a sliding scale under section 256.9358 only if the family or individual meets the requirements in subdivisions 2 and 3.~~ Families and individuals who enroll on or after October 1, 1992, are eligible for subsidized premium payments based on a sliding scale under section 256.9358 only if the family or individual meets the requirements in subdivisions 2 and 3. Children already enrolled in the children's health plan as of September 30, 1992, eligible under section 256.9354, subdivision 1, paragraph (a), children who enroll in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who enroll under section 256.9354, subdivision 4a, are eligible for subsidized premium payments without meeting these requirements, as long as they maintain continuous coverage in the MinnesotaCare plan or medical assistance.

Families and individuals who initially enrolled in MinnesotaCare under section 256.9354, and whose income increases above the limits established in section 256.9358, may continue enrollment and pay the full cost of coverage.

Sec. 12. Minnesota Statutes 1994, 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 program. 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: (1) employer-subsidized coverage was lost due to the death of an employee or divorce; (2) employer-subsidized coverage was lost because an individual became ineligible for coverage as a child or dependent; or (3) 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~~ loss of coverage. 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 application, as long as the children have not had access to employer subsidized coverage since the disqualifying event. The requirement that the family or individual must not have had access to employer-subsidized coverage during the previous 18 months does apply if employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit.

(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. 13. Minnesota Statutes 1994, section 256.9357, subdivision 3, is amended to read:

Subd. 3. **PERIOD UNINSURED.** To be eligible for subsidized premium payments based on a sliding scale, families and individuals initially enrolled in the MinnesotaCare program under section 256.9354, subdivisions 4 and 5, must have had no health coverage for at least four months prior to application. The commissioner may change this eligibility criterion for sliding scale premiums without complying with rulemaking requirements in order to remain within the limits of available appropriations. The requirement of at least four months of no health coverage prior to application for the MinnesotaCare program does not apply to:

(1) families, children, and individuals who want to apply for the MinnesotaCare program upon termination from the medical assistance program, general assistance medical care program, or coverage under a regional demonstration project for the uninsured funded under section 256B.73, the Hennepin county assured care program, or the Group Health, Inc., community health plan. ~~This subdivision does not apply to~~;

(2) families and individuals initially enrolled under ~~sections~~ section 256.9354, subdivisions 1, paragraph (a), and 2; ~~or to~~;

(3) children enrolled pursuant to Laws 1992, chapter 549, article 4, section 17; or

(4) individuals currently serving or who have served in the military reserves, and dependents of these individuals, if these individuals: (i) reapply for MinnesotaCare coverage after a period of active military service during which they had been covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); (ii) were covered under MinnesotaCare immediately prior to obtaining coverage under CHAMPUS; and (iii) have maintained continuous coverage.

Sec. 14. Minnesota Statutes 1994, section 256.9358, subdivision 3, is amended to read:

Subd. 3. **SLIDING SCALES AFTER JUNE 30, 1993.** Beginning July 1, 1993, the sliding scales begin with a premium of 1.5 percent of gross family income for individuals with incomes below the limits for the medical assistance program set at 133-1/3 percent of the AFDC payment standard and proceed

through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit to a gross monthly income of $1,600 for an individual, $2,160 for a household of two, $2,720 for a household of three, $3,280 for a household of four, and $3,840 for a household of five~~, and $4,400 for households of six~~ or more persons. ~~For the period October 1, 1992 through June 30, 1993, the commissioner shall employ a sliding scale that sets required premiums at percentages of gross family income equal to two-thirds of the percentages specified in this subdivision.~~

Sec. 15. Minnesota Statutes 1994, section 256.9358, subdivision 4, is amended to read:

Subd. 4. **INELIGIBILITY.** Families with children whose gross monthly income is above the amount specified in subdivision 3 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~~ greater than 125 percent of the federal poverty guidelines are ineligible for the plan.

Sec. 16. Minnesota Statutes 1994, section 256.9358, is amended by adding a subdivision to read:

Subd. 7. **MINIMUM PREMIUM PAYMENT.** Beginning with premium payments due on or after July 1, 1995, the commissioner shall require all MinnesotaCare enrollees to pay a minimum premium of $4 per month.

Sec. 17. Minnesota Statutes 1994, section 256.9363, subdivision 5, is amended to read:

Subd. 5. **ELIGIBILITY FOR OTHER STATE PROGRAMS.** MinnesotaCare enrollees who become eligible for medical assistance or general assistance medical care will remain in the same managed care plan if the managed care plan has a contract for that population. Contracts between the department of human services and managed care plans must include MinnesotaCare, and medical assistance and may, at the option of the commissioner of human services, also include general assistance medical care.

Sec. 18. **[256.9366] ELIGIBILITY FOR MINNESOTACARE FOR FAMILIES AND CHILDREN UNDER THE MINNESOTACARE HEALTH CARE REFORM WAIVER.**

Subdivision 1. **FAMILIES WITH CHILDREN; IN GENERAL.** Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be determined eligible for MinnesotaCare according to this section, and section 256.9354, subdivisions 2 to 4a, shall no longer apply. All other provisions of sections 256.9351 to

256.9363, including the insurance-related barriers to enrollment under section 256.9357, shall apply unless otherwise specified in sections 256.9366 to 256.9369.

Subd. 2. **CHILDREN.** For purposes of sections 256.9366 to 256.9369, a "child" is an individual under 21 years of age, including the unborn child of a pregnant woman, and including an emancipated minor, and the emancipated minor's spouse.

Subd. 3. **FAMILIES WITH CHILDREN.** For purposes of sections 256.9366 to 256.9369, a "family with children" means a parent or parents and their children, or legal guardians and their wards who are children, and dependent siblings, residing in the same household. The term includes children and dependent siblings who are temporarily absent from the household in settings such as schools, camps, or visitation with noncustodial parents. 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.

Subd. 4. **CHILDREN IN FAMILIES WITH INCOME AT OR LESS THAN 150 PERCENT OF FEDERAL POVERTY GUIDELINES.** Children who have gross family incomes that are equal to or less than 150 percent of the federal poverty guidelines and who are not otherwise insured for the covered services, are eligible for enrollment under sections 256.9366 to 256.9369. For the purposes of this section, "not otherwise insured for covered services" has the meaning given in Minnesota Rules, part 9506.0020, subpart 3, item B.

Subd. 5. **RESIDENCY.** Families and children who are otherwise eligible for enrollment under section 256.9366 are exempt from the Minnesota residency requirements of section 256.9359, if they meet the residency requirements of the medical assistance program according to chapter 256B.

Subd. 6. **COOPERATION WITH MEDICAL ASSISTANCE.** Pregnant women and children applying for MinnesotaCare under this section are not required to apply for the medical assistance program as a condition of enrollment. Other adults enrolled in MinnesotaCare determined by the commissioner to have a basis of eligibility for medical assistance must cooperate in completing an application for medical assistance by the last day of the third month following admission to an inpatient hospital. If an enrollee fails to complete an application for medical assistance within this time period, the enrollee shall be disenrolled and may not reenroll.

Subd. 7. **COOPERATION IN ESTABLISHING PATERNITY AND OTHER MEDICAL SUPPORT.** Families and children enrolled in the MinnesotaCare program must cooperate with the department of human services and the local agency in establishing paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or

disenrolled from the MinnesotaCare program solely because of the child's parent or caretaker's failure to cooperate in establishing paternity or obtaining medical support.

Sec. 19. **[256.9367] COVERED SERVICES FOR PREGNANT WOMEN AND CHILDREN UNDER THE MINNESOTACARE HEALTH CARE REFORM WAIVER.**

Children and pregnant women are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B. Pregnant women and children are exempt from the provisions of section 256.9353, subdivision 7, regarding copayments.

Sec. 20. **[256.9368] PREMIUMS.**

Subdivision 1. **PREMIUM DETERMINATION.** Families and children enrolled according to sections 256.9366 to 256.9369 shall pay a premium determined according to a sliding fee based on the cost of coverage as a percentage of the family's gross family income. Pregnant women and children under age two are exempt from the provisions of section 256.9356, subdivision 3, clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256.9356.

Subd. 2. **SLIDING SCALE TO DETERMINE PERCENTAGE OF GROSS FAMILY INCOME.** The commissioner shall establish a sliding fee scale to determine the percentage of gross family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's gross family income during the previous four months. The sliding fee scale begins with a premium of 1.5 percent of gross family income for families with incomes below the limits for the medical assistance program for families and children and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children to 275 percent of the federal poverty guidelines for the applicable family size. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family reports increased income after enrollment, premiums shall not be adjusted until eligibility renewal.

Subd. 3. **EXCEPTIONS TO SLIDING SCALE.** An annual premium of $48 is required for all children who are eligible according to section 256.9366, subdivision 4.

Sec. 21. **[256.9369] PAYMENT RATES; SERVICES FOR FAMILIES AND CHILDREN UNDER THE MINNESOTACARE HEALTH CARE REFORM WAIVER.**

Section 256.9362, subdivision 2, shall not apply to services provided to children who are eligible to receive expanded services according to section 256.9367.

Sec. 22. Minnesota Statutes 1994, section 256B.037, subdivision 1, is amended to read:

Subdivision 1. **CONTRACT FOR DENTAL SERVICES.** The commissioner may conduct a demonstration project to contract, on a prospective per capita payment basis, with an organization or organizations licensed under chapter 62C ~~or~~, 62D, or 62N for the provision of all dental care services beginning July 1, 1994, under the medical assistance, general assistance medical care, and MinnesotaCare programs, or when necessary waivers are granted by the secretary of health and human services, whichever occurs later. The commissioner shall identify a geographic area or areas, including both urban and rural areas, where access to dental services has been inadequate, in which to conduct demonstration projects. The commissioner shall seek any federal waivers or approvals necessary to implement this section from the secretary of health and human services.

The commissioner may exclude from participation in the demonstration project any or all groups currently excluded from participation in the prepaid medical assistance program under section 256B.69. Except for persons excluded from participation in the demonstration project, all persons who have been determined eligible for medical assistance, general assistance medical care and, if applicable, MinnesotaCare and reside in the designated geographic areas are required to enroll in a dental plan to receive their dental care services. Except for emergency services or out-of-plan services authorized by the dental plan, recipients must receive their dental services from dental care providers who are part of the dental plan provider network.

The commissioner shall select either multiple dental plans or a single dental plan in a designated area. A dental plan under contract with the department must serve both medical assistance recipients and general assistance medical care recipients in a designated geographic area and may serve MinnesotaCare recipients. The commissioner may limit the number of dental plans with which the department contracts within a designated geographic area, taking into consideration the number of recipients within the designated geographic area; the number of potential dental plan contractors; the size of the provider network offered by dental plans; the dental care services offered by a dental plan; qualifications of dental plan personnel; accessibility of services to recipients; dental plan assurances of recipient confidentiality; dental plan marketing and enrollment activities; dental plan compliance with this section; dental plan performance under other contracts with the department to serve medical assistance, general assistance medical care, or MinnesotaCare recipients; or any other factors necessary to provide the most economical care consistent with high standards of dental care.

For purposes of this section, "dental plan" means an organization licensed under chapter 62C, 62D, or 62N that contracts with the department to provide covered dental care services to recipients on a prepaid capitation basis. "Emergency services" has the meaning given in section 256B.0625, subdivision 4. "Multiple dental plan area" means a designated area in which more than one dental plan is offered. "Participating provider" means a dentist or dental clinic who is employed by or under contract with a dental plan to provide dental care services to recipients. "Single dental plan area" means a designated area in which only one dental plan is available.

Sec. 23. Minnesota Statutes 1994, section 256B.037, is amended by adding a subdivision to read:

Subd. 1a. **MULTIPLE DENTAL PLAN AREAS.** After the department has executed contracts with dental plans to provide covered dental care services in a multiple dental plan area, the department shall:

(1) inform applicants and recipients, in writing, of available dental plans, when written notice of dental plan selection must be submitted to the department, and when dental plan participation begins;

(2) randomly assign to a dental plan recipients who fail to notify the department in writing of their dental plan choice; and

(3) notify recipients, in writing, of their assigned dental plan before the effective date of the recipient's dental plan participation.

Sec. 24. Minnesota Statutes 1994, section 256B.037, is amended by adding a subdivision to read:

Subd. 1b. **SINGLE DENTAL PLAN AREAS.** After the department has executed a contract with a dental plan to provide covered dental care services as the sole dental plan in a geographic area, the provisions in paragraphs (a) to (c) apply.

(a) The department shall assure that applicants and recipients are informed, in writing, of participating providers in the dental plan and when dental plan participation begins.

(b) The dental plan may require the recipient to select a specific dentist or dental clinic and may assign to a specific dentist or dental clinic recipients who fail to notify the dental plan of their selection.

(c) The dental plan shall notify recipients in writing of their assigned providers before the effective date of dental plan participation.

Sec. 25. Minnesota Statutes 1994, section 256B.037, is amended by adding a subdivision to read:

Subd. 1c. **DENTAL CHOICE.** (a) In multiple dental plan areas, recipients

may change dental plans once within the first year the recipient participates in a dental plan. After the first year of dental plan participation, recipients may change dental plans during the annual 30-day open enrollment period.

(b) In single dental plan areas, recipients may change their specific dentist or clinic at least once during the first year of dental plan participation. After the first year of dental plan participation, recipients may change their specific dentist or clinic at least once annually. The dental plan shall notify recipients of this change option.

(c) If a dental plan's contract with the department is terminated for any reason, recipients in that dental plan shall select a new dental plan and may change dental plans or a specific dentist or clinic within the first 60 days of participation in the second dental plan.

(d) Recipients may change dental plans or a specific dentist or clinic at any time as follows:

(1) in multiple dental plan areas, if the travel time from the recipient's residence to a general practice dentist is over 30 minutes, the recipient may change dental plans;

(2) in single dental plan areas, if the travel time from the recipient's residence to the recipient's specific dentist or clinic is over 30 minutes, the recipient may change providers; or

(3) if the recipient's dental plan or specific dentist or clinic was incorrectly designated due to department or dental plan error.

(e) Requests for change under this subdivision must be submitted to the department or dental plan in writing. The department or dental plan shall notify recipients whether the request is approved or denied within 30 days after receipt of the written request.

Sec. 26. Minnesota Statutes 1994, section 256B.037, subdivision 3, is amended to read:

Subd. 3. **APPEALS.** All recipients of services under this section have the right to appeal to the commissioner under section 256.045. A recipient participating in a dental plan may utilize the dental plan's internal complaint procedure but is not required to exhaust the internal complaint procedure before appealing to the commissioner. The appeal rights and procedures in Minnesota Rules, part 9500.1463, apply to recipients who enroll in dental plans.

Sec. 27. Minnesota Statutes 1994, section 256B.037, subdivision 4, is amended to read:

Subd. 4. **INFORMATION REQUIRED BY COMMISSIONER.** A contractor shall submit encounter-specific information as required by the commissioner, including, but not limited to, information required for assessing client

satisfaction, quality of care, and cost and utilization of services. Dental plans and participating providers must provide the commissioner access to recipient dental records to monitor compliance with the requirements of this section.

Sec. 28. Minnesota Statutes 1994, section 256B.037, is amended by adding a subdivision to read:

Subd. 6. **RECIPIENT COSTS.** A dental plan and its participating providers or nonparticipating providers who provide emergency services or services authorized by the dental plan shall not charge recipients for any costs for covered services.

Sec. 29. Minnesota Statutes 1994, section 256B.037, is amended by adding a subdivision to read:

Subd. 7. **FINANCIAL ACCOUNTABILITY.** A dental plan is accountable to the commissioner for the fiscal management of covered dental care services. The state of Minnesota and recipients shall be held harmless for the payment of obligations incurred by a dental plan if the dental plan or a participating provider becomes insolvent and the department has made the payments due to the dental plan under the contract.

Sec. 30. Minnesota Statutes 1994, section 256B.037, is amended by adding a subdivision to read:

Subd. 8. **QUALITY IMPROVEMENT.** A dental plan shall have an internal quality improvement system. A dental plan shall permit the commissioner or the commissioner's agents to evaluate the quality, appropriateness, and timeliness of covered dental care services through inspections, site visits, and review of dental records.

Sec. 31. Minnesota Statutes 1994, section 256B.037, is amended by adding a subdivision to read:

Subd. 9. **THIRD-PARTY LIABILITY.** To the extent required under section 62A.046 and Minnesota Rules, part 9506.0080, a dental plan shall coordinate benefits for or recover the cost of dental care services provided recipients who have other dental care coverage. Coordination of benefits includes the dental plan paying applicable copayments or deductibles on behalf of a recipient.

Sec. 32. Minnesota Statutes 1994, section 256B.037, is amended by adding a subdivision to read:

Subd. 10. **FINANCIAL CAPACITY.** A dental plan shall demonstrate that its financial risk capacity is acceptable to its participating providers; except, an organization licensed as a health maintenance organization under chapter 62D, a nonprofit health service plan under chapter 62C, or an integrated service network or a community integrated service network under chapter 62N, is not required to demonstrate financial risk capacity beyond the requirements in those chapters for licensure or a certificate of authority.

Sec. 33. Minnesota Statutes 1994, section 256B.037, is amended by adding a subdivision to read:

Subd. 11. **DATA PRIVACY.** The contract between the commissioner and the dental plan must specify that the dental plan is an agent of the welfare system and shall have access to welfare data on recipients to the extent necessary to carry out the dental plan's responsibilities under the contract. The dental plan shall comply with chapter 13, the Minnesota government data practices act.

Sec. 34. Minnesota Statutes 1994, section 256B.04, is amended by adding a subdivision to read:

Subd. 18. **APPLICATIONS FOR MEDICAL ASSISTANCE.** The state agency may take applications for medical assistance and conduct eligibility determinations for MinnesotaCare enrollees who are required to apply for medical assistance according to section 256.9353, subdivision 3, paragraph (b).

Sec. 35. Minnesota Statutes 1994, section 256B.055, is amended by adding a subdivision to read:

Subd. 10a. **CHILDREN.** This subdivision supersedes subdivision 10, as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this subdivision expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. Medical assistance may be paid for a child less than two years of age, whose mother was eligible for and receiving medical assistance at the time of birth and who remains in the mother's household or who is in a family with countable income that is equal to or less than the income standard established under section 256B.057, subdivision 1.

Sec. 36. Minnesota Statutes 1994, section 256B.057, is amended by adding a subdivision to read:

Subd. 1b. **PREGNANT WOMEN AND INFANTS; EXPANSION.** This subdivision supersedes subdivision 1 as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. An infant less than two years of age or a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, is eligible for medical assistance if countable family income is equal to or less than 275 percent of the federal poverty guideline for the same family size. For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program, except for the earned income disregard and employment deductions. An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions of the AFDC program exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants

less than two years of age. Eligibility for a pregnant woman or infant less than two years of age under this subdivision must be determined without regard to asset standards established in section 256B.056, subdivision 3.

An infant born on or after January 1, 1991, to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's second birthday, as long as the child remains in the woman's household.

Sec. 37. Minnesota Statutes 1994, section 256B.057, is amended by adding a subdivision to read:

Subd. 2b. **NO ASSET TEST FOR CHILDREN AND THEIR PARENTS; EXPANSION.** This subdivision supersedes subdivision 2a as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this subdivision expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. Eligibility for medical assistance for a person under age 21, and the person's parents or relative caretakers as defined in the aid to families with dependent children program according to chapter 256, who are eligible under section 256B.055, subdivision 3, and who live in the same household as the person eligible under age 21, must be determined without regard to asset standards established in section 256B.056.

Sec. 38. Minnesota Statutes 1994, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **OTHER CLINIC SERVICES.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services, and the services of a clinic meeting the criteria established in rule by the commissioner. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the department of health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years of essential community provider status. For federally qualified health centers and rural health clinics that either do not apply within the time specified above, that are denied essential community provider status by the department of health, or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics. This paragraph takes effect only if the Minnesota health care reform waiver is approved by the federal government, and remains in effect for as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this paragraph expires, and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes.

Sec. 39. **[256B.0645] PROVIDER PAYMENTS; RETROACTIVE CHANGES IN ELIGIBILITY.**

Payment to a provider for a health care service provided to a general assistance medical care recipient who is later determined eligible for medical assistance or MinnesotaCare according to section 256.9367 for the period in which the health care service was provided, shall be considered payment in full, and shall not be adjusted due to the change in eligibility. This section applies to both fee-for-service payments and payments made to health plans on a prepaid capitated basis.

Sec. 40. Minnesota Statutes 1994, section 256B.69, subdivision 2, is amended to read:

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

(a) "Commissioner" means the commissioner of human services. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

(b) "Demonstration provider" means an individual, agency, organization, or group of these entities that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner.

(c) "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06.

(d) "Limitation of choice" means suspending freedom of choice while allowing eligible individuals to choose among the demonstration providers.

(e) This paragraph supersedes paragraph (c) as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this paragraph expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06. Notwithstanding sections 256B.055, 256B.056, and 256B.06, an individual who becomes ineligible for the program because of failure to submit income reports or recertification forms in a timely manner, shall remain enrolled in the prepaid health plan and shall remain eligible to receive medical assistance coverage through the last day of the month following the month in which the enrollee became ineligible for the medical assistance program.

Sec. 41. Minnesota Statutes 1994, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **LIMITATION OF CHOICE.** The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6. The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice: (1) persons eligible for medical assistance according to section 256B.055, subdivision 1, and children under age 21 who are in foster placement; (2) persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless they are 65 years of age or older, or unless they reside in Itasca county or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act; (3) recipients who currently have private coverage through a health maintenance organization; and (4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense. Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

Sec. 42. Laws 1993, First Special Session chapter 1, article 8, section 30, subdivision 2, is amended to read:

Subd. 2. ~~Sections 1 to 3, 8, 9, 13 to 17, 22, 23, and 26 to 29 are effective July 1, 1994, contingent upon federal recognition that group residential housing payments qualify as optional state supplement payments to the supplemental security income program under title XVI of the Social Security Act and confer categorical eligibility for medical assistance under the state plan for medical assistance.~~ The amendments and repeals by Laws 1993, First Special Session chapter 1, article 8, sections 1 to 3, 8, 9, 13 to 17, 22, 23, 26, and 29, are effective July 1, 1994.

Sec. 43. **MANAGED CARE IMPLEMENTATION PLANS.**

Prior to enrollment of medical assistance or general assistance medical care recipients residing on an Indian Reservation into managed care plans, the commissioner shall consult with representatives of the Indian Reservation in developing a plan to implement managed care in that community, and shall present this implementation plan to the legislature and to the legislative commission on health care access.

Sec. 44. **MINNESOTACARE PROGRAM ADMINISTRATION.**

The commissioner of administration shall study the potential effectiveness of contracting with a private sector third-party administrator to administer the MinnesotaCare program. The commissioner shall determine whether the use of a third-party administrator to determine enrollee eligibility and process provider claims will reduce state administrative costs, improve the accuracy and timeliness of eligibility determination and claims payment, and allow effective coordination of MinnesotaCare with the medical assistance program and county social service agencies. The commissioner shall present recommendations to the legislature by February 1, 1996.

Sec. 45. **WAIVER REQUEST.**

(a) The commissioner of human services shall seek federal approval to add the benefit of drug coverage for qualified Medicare beneficiaries with incomes up to 150 percent of the federal poverty guidelines and to charge a copayment for this benefit.

(b) If federal approval is obtained, the commissioner of human services shall report to the legislature and present draft legislation expanding the qualified Medicare beneficiary program to the legislature for approval.

Sec. 46. **REPEALER.**

Minnesota Statutes 1994, section 256.9353, subdivisions 4 and 5, are repealed.

Sec. 47. **EFFECTIVE DATE.**

Sections 18 to 21 (256.9366 to 256.9369), 35, 36, 37, and 38 (256B.055, subdivision 10a; 256B.057, subdivision 1b; 256B.057, subdivision 2b; and

256B.0625, subdivision 30) are effective July 1, 1995. The commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes when the waiver expires and the provisions in this section expire.

ARTICLE 7

INSURANCE REFORM

Section 1. Minnesota Statutes 1994, section 60A.02, is amended by adding a subdivision to read:

Subd. 29. **MULTIPLE EMPLOYER TRUST.** "Multiple employer trust" means a trust organized for the benefit of two or more employers for the purpose of providing health insurance coverage to employees and dependents.

Sec. 2. Minnesota Statutes 1994, section 62A.10, subdivision 1, is amended to read:

Subdivision 1. **REQUIREMENTS.** Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than two employees nor less than ten members, and which may include the employee's or member's dependents, consisting of husband, wife, children, and actual dependents residing in the household, written under a master policy issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, copartnership, individual, employer, ~~or~~ to a purchasing pool as described in section 62Q.17, to any association as defined by section 60A.02, subdivision 1a, or to a multiple employer trust, or to the trustee of a fund, established or adopted by two or more employers or maintained for the benefit of members of an association, where officers, members, employees, or classes or divisions thereof, may be insured for their individual benefit.

Any insurer authorized to write accident and health insurance in this state shall have power to issue group accident and health policies.

Sec. 3. Minnesota Statutes 1994, section 62A.10, subdivision 2, is amended to read:

Subd. 2. **POLICY FORMS.** No policy or certificate of group accident and health insurance may be issued or delivered in this state unless the same has been approved by the commissioner in accordance with section 62A.02, subdivisions 1 to 6. These forms shall contain the standard provisions relating and applicable to health and accident insurance and shall conform with the other requirements of law relating to the contents and terms of policies of accident and sickness insurance in so far as they may be applicable to group accident and health insurance, and also the following provisions:

(1) **ENTIRE CONTRACT.** A provision that the policy and the application

of the employer, trustee, or executive officer or trustee of any association, and the individual applications, if any, of the employees or members insured, shall constitute the entire contract between the parties, and that all statements made by the employer, trustee, or any executive officer or trustee in behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in the written application;

(2) **MASTER POLICY-CERTIFICATES.** A provision that the insurer will issue a master policy to the employer, trustee, or to the executive officer or trustee of the association; and the insurer shall also issue to the employer, trustee, or to the executive officer or trustee of the association, for delivery to the employee or member who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which the employee or member is entitled and to whom payable, together with a statement as to when and where the master policy, or a copy thereof, may be seen for inspection by the individual insured; this individual certificate may contain the names of, and insure the dependents of, the employee or member, as provided for herein;

(3) **NEW INSUREDS.** A provision that to the group or class thereof originally insured may be added, from time to time, all new employees of the employer or members of the association eligible to and applying for insurance in that group or class and covered or to be covered by the master policy.

Sec. 4. Minnesota Statutes 1994, 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~~, preexisting condition exclusion, or exclusionary rider, unless the limitation or exclusion is permitted under 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 subjected to an 18-month preexisting condition limitation, unless the individual has maintained continuous coverage as defined in 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 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. Credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual must not be subject to any preexisting condition limitation ~~or~~, preexisting condition 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 as defined in section 62L.02.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in 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 as defined in section 62E.02 and must not contain any preexisting condition limitation ~~or,~~ preexisting condition 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 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. Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph.

Sec. 5. Minnesota Statutes 1994, section 62A.65, subdivision 8, is amended 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 health plan market in this state if it complies with the requirements of this subdivision. For purposes of this section, "cease doing business" means to discontinue issuing new individual health plans and to refuse to renew all of the health carrier's existing individual health plans issued in this state whose terms permit refusal to renew under the circumstances specified in this subdivision. This subdivision does not permit cancellation of an individual health plan, unless the terms of the health plan permit cancellation under the circumstances specified in this subdivision. A health carrier electing to cease doing business in the individual health plan market in this state 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 health plan market or continue an existing product line in that market, provided that a health carrier does not terminate, cancel, or fail to renew its current individual health plan business ~~or other product lines~~. A health carrier electing to cease doing business in the individual health plan market shall provide 120 days' written notice to each policyholder covered by ~~a~~ an

individual health plan issued by the health carrier. A health carrier that ceases to write new business in the individual health plan market shall continue to be governed by this section with respect to continuing individual health plan business conducted by the health carrier. A health carrier that ceases to do business in the individual health plan market after July 1, 1994, is prohibited from writing new business in the individual health plan 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 health plan 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 health plan 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 that does not permit refusal to renew under the circumstances specified in this subdivision.

Sec. 6. Minnesota Statutes 1994, section 62D.02, subdivision 8, is amended to read:

Subd. 8. "Health maintenance contract" means any contract whereby a health maintenance organization agrees to provide comprehensive health maintenance services to enrollees, provided that the contract may contain reasonable enrollee copayment provisions. An individual or group health maintenance contract may contain the copayment and deductible provisions specified in this subdivision. Copayment and deductible provisions in group contracts shall not discriminate on the basis of age, sex, race, length of enrollment in the plan, or economic status; and during every open enrollment period in which all offered health benefit plans, including those subject to the jurisdiction of the commissioners of commerce or health, fully participate without any underwriting restrictions, copayment and deductible provisions shall not discriminate on the basis of preexisting health status. In no event shall the sum of the annual ~~copayment~~ copayments and deductible exceed the maximum out-of-pocket expenses allowable for a number three qualified ~~insurance policy~~ plan under section 62E.06, nor shall that sum exceed $5,000 per family. The annual deductible must not exceed $1,000 per person. The annual deductible must not apply to preventive health services as described in Minnesota Rules, part 4685.0801, subpart 8. Where sections 62D.01 to 62D.30 permit a health maintenance organization to contain reasonable copayment provisions for preexisting health status, these provisions may vary with respect to length of enrollment in the plan. Any contract may provide for health care services in addition to those set forth in subdivision 7.

Sec. 7. Minnesota Statutes 1994, section 62D.042, subdivision 2, is amended to read:

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

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

(c) Notwithstanding paragraphs (a) and (b), any health maintenance organization owned by a political subdivision of this state, which has a higher than average percentage of enrollees who are enrolled in medical assistance or general assistance medical care, may exceed the maximum net worth limits provided in paragraphs (a) and (b), with the advance approval of the commissioner.

Sec. 8. Minnesota Statutes 1994, section 62E.05, is amended to read:

62E.05 ~~CERTIFICATION OF~~ INFORMATION ON QUALIFIED PLANS.

Subdivision 1. **CERTIFICATION.** Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified medicare supplement plan for the purposes of sections 62E.01 to 62E.16, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All plans of health coverage, except Medicare supplement policies, shall be labeled as "qualified" or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

Subd. 2. **ANNUAL REPORT.** All health plan companies, as defined in section 62Q.01, shall annually report to the commissioner responsible for their regulation. The following information shall be reported to the appropriate commissioner on February 1 of each year:

(1) the number of individuals and groups who received coverage in the prior year through the qualified plans; and

(2) the number of individuals and groups who received coverage in the prior year through each of the unqualified plans sold by the company.

Sec. 9. Minnesota Statutes 1994, section 62E.141, is amended to read:

62E.141 **INCLUSION IN EMPLOYER-SPONSORED PLAN.**

No employee~~, or dependent of an employee,~~ of an employer that offers a health plan, under which the employee ~~or dependent~~ is eligible 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~~, preexisting condition exclusion, or exclusionary rider under the employer's health 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. 10. Minnesota Statutes 1994, section 62H.04, is amended to read:

62H.04 **COMPLIANCE WITH OTHER LAWS.**

A joint self-insurance plan is subject to the requirements of chapters 62A, ~~and~~ 62E, and 62L, and sections 72A.17 to 72A.32 unless otherwise specifically exempt. A joint self-insurance plan must not offer less than a number two qualified plan or its actuarial equivalent.

Sec. 11. Minnesota Statutes 1994, section 62H.08, is amended to read:

62H.08 **EXEMPTION.**

A homogenous joint employer plan providing group health benefits, which was in existence prior to March 1, 1983, and which is associated with, or organized or sponsored by, an association exempt from taxation under United States Code, title 26, section 501(c)(6), and controlled by a board of trustees a majority of whom are members of the association, is exempt from the requirements of sections 62H.01 to 62H.08 and 471.617, subdivisions 1 to 3, and the insurance laws of this state, except that the association must comply with the provisions of chapter 62L with respect to any members that are small employers.

Sec. 12. Minnesota Statutes 1994, 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, dependent child of any age who is handicapped and who meets the eligibility criteria in section 62A.14, subdivision 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~~ includes a child for whom the employee or the employee's spouse has been appointed legal guardian.

Sec. 13. Minnesota Statutes 1994, 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 corporation licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network and an integrated service network operating under chapter 62N; 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. ~~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

New language is indicated by underline, deletions by ~~strikeout~~.

another chapter by reference does not include a community integrated service network or 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. 14. Minnesota Statutes 1994, section 62L.02, subdivision 24, is amended to read:

Subd. 24. **QUALIFYING COVERAGE.** "Qualifying 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 MinnesotaCare 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) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);

(10) coverage provided by a health care network cooperative under chapter 62R or by a health provider cooperative under section 62R.17; or

(11) a plan similar to any of the above plans provided in this state or in another state as determined by the commissioner.

Sec. 15. Minnesota Statutes 1994, 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 business, including a political subdivision of the state, that, on at least 50 percent of its working days during the preceding 12 months, employed no fewer than two nor more than 29, 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 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~~ as defined in section ~~62A.10, subdivision 1~~ 62L.045, 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~~ and health benefit plans it provides to small ~~employer~~ employers, are subject to section 62L.045, with respect to ~~those~~ small employers in the association ~~that employ no fewer than two nor more than 29, or after June 30, 1995, more than 49, current employees~~, even though the association also 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 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 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.

Sec. 16. Minnesota Statutes 1994, 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 each eligible ~~employees~~ employee 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 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; or (4) coverage under medical assistance under chapter 256B or general assistance medical care under chapter 256D.

(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 health plans, or a health benefit plan which must fully comply with this chapter. A health carrier that provides 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 health plan, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers the individual health plan, on a guaranteed issue basis, to all other employees of the same employer.

(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. 17. Minnesota Statutes 1994, 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 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, any preexisting condition limitation ~~or~~, preexisting condition 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 preexisting condition exclusion. The credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. Section 60A.082, relating to replacement of group coverage, and the rules adopted under that section apply to this chapter, and this chapter's requirements are in addition to the requirements of that section and the rules adopted under it. 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 coverage, if the person has maintained continuous coverage.

Sec. 18. Minnesota Statutes 1994, 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.

(b) A health carrier may cancel or fail to renew a health benefit plan:

(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 required under subdivision 3; or

(4) 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.

(c) A health carrier may fail to renew a health benefit plan:

(1) 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;

~~(5)~~ (2) if the health carrier ceases to do business in the small employer market under section 62L.09; or

~~(6)~~ (3) 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)~~ (d) 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. 19. **[62L.045] ASSOCIATIONS.**

Subdivision 1. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given:

(a) "Association" means:

(1) an association as defined in section 60A.02;

(2) a group or organization of political subdivisions;

(3) an educational cooperative service unit created under section 123.58; or

(4) a joint self-insurance pool authorized under section 471.617, subdivision 2.

(b) "Qualified association" means an association, as defined in this subdivision, that:

(1) is registered with the commissioner of commerce;

(2) provides health plan coverage through a health carrier that participates in the small employer market in this state, other than through associations;

(3) has and adheres to membership and participation criteria and health plan eligibility criteria that are not designed to disproportionately include or attract small employers that are likely to have low costs of health coverage or to disproportionately exclude or repel small employers that are likely to have high costs of health coverage; and

(4) permits any small employer that meets its membership, participation, and eligibility criteria to become a member and to obtain health plan coverage through the association.

Subd. 2. **QUALIFIED ASSOCIATIONS.** (a) A qualified association, as defined in this section, and health benefit plans offered by it, to it, or through it, to a small employer in this state must comply with the requirements of this chapter regarding guaranteed issue, guaranteed renewal, preexisting condition limitations, credit against preexisting condition limitations for continuous coverage, treatment of MCHA enrollees, and the definition of dependent, and with section 62A.65, subdivision 5, paragraph (b). They must also comply with all other requirements of this chapter not specifically exempted in paragraph (b) or (c).

(b) A qualified association and a health carrier offering, selling, issuing, or renewing a health benefit plan to, or to cover, a small employer in this state through the qualified association, may, but are not, in connection with that health benefit plan, required to:

(1) offer the two small employer plans described in section 62L.05; and

(2) offer to small employers that are not members of the association, health benefit plans offered to, by, or through the qualified association.

(c) A qualified association, and a health carrier offering, selling, issuing, and renewing a health benefit plan to, or to cover, a small employer in this state must comply with section 62L.08, except that a separate index rate may be applied by a health carrier to each qualified association, provided that:

(1) the premium rate applied to participating small employer members of the qualified association is no more than 25 percent above and no more than 25 percent below the index rate applied to the qualified association, irrespective of when members applied for health coverage; and

(2) the index rate applied by a health carrier to a qualified association is no more than 20 percent above and no more than 20 percent below the index rate applied by the health carrier to any other qualified association or to any small employer. In comparing index rates for purposes of this clause, the 20 percent shall be calculated as a percent of the larger index rate.

Subd. 3. **OTHER ASSOCIATIONS.** Associations as defined in this section

that are not qualified associations; health benefit plans offered, sold, issued, or renewed through them; and the health carriers doing so, must fully comply with this chapter with respect to small employers that are members of the association.

Subd. 4. **PRINCIPLES; ASSOCIATION COVERAGE.** (a) This subdivision applies to associations as defined in this section, whether qualified associations or not, and is intended to clarify subdivisions 1 to 3.

(b) This section applies only to associations that provide coverage to small employers.

(c) The requirements of guaranteed issue and guaranteed renewal apply to coverage issued to cover small employers and persons covered through them, within the context of an arrangement between an association and a health carrier. A health carrier is not required under this chapter to comply with guaranteed issue and guaranteed renewal with respect to its relationship with the association itself. An arrangement between the health carrier and the association, once entered into, must comply with guaranteed issue and guaranteed renewal with respect to members of the association that are small employers and persons covered through them.

(d) When an arrangement between a health carrier and an association has validly terminated, the health carrier has no continuing obligation to small employers and persons covered through them, except as otherwise provided in:

(1) section 62A.65, subdivision 5, paragraph (b);

(2) any other continuation or conversion rights applicable under state or federal law; and

(3) section 60A.082, relating to group replacement coverage, and rules adopted under that section.

(e) When an association's arrangement with a health carrier has terminated and the association has entered into a new arrangement with that health carrier or a different health carrier, the new arrangement is subject to section 60A.082 and rules adopted under it, with respect to members of the association that are small employers and persons covered through them.

(f) An association that offers its members more than one health plan may have uniform rules restricting movement between the health plans, if the rules do not discriminate against small employers.

(g) This chapter does not require or prohibit separation of an association's members into one group consisting only of small employers and another group or other groups consisting of all other members. The association must comply with this section with respect to the small employer group.

(h) For purposes of this section, "member" of an association includes an employer participant in the association.

(i) For purposes of this section, coverage issued to, or to cover, a small employer includes a certificate of coverage issued directly to the employer's employees and dependents, rather than to the small employer.

Subd. 5. **REGISTRATION.** The commissioner may require all associations that are subject to this section to register with the commissioner prior to an initial purchase of coverage under this section.

Sec. 20. Minnesota Statutes 1994, section 62L.09, subdivision 1, is amended to read:

Subdivision 1. **NOTICE TO COMMISSIONER.** A health carrier electing to cease doing business in the small employer market shall notify the commissioner 180 days prior to the effective date of the cessation. The health carrier shall simultaneously provide a copy of the notice to each small employer covered by a health benefit plan issued by the health carrier. For purposes of this section, "cease doing business" means to discontinue issuing new health benefit plans to small employers and to refuse to renew all of the health carrier's existing health benefit plans issued to small employers, the terms of which permit refusal to renew under the circumstances specified in this subdivision. This section does not permit cancellation of a health benefit plan, unless permitted under its terms.

Upon making the notification, the health carrier shall not offer or issue new business in the small employer market. The health carrier shall renew its current small employer business due for renewal within 120 days after the date of the notification but shall not renew any small employer business more than 120 days after the date of the notification. The renewal period for business renewed during that 120-day period shall end on the effective date of the cessation.

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

Sec. 21. Minnesota Statutes 1994, section 62L.12, subdivision 2, is amended to read:

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 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 health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to substitute individual health plans for a group 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.

Sec. 22. Minnesota Statutes 1994, section 62L.17, is amended by adding a subdivision to read:

Subd. 2a. **PARTICIPATION OF NEW SMALL EMPLOYER HEALTH CARRIERS.** A health carrier that enters the small employer market subsequent to February 1993, may elect to not participate in the reinsurance association by filing an application within 60 days of entry into the small employer market or the effective date of this section, whichever is later. The commissioner shall make a determination and notify the health carrier no later than 60 days after receipt of the application. In determining whether to approve the application, the commissioner shall consider the standards defined in subdivision 2, except that the commissioner may also consider whether the health carrier has a guaranteeing organization as defined in section 62D.043, subdivision 1, or as permitted under chapter 62N.

Sec. 23. Minnesota Statutes 1994, section 62L.18, subdivision 2, is amended to read:

Subd. 2. **ELIGIBILITY FOR REINSURANCE.** (a) A health carrier may not reinsure existing small employer business through the association. A health carrier may reinsure an employee or dependent who previously had coverage

from MCHA who is now eligible for coverage through the small employer group at the time of enrollment as defined in section 62L.03, subdivision 6. A health carrier may not reinsure individuals who have existing individual health care coverage with that health carrier upon replacement of the individual coverage with group coverage as provided in section 62L.04, subdivision 1.

(b) A health carrier may cede to the association the risk of any newly eligible employees or continue to reinsure small employer business for employers who, at the time of renewal of coverage by the same health carrier prior to July 1, 1995, have more than 29 current employees but fewer than 49 current employees. This paragraph is effective retroactively for coverage renewed on or after July 1, 1994.

Sec. 24. Minnesota Statutes 1994, section 62Q.17, subdivision 2, is amended to read:

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 other common factor as approved by the commissioner of commerce. The membership criteria must not be designed to include disproportionately employers, groups, or individuals likely to have low costs of health coverage, or to exclude disproportionately employers, groups, or individuals likely to have high costs of health coverage.

Sec. 25. Minnesota Statutes 1994, section 62Q.17, subdivision 8, is amended to read:

Subd. 8. **REPORTS.** Prior to the initial effective date of coverage, and annually on July 1 thereafter, each pool shall file a report with the information clearinghouse and the commissioner of commerce. 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. 26. Minnesota Statutes 1994, section 62Q.17, is amended by adding a subdivision to read:

Subd. 9. **ENFORCEMENT.** Purchasing pools must register prior to offering coverage, and annually on July 1 thereafter, with the commissioner of commerce on a form prescribed by the commissioner. The commissioner of commerce shall enforce this section and all other state laws with respect to purchasing pools, and has for that purpose all general rulemaking and enforcement powers otherwise available to the commissioner of commerce. The commissioner may charge an annual registration fee sufficient to meet the costs of the commissioner's duties under this section.

Sec. 27. Minnesota Statutes 1994, section 72A.201, is amended by adding a subdivision to read:

Subd. 13. **IMPROPER CLAIM OF DISCOUNT.** (a) No insurer, integrated service network, or community integrated service network shall intentionally provide a health care provider with an explanation of benefits or similar document claiming a right to a discounted fee, price, or other charge, when the insurer, integrated service network, or community integrated service network does not have an agreement with the provider for the discount with respect to the patient involved.

(b) The insurer, integrated service network, or community integrated service network may, notwithstanding paragraph (a), claim the right to a discount based upon a discount agreement between the health care provider and another entity, but only if:

(1) that agreement expressly permitted the entity to assign its right to receive the discount;

(2) an assignment to the insurer, integrated service network, or community integrated service network of the right to receive the discount complies with any relevant requirements for assignments contained in the discount agreement; and

(3) the insurer, integrated service network, or community integrated service network has complied with any relevant requirements contained in the assignment.

(c) When an explanation of benefits or similar document claims a discount permitted under paragraph (b), it shall prominently state that the discount claimed is based upon an assignment and shall state the name of the entity from whom the assignment was received. This paragraph does not apply if the entity that issues the explanation of benefits or similar document has a provider agreement with the provider.

(d) No insurer, integrated service network, or community integrated service network that has entered into an agreement with a health care provider that involves discounted fees, prices, or other charges shall disclose the discounts to

another entity, with the knowledge or expectation that the disclosure will result in claims for discounts prohibited under paragraphs (a) and (b).

Sec. 28. **REPEALER; POLITICAL SUBDIVISION ASSOCIATIONS.**

Minnesota Statutes 1994, section 62L.08, subdivision 7a, is repealed effective January 1, 1996.

Sec. 29. **EFFECTIVE DATES.**

Sections 1, 2, 3, 10, 11, 15, and 19 are effective January 1, 1996. Section 13 is effective retroactively to January 1, 1995. Sections 17 and 22 are effective the day following final enactment. Section 23 is effective retroactively to July 1, 1994.

ARTICLE 8

RURAL HEALTH INITIATIVES AND MISCELLANEOUS PROVISIONS

Section 1. Minnesota Statutes 1994, section 62J.05, subdivision 2, is amended to read:

Subd. 2. **MEMBERSHIP.** (a) **NUMBER.** The Minnesota health care commission consists of ~~27~~ 28 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 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.

(h) **REGIONAL COORDINATING BOARDS.** The commission includes one member who is the chair of a regional coordinating board, elected by a majority vote of the chairs of the regional coordinating boards.

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

Sec. 2. Minnesota Statutes 1994, section 62J.05, subdivision 9, is amended to read:

Subd. 9. **REPEALER.** This section is repealed effective July 1, ~~1996~~ 2000.

Sec. 3. Minnesota Statutes 1994, section 62J.09, subdivision 1, is amended to read:

Subdivision 1. **GENERAL DUTIES.** The regional coordinating boards are locally controlled boards consisting of providers, health plan companies, employers, consumers, and elected officials. Regional coordinating boards may:

(1) ~~recommend that the commissioner approve voluntary agreements between providers in the region that will improve quality, access, or affordability of health care but might constitute a violation of antitrust laws if undertaken without government direction;~~

~~(2) make recommendations to the commissioner regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by providers;~~

~~(3)~~ undertake voluntary activities to educate consumers, providers, and purchasers ~~or to promote voluntary, cooperative community cost containment, access, or quality of care projects~~ about community plans and projects promoting health care cost containment, consumer accountability, access, and quality and efforts to achieve public health goals;

~~(4)~~ (2) make recommendations to the commissioner regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state~~.~~;

(3) provide technical assistance to parties interested in establishing or operating 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;

(4) advise the commissioner on public health goals, taking into consideration the relevant portions of the community health service plans, plans required by the Minnesota comprehensive adult mental health act, the Minnesota comprehensive children's mental health act, and the community social service act plans developed by county boards or community health boards in the region under chapters 145A, 245, and 256E;

(5) prepare an annual regional education plan that is consistent with and supportive of public health goals identified by community health boards in the region; and

(6) serve as advisory bodies to identify potential applicants for federal Health Professional Shortage Area and federal Medically Underserved Area designation as requested by the commissioner.

Sec. 4. Minnesota Statutes 1994, section 62J.09, subdivision 2, is amended to read:

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 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~~ legislative commission on health care access. 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. 5. Minnesota Statutes 1994, section 62J.09, is amended by adding a subdivision to read:

Subd. 3a. **COMMUNICATION WITH HEALTH CARE COMMISSION.** The chairs of the regional coordinating boards shall meet with the chair and the executive director of the health care commission on a periodic basis, but no less than biennially.

Sec. 6. Minnesota Statutes 1994, section 62J.09, subdivision 6, is amended to read:

Subd. 6. **TECHNICAL ASSISTANCE.** The commissioner shall provide technical assistance to regional coordinating boards. Technical assistance includes providing each regional board with timely information concerning action plans, enrollment data, and health care expenditures affecting the regional board's region.

Sec. 7. Minnesota Statutes 1994, section 62J.09, subdivision 8, is amended to read:

Subd. 8. **REPEALER.** This section is repealed effective July 1, ~~1996~~ 2000.

Sec. 8. Minnesota Statutes 1994, section 62J.17, subdivision 4a, is amended to read:

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

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

(1) a detailed description of the major spending commitment, including the specific dollar amount of each expenditure, and its purpose;

(2) the date of the major spending commitment;

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

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

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 1994, section 62J.17, subdivision 6a, is amended to read:

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

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

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

(b) **APPLICATION.** A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The application must address each item listed in subdivision 4a, paragraph (a), and must also include documentation to support the response to each item. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under ~~paragraph (d)~~ subdivision 7. The submission may be made either in addition to or instead of the submission of information relating to the items listed in subdivision 4a, paragraph (a).

(c) **REVIEW.** The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under ~~paragraph (d)~~ subdivision 7. In making this determination, the commissioner may also consider relevant information from other sources. At the request of the commissioner, the Minnesota health care commission shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner. The commissioner shall make a decision on the application within 60 days after an application is received.

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

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

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

~~(3) a major spending commitment to repair, remodel, or replace existing~~

~~buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided; and~~

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

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

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

Sec. 10. Minnesota Statutes 1994, section 62J.17, is amended by adding a subdivision to read:

Subd. 7. **EXCEPTIONS.** (a) The retrospective review process as described in subdivision 5a and the prospective review and approval process as described in subdivision 6a do not apply to:

(1) a major spending commitment to replace existing equipment with comparable equipment used for direct patient care, upgrades of equipment beyond the current model, or comparable model must be reported;

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

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

(4) a major spending commitment for building maintenance including heating, water, electricity, and other maintenance-related expenditures;

(5) a major spending commitment for activities, not directly related to the delivery of patient care services, including food service, laundry, housekeeping, and other service-related activities; and

(6) a major spending commitment for computer equipment or data systems not directly related to the delivery of patient care services, including computer equipment or data systems related to medical record automation.

(b) In addition to the exceptions listed in subdivision 7, paragraph (a), the prospective review and approval process described in subdivision 6a does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

Sec. 11. Minnesota Statutes 1994, section 62J.48, is amended to read:

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~~ health plan companies. The commissioner shall require ~~community integrated service networks, integrated service networks, and all-payer insurers~~ health plan companies 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~~ a health plan company, if approved by a designated representative of ~~an integrated service network or a community service network~~ a health plan company 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. 12. Minnesota Statutes 1994, section 62M.07, is amended to read:

62M.07 **PRIOR AUTHORIZATION OF SERVICES.**

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 72A.201, subdivision 4a, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of section 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

Sec. 13. Minnesota Statutes 1994, section 62M.09, subdivision 5, is amended to read:

Subd. 5. **WRITTEN CLINICAL CRITERIA.** A utilization review organization's decisions must be supported by written clinical criteria and review procedures in compliance with section 62M.07, paragraph (c). Clinical criteria and review procedures must be established with appropriate involvement from actively practicing physicians. A utilization review organization must use written clinical criteria, as required, for determining the appropriateness of the certification request. The utilization review organization must have a procedure for ensuring, at a minimum, the ~~periodic~~ annual evaluation and updating of the written criteria based on sound clinical principles.

Sec. 14. Minnesota Statutes 1994, section 62M.10, is amended by adding a subdivision to read:

Subd. 7. **AVAILABILITY OF CRITERIA.** Upon request, a utilization review organization shall provide to an enrollee or to an attending physician or provider the criteria used for a specific procedure to determine the necessity, appropriateness, and efficacy of that procedure and identify the database, professional treatment guideline, or other basis for the criteria.

Sec. 15. Minnesota Statutes 1994, section 62P.05, subdivision 4, is amended to read:

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. 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 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 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, and 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 percentage increase in the average fee from 1995 to 1996, and from 1996 to 1997 is subject to the change in the regional consumer price index for urban consumers for the previous year published in the State Register in January of the year that the growth limit is in effect. 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.

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 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. 16. Minnesota Statutes 1994, section 62P.05, is amended by adding a subdivision to read:

Subd. 5. **SMALL RURAL HOSPITALS.** Each small rural hospital shall file information with the commissioner of health and calculate its growth in revenues pursuant to the requirements of this chapter. Small rural hospitals that do not file as part of a hospital system are exempt from the repayment provisions of

subdivision 4. However, the commissioner retains the authority to initiate an investigation and order repayment pursuant to this section, if the commissioner believes that there is an unreasonable rate of growth in revenues and if the hospital fails to demonstrate good cause for exceeding the statutory growth limits. For purposes of this subdivision, small rural hospital is defined as a hospital with less than 50 licensed beds.

Sec. 17. Minnesota Statutes 1994, section 62Q.075, subdivision 4, is amended to read:

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. The commissioner of health shall develop recommendations to utilize the written comments submitted as part of the licensure process to ensure local public accountability. These recommendations shall be reported to the legislative commission on health care access by January 15, 1996. 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.

Sec. 18. Minnesota Statutes 1994, section 62Q.32, is amended to read:

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. The commissioner of health shall make recommendations for funding these functions including the amount of funding needed and a plan for distribution. The commissioner shall submit these recommendations to the legislative commission on health care access by January 15, 1996.

Sec. 19. Minnesota Statutes 1994, section 62Q.33, subdivision 4, is amended to read:

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 services ~~within the uniform benefits set~~ through the health plan companies 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. Funding recommendations must be broad-based and must consider all financial resources.

Sec. 20. Minnesota Statutes 1994, section 62Q.33, subdivision 5, is amended to read:

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~~ January 15, ~~1995~~ 1996, 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)~~ (b) By January ~~1~~ 15, 1997, and by January ~~1~~ 15 of each odd-numbered year thereafter, the commissioner shall present to the legislature an updated report and recommendations.

Sec. 21. Minnesota Statutes 1994, section 72A.20, is amended by adding a subdivision to read:

Subd. 32. **UNFAIR HEALTH RISK AVOIDANCE.** No insurer or health plan company may design a network of providers, policies on access to providers, or marketing strategy in such a way as to discourage enrollment by individuals or groups whose health care needs are perceived as likely to be more expensive than the average. This subdivision does not prohibit underwriting and rating practices that comply with Minnesota law.

Sec. 22. Minnesota Statutes 1994, section 72A.20, is amended by adding a subdivision to read:

Subd. 33. **PROHIBITION OF INAPPROPRIATE INCENTIVES.** No insurer or health plan company may give any financial incentive to a health care provider based solely on the number of services denied or referrals not authorized by the provider. This subdivision does not prohibit capitation or other compensation methods that serve to hold health care providers financially accountable for the cost of caring for a patient population.

Sec. 23. Minnesota Statutes 1994, section 136A.1355, subdivision 3, is amended to read:

Subd. 3. **LOAN FORGIVENESS.** For ~~the period July 1, 1993 through June 30, 1995~~ fiscal years beginning on and after July 1, 1995, the higher education coordinating board may accept up to four applicants who are fourth year medical students, three applicants who are pediatric residents, and four applicants who are family practice residents, and one applicant who is an internal medicine resident, per fiscal year for participation in the loan forgiveness program. If the higher education coordinating board does not receive enough applicants per fiscal year to fill the number of residents in the specific areas of practice, the resident applicants may be from any area of practice. The eight resident applicants ~~can~~ may be in any year of training; however, priority must be given to the following categories of residents in descending order: third year residents, second year residents, and first year residents. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed $10,000, as a qualified loan. For each year that a participant serves as a physician in a designated rural area, up to a maximum of four years, the higher education coordinating board shall annually pay an amount equal to one year of qualified loans. Participants who move their practice from one designated rural area to another remain eligible for loan repayment. In addition, if a resident participating in the loan forgiveness program serves at least four weeks during a year of residency substituting for a rural physician to temporarily relieve the rural physician of

rural practice commitments to enable the rural physician to take a vacation, engage in activities outside the practice area, or otherwise be relieved of rural practice commitments, the participating resident may designate up to an additional $2,000, above the $10,000 maximum, for each year of residency during which the resident substitutes for a rural physician for four or more weeks.

Sec. 24. Minnesota Statutes 1994, section 136A.1355, subdivision 5, is amended to read:

Subd. 5. **LOAN FORGIVENESS; UNDERSERVED URBAN COMMUNITIES.** For ~~the period July 1, 1993 to June 30, 1995~~ fiscal years beginning on and after July 1, 1995, the higher education coordinating board may accept up to four applicants who are either fourth year medical students, or residents in family practice, pediatrics, or internal medicine per fiscal year for participation in the urban primary care physician loan forgiveness program. The resident applicants may be in any year of residency training; however, priority will be given to the following categories of residents in descending order: third year residents, second year residents, and first year residents. If the higher education coordinating board does not receive enough qualified applicants per fiscal year to fill the number of slots for urban underserved communities, the slots may be allocated to students or residents who have applied for the rural physician loan forgiveness program in subdivision 1. Applicants are responsible for securing their own loans. For purposes of this provision, "qualifying educational loans" are government and commercial loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional. Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed $10,000, as a qualified loan. For each year that a participant serves as a physician in a designated underserved urban area, up to a maximum of four years, the higher education coordinating board shall annually pay an amount equal to one year of qualified loans. Participants who move their practice from one designated underserved urban community to another remain eligible for loan repayment.

Sec. 25. Minnesota Statutes 1994, section 136A.1356, subdivision 3, is amended to read:

Subd. 3. **ELIGIBILITY.** To be eligible to participate in the program, a prospective midlevel practitioner must submit a letter of interest to the higher education coordinating board prior to or while attending a program of study designed to prepare the individual for service as a midlevel practitioner. ~~Before completing the first year of this program,~~ A midlevel practitioner student who is accepted into this program must sign a contract to agree to serve at least two of the first four years following graduation from the program in a designated rural area.

Sec. 26. Minnesota Statutes 1994, section 136A.1356, subdivision 4, is amended to read:

Subd. 4. **LOAN FORGIVENESS.** The higher education coordinating board may accept up to eight applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of midlevel practitioner study, up to a maximum of two years, an agreed amount, not to exceed $7,000, as a qualified loan. For purposes of this provision, "qualifying educational loans" are government and commercial loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional. For each year that a participant serves as a midlevel practitioner in a designated rural area, up to a maximum of four years, the higher education coordinating board shall annually repay an amount equal to one-half a qualified loan. Participants who move their practice from one designated rural area to another remain eligible for loan repayment.

Sec. 27. **[137.42] GRANTS FOR AREA HEALTH EDUCATION CENTER PROGRAMS.**

Subdivision 1. **GRANT APPLICATION.** The board of regents of the University of Minnesota, through the academic health center and the University of Minnesota-Duluth School of Medicine, is requested to apply for a federal Area Health Education Center Program grant. If awarded a grant, the University of Minnesota-Duluth School of Medicine, in cooperation with public or private, nonprofit area health education centers, is requested to plan, develop, and operate area health education center programs. The University of Minnesota-Duluth School of Medicine is requested to develop cooperative arrangements with two area health education centers in year two of the grant, and develop cooperative arrangements with an additional two centers in year three of the grant.

Subd. 2. **PROGRAM REQUIREMENTS.** Each program must:

(1) provide preceptorship educational experiences for health science students;

(2) maintain community-based primary care residency programs or be affiliated with such programs;

(3) maintain continuing education programs for health professionals or coordinate its activities with such programs;

(4) maintain learning resources and dissemination systems;

(5) have agreements with community-based organizations for educating and training health professionals;

(6) train health professionals, including nurses and allied health professionals; and

(7) carry out recruitment and health career awareness programs among minority and other students in medically underserved areas of the state.

Sec. 28. **[137.43] SUBSTITUTE PHYSICIAN DEMONSTRATION PROJECT.**

Subdivision 1. **ESTABLISHMENT.** The board of regents, through the University of Minnesota academic health center, is requested to establish and administer a substitute physician (locum tenens and emergency room coverage) demonstration project at up to four rural demonstration sites within the state. The academic health center is requested to coordinate the administration of the project with the commissioner of health and the office of rural health and primary health care.

Subd. 2. **PROJECT ACTIVITIES.** The project must:

(1) encourage physicians to serve as substitute physicians for the demonstration sites;

(2) provide a central register of physicians interested in serving as substitute physicians at the demonstration sites;

(3) provide a referral service for requests from demonstration sites for substitute physicians; and

(4) provide substitute physician services at rates that reflect the administrative savings resulting from centralized referral and credentialing.

Subd. 3. **CREDENTIALING; PROFESSIONAL EDUCATION.** The academic health center is requested to credential persons desiring to serve as substitute physicians. The academic health center may employ substitute physicians serving in the demonstration project as temporary clinical faculty and may provide substitute physicians with additional opportunities for professional education and interaction.

Subd. 4. **DEMONSTRATION SITES.** The academic health center is requested to designate up to four rural communities as demonstration sites for the project. The academic health center is requested to choose sites based on a community's need for substitute physician services and the willingness of the community to work cooperatively with the academic health center and participate in the demonstration project evaluation.

Sec. 29. Minnesota Statutes 1994, section 144.1464, subdivision 2, is amended to read:

Subd. 2. **CRITERIA.** (a) The commissioner, through the organization under contract, shall award grants to hospitals and clinics that agree to:

(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 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; and

(5) employ at least one secondary student for each post-secondary student employed, to the extent that there are sufficient qualifying secondary student applicants.

(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 enrolled in a Minnesota educational institution or be a resident of the state of Minnesota; priority must be given to applicants 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.

Sec. 30. Minnesota Statutes 1994, section 144.1464, subdivision 3, is amended to read:

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 secondary and post-secondary pupils in a hospital or clinic during the course of the program. No more than 50 percent of the participants may be post-secondary students, unless the program does not receive enough qualified

secondary applicants per fiscal year. No more than five pupils may be selected from any 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.

Sec. 31. Minnesota Statutes 1994, section 144.1464, subdivision 4, is amended to read:

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. Grant funds that are not used in one fiscal year may be carried over to the next fiscal year. 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. 32. Minnesota Statutes 1994, section 144.147, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 5,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 100 or fewer beds;

(3) is not for profit; and

(4) has not been awarded a grant under the federal rural health transition grant program, which would be received concurrently with any portion of the grant period for this program.

Sec. 33. Minnesota Statutes 1994, section 144.1484, subdivision 1, is amended to read:

Subdivision 1. **SOLE COMMUNITY HOSPITAL FINANCIAL ASSISTANCE GRANTS.** The commissioner of health shall award financial assistance grants to rural hospitals in isolated areas of the state. To qualify for a grant, a hospital must: (1) be eligible to be classified as a sole community hospital according to the criteria in Code of Federal Regulations, title 42, section 412.92 or be located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services; (2) have experienced net income losses in the two most recent consecutive hospital fiscal years for which audited financial information is available; (3) consist of 40 or fewer licensed beds; and (4) demonstrate to the commissioner that it has obtained local support for the hospital and that any state support awarded

under this program will not be used to supplant local support for the hospital. The commissioner shall review audited financial statements of the hospital to assess the extent of local support. Evidence of local support may include bonds issued by a local government entity such as a city, county, or hospital district for the purpose of financing hospital projects; and loans, grants, or donations to the hospital from local government entities, private organizations, or individuals. The commissioner shall determine the amount of the award to be given to each eligible hospital based on the hospital's ~~financial need~~ operating loss margin (total operating losses as a percentage of total operating revenue) for the two most recent consecutive fiscal years for which audited financial information is available and the total amount of funding available. One hundred percent of the available funds will be disbursed proportionately based on the operating loss margins of the eligible hospitals.

Sec. 34. Minnesota Statutes 1994, section 144.1486, subdivision 4, is amended to read:

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~~ seven-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;

(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 or was not served prior to establishment of a state-funded community health center by a federally certified medical organization.

Sec. 35. Minnesota Statutes 1994, section 144.1487, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** (a) For purposes of sections 144.1487 to 144.1492, the following ~~definitions apply~~ definition applies.

(b) ~~"Board" means the higher education coordinating board.~~

~~(c)~~ "Health professional shortage area" means an area designated as such by the federal Secretary of Health and Human Services, as provided under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E.

Sec. 36. Minnesota Statutes 1994, section 144.1488, subdivision 1, is amended to read:

Subdivision 1. **DUTIES OF THE COMMISSIONER OF HEALTH.** The commissioner shall administer the state loan repayment program. The commissioner shall:

(1) ensure that federal funds are used in accordance with program requirements established by the federal National Health Services Corps;

(2) notify potentially eligible loan repayment sites about the program;

(3) develop and disseminate application materials to sites;

(4) review and rank applications using the scoring criteria approved by the federal Department of Health and Human Services as part of the Minnesota department of health's National Health Services Corps state loan repayment program application;

(5) select sites that qualify for loan repayment based upon the availability of federal and state funding;

(6) ~~provide the higher education coordinating board with a list of qualifying sites; and~~

~~(7)~~ carry out other activities necessary to implement and administer sections 144.1487 to 144.1492.;

~~The commissioner shall enter into an interagency agreement with the higher education coordinating board to carry out the duties assigned to the board under sections 144.1487 to 144.1492.~~

(7) verify the eligibility of program participants;

(8) sign a contract with each participant that specifies the obligations of the participant and the state;

(9) arrange for the payment of qualifying educational loans for program participants;

(10) monitor the obligated service of program participants;

(11) waive or suspend service or payment obligations of participants in appropriate situations;

(12) place participants who fail to meet their obligations in default; and

(13) enforce penalties for default.

Sec. 37. Minnesota Statutes 1994, section 144.1488, subdivision 4, is amended to read:

Subd. 4. **ELIGIBLE HEALTH PROFESSIONALS.** (a) To be eligible to apply to the ~~higher education coordinating board~~ commissioner for the loan repayment program, health professionals must be citizens or nationals of the United States, must not have any unserved obligations for service to a federal, state, or local government, or other entity, and must be ready to begin full-time clinical practice upon signing a contract for obligated service.

(b) In selecting physicians for participation, the ~~board~~ commissioner shall give priority to physicians who are board certified or have completed a residency in family practice, osteopathic general practice, obstetrics and gynecology, internal medicine, or pediatrics. A physician selected for participation is not eligible for loan repayment until the physician has an employment agreement or contract with an eligible loan repayment site and has signed a contract for obligated service with the ~~higher education coordinating board~~ commissioner.

Sec. 38. Minnesota Statutes 1994, section 144.1489, subdivision 1, is amended to read:

Subdivision 1. **CONTRACT REQUIRED.** Before starting the period of obligated service, a participant must sign a contract with the ~~higher education coordinating board~~ commissioner that specifies the obligations of the participant and the ~~board~~ commissioner.

Sec. 39. Minnesota Statutes 1994, section 144.1489, subdivision 3, is amended to read:

Subd. 3. **LENGTH OF SERVICE.** Participants must agree to provide obligated service for a minimum of two years. A participant may extend a contract to provide obligated service for a third and fourth year, subject to board approval and the availability of federal and state funding.

Sec. 40. Minnesota Statutes 1994, section 144.1489, subdivision 4, is amended to read:

Subd. 4. **AFFIDAVIT OF SERVICE REQUIRED.** Within 30 days of the start of obligated service, and by February 1 of each succeeding calendar year, a participant shall submit an affidavit to the ~~board~~ commissioner stating that the participant is providing the obligated service and which is signed by a representative of the organizational entity in which the service is provided. Participants must provide written notice to the ~~board~~ commissioner within 30 days of: a

change in name or address, a decision not to fulfill a service obligation, or cessation of clinical practice.

Sec. 41. Minnesota Statutes 1994, section 144.1490, is amended to read:

144.1490 **RESPONSIBILITIES OF THE LOAN REPAYMENT PROGRAM.**

Subdivision 1. **LOAN REPAYMENT.** Subject to the availability of federal and state funds for the loan repayment program, the ~~higher education coordinating board~~ commissioner shall pay all or part of the qualifying education loans up to $20,000 annually for each primary care physician participant that fulfills the required service obligation. For purposes of this provision, "qualifying educational loans" are government and commercial loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

Subd. 2. **PROCEDURE FOR LOAN REPAYMENT.** Program participants, at the time of signing a contract, shall designate the qualifying loan or loans for which the ~~higher education coordinating board~~ commissioner is to make payments. The participant shall submit to the ~~board~~ commissioner all payment books for the designated loan or loans or all monthly billings for the designated loan or loans within five days of receipt. The ~~board~~ commissioner shall make payments in accordance with the terms and conditions of the designated loans, in an amount not to exceed $20,000 when annualized. If the amount paid by the ~~board~~ commissioner is less than $20,000 during a 12-month period, the ~~board~~ commissioner shall pay during the 12th month an additional amount towards a loan or loans designated by the participant, to bring the total paid to $20,000. The total amount paid by the ~~board~~ commissioner must not exceed the amount of principal and accrued interest of the designated loans.

Sec. 42. Minnesota Statutes 1994, section 144.1491, subdivision 2, is amended to read:

Subd. 2. **SUSPENSION OR WAIVER OF OBLIGATION.** Payment or service obligations cancel in the event of a participant's death. The ~~board~~ commissioner may waive or suspend payment or service obligations in case of total and permanent disability or long-term temporary disability lasting for more than two years. The ~~board~~ commissioner shall evaluate all other requests for suspension or waivers on a case-by-case basis.

Sec. 43. **[144.1493] NURSING GRANT PROGRAM.**

Subdivision 1. **ESTABLISHMENT.** A nursing grant program is established under the supervision of the commissioner of health and the administration of the metropolitan healthcare foundation's project LINC to provide grants to Minnesota health care facility employees seeking to complete a baccalaureate or master's degree in nursing.

Subd. 2. **RESPONSIBILITY OF METROPOLITAN HEALTHCARE FOUNDATION'S PROJECT LINC.** The metropolitan healthcare foundation's project LINC shall administer the grant program and award grants to eligible health care facility employees. To be eligible to receive a grant, a person must be:

(1) an employee of a health care facility located in Minnesota, whom the facility has recommended to the metropolitan healthcare foundation's project LINC for consideration;

(2) working part time, up to 32 hours per pay period, for the health care facility, while maintaining full salary and benefits;

(3) enrolled full time in a Minnesota school or college of nursing to complete a baccalaureate or master's degree in nursing; and

(4) a resident of the state of Minnesota.

The grant must be awarded for one academic year but is renewable for a maximum of six semesters or nine quarters of full-time study, or their equivalent. The grant must be used for tuition, fees, and books. Priority in awarding grants shall be given to persons with the greatest financial need. The health care facility may require its employee to commit to a reasonable postprogram completion of employment at the health care facility as a condition for the financial support the facility provides.

Subd. 3. **RESPONSIBILITY OF COMMISSIONER.** The commissioner shall distribute money each year to the metropolitan healthcare foundation's project LINC to be used to award grants under this section, provided that the commissioner shall not distribute the money unless the metropolitan healthcare foundation's project LINC matches the money with an equal amount from nonstate sources. The metropolitan healthcare foundation's project LINC shall expend nonstate money prior to expending state money and shall return to the commissioner all state money not used each year for nursing program grants to be redistributed under this section. The metropolitan healthcare foundation's project LINC shall report to the commissioner on its program activity as requested by the commissioner.

Sec. 44. Minnesota Statutes 1994, section 144.801, is amended by adding a subdivision to read:

Subd. 11. **FIRST RESPONDER.** "First responder" means an individual who is certified by the commissioner to perform, at a minimum, basic emergency skills before the arrival of a licensed ambulance service, and is:

(1) a member of an organized service recognized by a local political subdivision whose primary responsibility is to respond to medical emergencies to provide initial medical care before the arrival of a licensed ambulance service; or

(2) a member of an organized industrial medical first response team.

Sec. 45. Minnesota Statutes 1994, section 144.804, subdivision 1, is amended to read:

Subdivision 1. **DRIVERS AND ATTENDANTS.** No publicly or privately owned basic ambulance service shall be operated in the state unless its drivers and attendants possess a current emergency care course certificate authorized by rules adopted by the commissioner of health according to chapter 14. Until August 1, ~~1994~~ 1997, a licensee may substitute a person currently certified by the American Red Cross in advanced first aid and emergency care or a person who has successfully completed the United States Department of Transportation first responder curriculum, and who has also been trained to use basic life support equipment as required by rules adopted by the commissioner under section 144.804, subdivision 3, for one of the persons on a basic ambulance, provided that person will function as the driver while transporting a patient. The commissioner may grant a variance to allow a licensed ambulance service to use attendants certified by the American Red Cross in advanced first aid and emergency care and, until August 1, 1997, to use attendants who have successfully completed the United States Department of Transportation first responder curriculum, and who have been trained to use basic life support equipment as required by rules adopted by the commissioner under subdivision 3, in order to ensure 24-hour emergency ambulance coverage. The commissioner shall study the roles and responsibilities of first responder units and report the findings by January 1, 1991. This study shall address at a minimum:

(1) education and training;

(2) appropriate equipment and its use;

(3) medical direction and supervision; and

(4) supervisory and regulatory requirements.

Sec. 46. Minnesota Statutes 1994, section 148B.32, subdivision 1, is amended to read:

Subdivision 1. **UNLICENSED PRACTICE PROHIBITED.** After adoption of rules by the board implementing sections 148B.29 to 148B.39, no individual shall engage in marriage and family therapy practice unless that individual holds a valid license issued under sections 148B.29 to 148B.39.

~~Marriage and family therapy practice is not medical care nor any other type of remedial care that may be reimbursed under medical assistance, chapter 256B, except to the extent such care is reimbursed under section 256B.0625, subdivision 5.~~ Marriage and family therapists may not be reimbursed under medical assistance, chapter 256B, except to the extent such care is reimbursed under section 256B.0625, subdivision 5, or when marriage and family therapists are employed by a managed care organization with a contract to provide mental health care to medical assistance enrollees, and are reimbursed through the managed care organization.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 47. Laws 1993, chapter 224, article 4, section 40, is amended to read:

Sec. 40. **INTEGRATED CHILDREN'S DATABASE.**

Subdivision 1. **PLAN.** The departments of education, administration, health and human services, and the office of strategic and long-range planning shall jointly develop a plan for an integrated statewide children's service database. The plan must contain common essential data elements that include all children from birth through kindergarten enrollment by July 1, 1995. The essential data elements shall be the basis for a statewide children's service database. Initial service areas shall include but are not limited to: early childhood and family education, ECFE tribal schools, children with special health care needs, learning readiness, way to grow, early childhood special education part H, even start, school health, home visitor, lead poisoning screening, child care resources and referral, child care service development, child trust fund, migrant child care, dependent child care, headstart and community resource program.

In developing a plan for a statewide integrated children's database the joint planning team must:

(1) conduct a high-level needs analysis of service delivery and reporting and decision making areas;

(2) catalogue current information systems;

(3) establish outcomes for developing systems;

(4) analyze the needs of individuals and organizations that will use the system; and

(5) identify barriers to sharing information and recommend changes to the Data Practices Act to remove those barriers.

Subd. 2. **DATA STORAGE.** The departments of education, administration, corrections, health and human services, and the office of strategic and long-range planning must provide to the legislature by January 30, 1995, a plan for storing essential data elements for family service centers to use. This plan will include reporting of data to the state as a by-product of both family service and school district internal operations.

Subd. 3. **AGENCY SYSTEM INTEGRATION.** Any state agency or department with programs serving children that is designing or redesigning its information system must ensure that the resulting information system can be fully integrated into the statewide children's service database by June 30, 1995. Agencies or departments must submit plans to design or redesign information systems for review by the information policy office to ensure that agency or department information can be fully integrated into the statewide children's service database.

Sec. 48. Laws 1990, chapter 591, article 4, section 9, is amended to read:

Sec. 9. **SUNSET.**

Sections ~~1 to~~ 2, 3, 4, and 6, are repealed on June 30, 1995.

Sec. 49. Laws 1994, chapter 625, article 5, section 7, is amended to read:

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, commerce, and labor and industry shall develop a 24-hour coverage plan, on a pilot project basis, ~~incorporating and~~ coordinating the ~~health component~~ medical benefits of workers' compensation with health care ~~coverage~~ benefits to be offered by an integrated service network, health maintenance organization, or an insurer or self-insured employer under chapters 79, 79A, 176, 181, 62C, 62D, 62H, and 62N. The commissioners shall ~~also make~~ provide the plan and recommendations of any legislative changes that may be needed to implement this plan, to the legislature by January 15, 1996.

Sec. 50. Laws 1994, chapter 625, article 5, section 10, subdivision 2, is amended to read:

Subd. 2. **SCOPE OF STUDY.** The commissioner of health shall ~~continue the study developed as part of Minnesota Statutes, section 62J.045, on~~ study 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~~ 1996.

Sec. 51. **MALPRACTICE REFORM STUDY.**

The attorney general shall study issues related to medical malpractice reform and shall present to the legislature, by December 15, 1995, recommendations and draft legislation for medical malpractice reforms that will reduce health care costs in Minnesota. In developing these recommendations, the attorney general shall consider medical malpractice laws in other states, with particular attention to medical malpractice laws in California.

Sec. 52. **HEALTH COVERAGE DEMONSTRATION PROJECT.**

Subdivision 1. **ESTABLISHMENT.** The commissioner of health shall award a grant to regional coordinating board five to develop a pilot project to provide information about health coverage and advocacy services to individuals

obtaining health care services within the geographic area served by the regional coordinating board. The board may contract with a nonprofit organization to develop and administer the pilot project. The pilot project must:

(1) provide individuals with assistance in interpreting the terms of their certificate, contract, or policy of health coverage, including but not limited to, terms relating to covered services, limitations on services, limitations on access to providers, and enrollee complaint and appeal procedures;

(2) maintain a current listing of health care providers serving health plan company enrollees within regional coordinating board five and assist individuals in determining whether services provided by a specific provider are covered under the health plan;

(3) assist and serve as advocates for enrollees in the complaint and appeals process; and

(4) provide information supplied by the health plan companies to individuals obtaining health care services within the geographic area served by the regional coordinating board regarding each company's expenditure and activity dedicated directly to community-based prevention and health promotion. The information supplied by the health plan company shall include a description of the community-based prevention and health promotion projects conducted or to be conducted in the geographic area served by the regional coordinating board.

The commissioner of health and the commissioner of commerce shall require all health plan companies serving enrollees within regional coordinating board five to regularly provide the regional coordinating board, or the entity under contract with the board, with current listings of providers and current certificates, contracts, or policies of coverage.

Subd. 2. **EVALUATION.** The commissioner of health, through the office of rural health and in consultation with the commissioner of commerce, shall evaluate the effectiveness of the pilot project. The commissioner of health shall recommend to the legislature by January 15, 1997, whether the pilot project should be extended beyond the sunset date, and whether the services provided by the pilot project should be made available to enrollees living within the areas served by other regional coordinating boards.

Subd. 3. **SUNSET.** This section expires July 1, 1997.

Sec. 53. **SURVEY OF LICENSURE RENEWAL.**

The legislative commission on health care access shall survey medical doctors and doctors of osteopathy who have discontinued their Minnesota licenses. The survey must identify the reasons why licensed physicians fail to renew licenses and determine whether the loss of licensed physicians is resulting in increased problems in accessing medical care. The legislative commission on health care access shall report survey findings to the legislature by December 15, 1995.

Sec. 54. **ALTERNATIVE LICENSING MODEL FOR RURAL HOSPITALS.**

The rural health advisory committee shall examine rural health care access needs and present recommendations on the need for an alternative licensing model for rural hospitals.

The committee must first examine:

(1) the projected demographics of rural populations;

(2) access to emergency care, obstetrics, and other traditional hospital-based services;

(3) access issues related to transportation;

(4) health care needs of different regions of the state, including those areas where access to care may be threatened by the financial instability of local hospitals; and

(5) other factors related to access to rural health care and hospital-based services.

Based upon this examination of access to health care in rural areas, the committee shall evaluate the need for and the feasibility of implementing an alternative licensing model for rural hospitals. This evaluation must consider:

(1) the goals of an alternative licensing model;

(2) federal and state regulatory barriers and options for reconfiguring traditional hospital-based health care services; and

(3) the feasibility of implementing an alternative licensing model, including the potential for integration with integrated networks and likelihood of obtaining a Medicare waiver and other necessary federal law changes.

If the committee determines that a need for an alternative licensing model exists and implementation is feasible, the committee shall identify changes needed in federal and state law, and develop draft legislation for a Minnesota-specific alternative licensing model.

The committee shall present a report to the legislature by December 15, 1996. This report must summarize rural access needs and present initial recommendations on the need for an alternative licensing model for rural hospitals.

Sec. 55. **STUDY OF REGULATORY BARRIERS.**

The rural health advisory committee, in consultation with the regional coordination boards, shall examine federal and state regulatory barriers that limit rural access to care or limit the ability of rural health care providers to provide care efficiently, without improving the quality of care. The commissioner of

health shall provide staff and technical assistance to the advisory committee and the regional coordinating boards. The commissioner shall apply for federal and private-sector grants and seek other nonstate sources of funding to supplement state funds appropriated for this study. The barriers to be studied must include, but are not limited to:

(1) requirements for emergency room staffing that increase hospital costs and limit access to care;

(2) limits on the ability of nurses to prescribe and administer prescription drugs under a physician's supervision in emergency situations;

(3) state and federal inspection and regulatory requirements that are duplicative and increase administrative costs;

(4) physician supervision requirements that limit the use of physician assistants; and

(5) the requirement that a hospital and its attached nursing home have separate directors of nursing.

The advisory committee shall present recommendations for eliminating these and other regulatory barriers to the commissioner of health by December 1, 1995. The commissioner of health shall consider these recommendations and shall present recommendations and draft legislation to the legislature on any needed changes in state and federal regulatory requirements, by February 1, 1996.

Sec. 56. **REVISOR INSTRUCTION.**

(a) The revisor of statutes is instructed to change the term "children's health plan" and similar terms to "MinnesotaCare program" and similar terms, wherever in Minnesota Statutes and Minnesota Rules the term "children's health plan" and similar terms appear, including the revisor's heading that immediately precedes Minnesota Statutes 1994, section 256.9351, except that the revisor shall retain the reference to "children's health plan" in Minnesota Statutes, section 256.9357, subdivision 1.

(b) The revisor of statutes is instructed to change the title of Minnesota Statutes, chapter 62Q, to "REQUIREMENTS FOR HEALTH PLAN COMPANIES."

Sec. 57. **REPEALER.**

Minnesota Statutes 1994, sections 62J.045; 62J.07, subdivision 4; 62J.09, subdivision 1a; 62J.19; 62J.65; 144.1488, subdivision 2; and 148.236, are repealed.

Laws 1993, chapter 247, article 1, sections 12, 13, 14, 15, 18, and 19, are repealed.

Sec. 58. **EFFECTIVE DATE.**

Sections 31 to 34, 39, and 48 are effective the day following final enactment.

ARTICLE 9

FINANCING

Section 1. Minnesota Statutes 1994, section 16A.724, is amended to read:

16A.724 **HEALTH CARE ACCESS FUND.**

A health care access fund is created in the state treasury. The fund is a direct appropriated special revenue fund. The commissioner shall deposit to the credit of the fund money made available to the fund. Notwithstanding section 11A.20, after June 30, 1997, all investment income and all investment losses attributable to the investment of the health care access fund not currently needed shall be credited to the health care access fund.

Sec. 2. Minnesota Statutes 1994, section 151.48, is amended to read:

151.48 **OUT-OF-STATE WHOLESALE DRUG DISTRIBUTOR LICENSING REQUIREMENTS.**

(a) It is unlawful for an out-of-state wholesale drug distributor to conduct business in the state without first obtaining a license from the board and paying the required fee.

(b) Application for an out-of-state wholesale drug distributor license under this section shall be made on a form furnished by the board.

(c) ~~The issuance of a license under sections 151.42 to 151.51 shall not change or affect tax liability imposed by the department of revenue on any out-of-state wholesale drug distributor.~~

~~(d)~~ No person acting as principal or agent for any out-of-state wholesale drug distributor may sell or distribute drugs in the state unless the distributor has obtained a license.

~~(e)~~ (d) The board may adopt regulations that permit out-of-state wholesale drug distributors to obtain a license on the basis of reciprocity to the extent that an out-of-state wholesale drug distributor:

(1) possesses a valid license granted by another state under legal standards comparable to those that must be met by a wholesale drug distributor of this state as prerequisites for obtaining a license under the laws of this state; and

(2) can show that the other state would extend reciprocal treatment under its own laws to a wholesale drug distributor of this state.

Sec. 3. Minnesota Statutes 1994, section 270.101, subdivision 1, is amended to read:

Subdivision 1. **LIABILITY IMPOSED.** A person who, either singly or jointly with others, has the control of, supervision of, or responsibility for filing returns or reports, paying taxes, or collecting or withholding and remitting taxes and who fails to do so, or a person who is liable under any other law, is liable for the payment of taxes, penalties, and interest arising under chapters 295, 296, 297, 297A, and 297C, or sections 290.92 and 297E.02.

Sec. 4. Minnesota Statutes 1994, section 295.50, subdivision 3, is amended to read:

Subd. 3. **GROSS REVENUES.** "Gross revenues" are total amounts received in money or otherwise by:

(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 or patient services provided in Minnesota;

(7) a wholesale drug distributor for sale or distribution of 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 legend drugs are delivered to another wholesale drug distributor who sells legend drugs exclusively at wholesale. Legend drugs do not include nutritional products as defined in Minnesota Rules, part 9505.0325;

(8) a staff model health 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 provided to consumers domiciled in Minnesota or delivered into Minnesota.

Sec. 5. Minnesota Statutes 1994, section 295.50, subdivision 4, is amended to read:

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. For purposes of this clause, "directly to a patient or consumer" includes goods and services provided in connection with independent medical examinations under section 65B.56 or other examinations for purposes of litigation or insurance claims;

(2) a staff model health 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. 6. Minnesota Statutes 1994, section 295.50, subdivision 10a, is amended to read:

Subd. 10a. **PHARMACY.** "Pharmacy" means a pharmacy~~, as defined in section 151.01~~ required to be licensed under chapter 151, or a pharmacy required to be licensed by any other jurisdiction.

Sec. 7. Minnesota Statutes 1994, section 295.53, subdivision 1, is amended to read:

Subdivision 1. **EXEMPTIONS.** (a) 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~~ Medicare enrollee or by ~~insurer or other third party~~ a Medicare supplemental coverage as defined in section 62A.011, subdivision 3, clause (10). 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 legend drugs, other than nutritional products, to a wholesale drug distributor reduced by reimbursements received for 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;

(8) payments received for providing services under the MinnesotaCare program including payments received directly from the government or from a prepaid plan and enrollee deductibles, coinsurance, and copayments~~;~~. For purposes of this clause, coinsurance means the portion of payment that the enrollee is required to pay for the covered service;

(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~~ incurred through a formal program of health care research conducted in conformity with federal regulations governing research on human subjects. Payments received from patients or from other persons paying on behalf of the patients are subject to tax;

(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;

(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.

(b) Payments received by wholesale drug distributors for prescription drugs sold directly to veterinarians or veterinary bulk purchasing organizations are excluded from the gross revenues subject to the wholesale drug distributor tax under sections 295.50 to 295.59.

Sec. 8. Minnesota Statutes 1994, section 295.53, subdivision 3, is amended to read:

Subd. 3. ~~**RESTRICTION ON ITEMIZATION**~~ **SEPARATE STATEMENT OF TAX.** A hospital, surgical center, pharmacy, or health care provider must not ~~separately~~ state the tax obligation under section 295.52 ~~on bills provided to individual patients~~ in a deceptive or misleading manner. It must not separately state tax obligations on bills provided to patients, consumers, or other payers when the amount received for the services or goods is not subject to tax.

Pharmacies that separately state the tax obligations on bills provided to consumers or to other payers who purchase legend drugs may state the tax obligation as two percent of the wholesale price of the legend drugs. Pharmacies must not state the tax obligation as two percent of the retail price.

Whenever the commissioner determines that a person has engaged in any act or practice constituting a violation of this subdivision, the commissioner may bring an action in the name of the state in the district court of the appropriate county to enjoin the act or practice and to enforce compliance with this subdivision, or the commissioner may refer the matter to the attorney general or the county attorney of the appropriate county. Upon a proper showing, a permanent or temporary injunction, restraining order, or other appropriate relief must be granted.

Sec. 9. Minnesota Statutes 1994, section 295.53, subdivision 4, is amended to read:

Subd. 4. **DEDUCTION FOR RESEARCH.** (a) In addition to the exemptions allowed under subdivision 1, a hospital or health care provider which is exempt under section 501(c)(3) of the Internal Revenue Code of 1986 or is owned and operated under authority of a governmental unit, may deduct from its gross revenues subject to the hospital or health care provider taxes under sections 295.50 to 295.57 revenues equal to expenditures for allowable research programs.

(b) For purposes of this subdivision, expenditures for allowable research programs are the direct and general program costs for activities which are part of a formal program of medical and health care research approved by the governing body of the hospital or health care provider which also includes active solicitation of research funds from government and private sources. ~~Any~~ Allowable research ~~on humans or animals~~ must:

(1) have as its purpose the development of new knowledge in basic or applied science relating to the diagnosis and treatment of conditions affecting the human body;

(2) be subject to review ~~by appropriate regulatory committees~~ by individuals with expertise in the subject matter of the proposed study but who have no financial interest in the proposed study and are not involved in the conduct of the proposed study; and

(3) be subject to review and supervision by an institutional review board operating in conformity with federal regulations ~~such as an institutional review board~~ if the research involves human subjects or an institutional animal care and use committee operating in conformity with federal regulations if the research involves animal subjects. Research expenses are not exempt if the study is a routine evaluation of health care methods or products used in a particular setting conducted for the purpose of making a management decision. Costs of clinical research activities paid directly for the benefit of an individual patient are excluded from this exemption. Basic research in fields including biochemistry, molecular biology, and physiology are also included if such programs are subject to a peer review process.

(c) No deduction shall be allowed under this subdivision for any revenue received by the hospital or health care provider in the form of a grant, gift, or otherwise, whether from a government or nongovernment source, on which the tax liability under section 295.52 is not imposed or for which the tax liability under section 295.52 has been received from a third party as provided for in section 295.582.

(d) Effective beginning with calendar year 1995, the taxpayer shall not take the deduction under this section into account in determining estimated tax payments or the payment made with the annual return under section 295.55. The

total deduction allowable to all taxpayers under this section for calendar years beginning after December 31, 1994, may not exceed $65,000,000. To implement this limit, each qualifying hospital and qualifying health care provider shall submit to the commissioner by March 15 its total expenditures qualifying for the deduction under this section for the previous calendar year. The commissioner shall sum the total expenditures of all taxpayers qualifying under this section for the calendar year. If the resulting amount exceeds $65,000,000, the commissioner shall allocate a part of the $65,000,000 deduction limit to each qualifying hospital and health care provider in proportion to its share of the total deductions. The commissioner shall pay a refund to each qualifying hospital or provider equal to its share of the deduction limit multiplied by two percent. The commissioner shall pay the refund no later than May 15 of the calendar year.

Sec. 10. Minnesota Statutes 1994, section 295.55, subdivision 4, is amended to read:

Subd. 4. **ELECTRONIC FUNDS TRANSFER PAYMENTS.** ~~A taxpayer with an aggregate tax liability of $30,000 or more during a calendar quarter ending the last day of March, June, September, or December of the first year the taxpayer is subject to the tax must remit all liabilities by means of a funds transfer as defined in section 336.4A-104, paragraph (a), for the remainder of the year.~~ A taxpayer with an aggregate tax liability of $120,000 or more during a ~~calendar~~ fiscal year ending June 30, must remit all liabilities by means of a funds transfer as defined in section 336.4A-104, paragraph (a), in the subsequent calendar year. The funds transfer payment date, as defined in section 336.4A-401, is on or before the date the tax is due. If the date the tax is due is not a funds-transfer business day, as defined in section 336.4A-105, paragraph (a), clause (4), the payment date is on or before the first funds-transfer business day after the date the tax is due.

Sec. 11. **[295.56] TRANSFER OF ACCOUNTS RECEIVABLE.**

When a hospital or health care provider transfers, assigns, or sells accounts receivable to another person who is subject to tax under this chapter, liability for the tax on the accounts receivable is imposed on the transferee, assignee, or buyer of the accounts receivable. No liability for these accounts receivable is imposed on the transferor, assignor, or seller of the accounts receivable.

Sec. 12. Minnesota Statutes 1994, section 295.57, is amended to read:

295.57 **COLLECTION AND ENFORCEMENT; REFUNDS; RULEMAKING; APPLICATION OF OTHER CHAPTERS; ACCESS TO RECORDS.**

Subdivision 1. **APPLICATION OF OTHER CHAPTERS.** Unless specifically provided otherwise by sections 295.50 to 295.58, the enforcement, interest, and penalty provisions under chapter 294, appeal provisions in sections 289A.43 and 289A.65, criminal penalties in section 289A.63, and refunds provisions in section 289A.50, and collection and rulemaking provisions under chapter 270, apply to a liability for the taxes imposed under sections 295.50 to 295.58.

Subd. 2. **ACCESS TO RECORDS.** For purposes of administering the taxes imposed by sections 295.50 to 295.59, the commissioner may access patients' records that contain billing or other financial information without prior consent from the patients. The data collected is classified as private or nonpublic data.

Sec. 13. **[295.581] PROHIBITION ON NON-MINNESOTACARE TRANSFERS FROM FUND.**

Notwithstanding any law to the contrary, and notwithstanding section 645.33, money in the health care access fund shall be appropriated only for purposes that are consistent with past and current MinnesotaCare appropriations in Laws 1992, chapter 549; Laws 1993, chapter 345; Laws 1994, chapter 625; and this act or for initiatives that are part of the section 1115 of the Social Security Act health care reform waiver submitted to the federal health care financing administration by the commissioner of human services as appropriated in this act.

Sec. 14. Minnesota Statutes 1994, 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 additional expense transferred to the third-party purchaser must not exceed two percent of the gross revenues received under the third-party contract, ~~plus~~ and 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, 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 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 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 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. 15. **EFFECTIVE DATE.**

Sections 2 and 6 are effective the day following final enactment.

Sections 3, 7, and 10 are effective for tax periods beginning on or after January 1, 1996.

Section 4 is effective for services provided on or after July 1, 1995.

Section 5 is effective January 1, 1995.

Section 8 is effective for statements of the tax made on or after July 1, 1995.

Section 9 is effective for research deductions incurred on or after July 1, 1995.

Section 11 is effective for transfers of accounts receivable on or after July 1, 1995.

Section 12 is effective for audits conducted on or after the day following final enactment.

Section 13, prohibiting non-MinnesotaCare transfers from the health care access fund, is effective the day following final enactment.

ARTICLE 10

HEALTH PROVIDER COOPERATIVES

Section 1. **[62R.17] PROVIDER COOPERATIVE DEMONSTRATION.**

A health provider cooperative incorporated and having adopted bylaws before May 1, 1995, that has members who provide services in Sibley, Nicollet, Blue Earth, Brown, Watonwan, Martin, Faribault, Waseca, and LeSueur counties, may contract with a qualified employer or self-insured employer plan to provide health care services in accordance with sections 62R.17 to 62R.26. The health provider cooperative, the qualified employer, or the self-insured employer plan shall not, solely on account of that contract, be subject to any provision of

Minnesota Statutes relating to health carriers except as provided in section 62R.21. The grant of contracting power under this section shall not be interpreted to permit or prohibit any other lawful arrangement between a health care provider and a self-insured employee welfare benefit plan or its sponsor.

Sec. 2. **[62R.18] DEFINITIONS.**

Subdivision 1. **APPLICATION.** For purposes of sections 62R.17 to 62R.26, the terms defined in this section have the meanings given.

Subd. 2. **HEALTH CARRIER.** "Health carrier" means a health carrier as defined in section 62A.011.

Subd. 3. **PLAN PARTICIPANT.** "Plan participant" means an eligible employee or retiree of a qualified employer or an eligible dependent of an employee or retired employee of a qualified employer.

Subd. 4. **QUALIFIED EMPLOYER.** "Qualified employer" means an employer sponsoring or maintaining a self-insured employer plan meeting the requirements of sections 62R.19 and 62R.21.

Subd. 5. **SELF-INSURED EMPLOYER PLAN.** "Self-insured employer plan" means a plan, fund, or program established or maintained by a qualified employer on or before January 1, 1995, for the purpose of providing medical, surgical, hospital, or other health care benefits to plan participants primarily on a self-insured basis. A governmental joint self-insurance plan established under chapter 471 is a self-insured employer plan for purposes of this definition.

Sec. 3. **[62R.19] STOP LOSS REQUIREMENT.**

A health provider cooperative shall not contract with a qualified employer or self-insured employer plan under section 62R.17 unless the qualified employer or self-insured employer plan maintains a policy of stop loss or excess loss insurance from an insurance company licensed to do business in this state in accordance with the following:

(1) A qualified employer with more than 750 employees as defined in section 62L.02 must not maintain a policy of stop loss, excess loss, or similar coverage with an attachment point less than 120 percent of the self-insured employer plan's annual expected benefit costs;

(2) A qualified employer with 200 or more but fewer than 750 employees as defined in section 62L.02 must maintain a policy providing aggregate stop loss insurance with an annual attachment point of no less than 120 percent of the self-insured employer plan's annual expected benefit costs and providing individual stop loss coverage with a deductible of no less than $10,000; and

(3) A qualified employer with fewer than 200 employees as defined in section 62L.02 must maintain a policy meeting the requirements of section 60A.235.

Sec. 4. **[62R.20] CONTRACT REQUIREMENTS.**

Any contract for health care services described in section 62R.17 is subject to the following requirements:

(1) The contract must be structured so that the health provider cooperative does not bear financial risk in excess of 50 percent of the self-insured employer plan's expected annual costs.

(2) The contract must not be effective prior to January 1, 1996.

(3) The contract must be limited to those services regularly provided by the cooperative or its members.

(4) The contract must obligate the qualified employer to maintain its self-insured employer plan in accordance with section 62R.21.

Sec. 5. **[62R.21] PLAN REQUIREMENTS.**

The requirements described in section 62R.20, clause (4), are as follows:

(1) The plan shall 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.

(2) Contributions to the cost of the self-insured employer plan from plan participants must not be based upon the gender of the plan participant.

Sec. 6. **[62R.22] PARTICIPANT HOLD HARMLESS.**

The health provider cooperative and its members and patrons must not have recourse against the plan participants of any self-insured employer plan with which the cooperative has contracted in accordance with sections 62R.17 to 62R.26, except for collection of copayments, coinsurance, or deductibles, or for health care services rendered that are not covered by the self-insured employer plan or that are in excess of the lifetime maximum benefit limit. This requirement applies to, but is not limited to, nonpayment of the cooperative by the self-insured employer plan or qualified employer, insolvency of the qualified employer, insolvency of the health provider cooperative, or nonpayment by the cooperative to the cooperative member or patron.

Sec. 7. **[62R.23] CONTINUATION OF CARE.**

In the event of the insolvency or bankruptcy of a qualified employer, a health provider cooperative described in section 62R.17 and its members shall continue to deliver the contracted health care services to plan participants for a period of 30 days, whether or not the cooperative receives payment from the qualified employer, its estate in bankruptcy, or from the self-insured employer plan. Section 62R.22 applies to this section. Nothing in this section, however,

limits the right of the cooperative to seek payment from the qualified employer, its estate, or the self-insured employer plan for services so rendered.

Sec. 8. **[62R.24] TAXES AND ASSESSMENTS.**

Effective January 1, 1998, as a condition to entering a contract described in section 62R.17, a self-insured employer plan or the qualified employer must voluntarily pay the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d), and assessments by the Minnesota Comprehensive Health Association.

Sec. 9. **[62R.25] NOTIFICATION OF CONTRACT; REPORT TO LEGISLATURE.**

(a) Each health provider cooperative shall notify the Office of Rural Health in writing upon entering a contract described in section 62R.17.

(b) The Department of Health, Office of Rural Health, shall provide an information report to the MinnesotaCare Finance Division of the House Health and Human Services Committee and the Senate Health Care Committee no later than January 15, 1999, on the status of direct contracting between health provider cooperatives and self-insured employer plans or qualified employers in accordance with sections 62R.17 to 62R.26. The report shall consider the effects on public policy and on health provider cooperatives of a possible requirement that health provider cooperatives using direct contracting be obligated to become community integrated service networks.

Sec. 10. **[62R.26] SUNSET.**

Sections 62R.17 to 62R.25 expire on December 31, 1999.

Sec. 11. **EFFECTIVE DATE.**

Sections 1 to 10 are effective the day following final enactment.

ARTICLE 11

APPROPRIATIONS

Section 1. **APPROPRIATIONS; SUMMARY.**

Except as otherwise provided in this act, the sums set forth in the columns designated "fiscal year 1996" and "fiscal year 1997" are appropriated from the general fund, or other named fund, to the agencies for the purposes specified in this act for the fiscal years ending June 30, 1996, and June 30, 1997.

Sec. 2. APPROPRIATIONS

SUMMARY BY FUND

	1996	1997	TOTAL
Health Care Access Fund	$ 98,472,000	$145,882,000	$244,354,000
State Government Special Revenue	$ 413,000	$ 557,000	$ 970,000

Subdivision 1. Department of Human Services

Health Care Access Fund	$ 85,420,000	$133,740,000	$219,160,000

FEDERAL RECEIPTS FOR ADMINISTRATION. Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota Health Care Reform Waiver shall be deposited as a nondedicated revenue to the Health Care Access Fund, while receipts received as a result of federal participation pertaining to grants shall be deposited to the federal fund and shall offset health care access funds for payments to providers.

1115 WAIVER Of this appropriation $695,000 in the fiscal year beginning July 1, 1995 and $855,000 in the fiscal year beginning July 1, 1996, is for administration of the section 1115 federal waiver. This appropriation shall not become part of the base for the fiscal year 1998-1999 biennium.

SENIOR DRUG PROGRAM ADMINISTRATION. Fees for the senior drug discount program are appropriated to and may be retained by the commissioner in the health care access fund for the purpose of administration of enrollment for the program.

Subd. 2. Department of Employee Relations

Health Care Access Fund	1,000,000	-0-	1,000,000

Subd. 3. Department of Health

Health Care Access Fund	7,609,000	7,528,000	15,137,000
State Government Special Revenue	413,000	557,000	970,000

1-800 PHONE LINE. Of this appropriation, $90,000 is for the fiscal year beginning July 1, 1996, for the operation of a 1-800 resource phone line for information on programs and services with children with special health care needs, and to conduct outreach and communications activities related to this resource phone line. The commissioner shall evaluate the effectiveness of this program and report to the House MinnesotaCare Finance Division and the Senate Health Care Committee by January 15, 1997. This appropriation shall not become part of the base for the fiscal year 1998-1999 biennium.

HEALTH COVERAGE DEMONSTRATION GRANT. Of this appropriation, $100,000 is for the fiscal year beginning July 1, 1996, for implementation of the health coverage demonstration project. This appropriation shall not become part of the base for the fiscal year 1998-1999 biennium.

STATE GOVERNMENT SPECIAL REVENUE FUND. Fees collected from integrated service networks and community integrated service networks shall be deposited in the state government special revenue fund.

COMPARATIVE PERFORMANCE MEASURES. Of this appropriation, $150,000 for the fiscal year beginning July 1, 1995, and $150,000 for the fiscal year beginning July 1, 1996, is for a grant to the Minnesota Health Data Institute, to transfer the responsibility for the development and implementation of comparative performance measurement.

ALTERNATIVE LICENSING. Of this appropriation, $50,000 for the fiscal year beginning July 1, 1995, is for an evaluation of alternative hospital licensing models. Unspent funds may be carried forward to the fiscal year beginning July 1, 1996.

Subd. 4. University of Minnesota

Health Care Access Fund	2,867,000	3,082,000	5,949,000

AHEC GRANT. Of this appropriation, $100,000 for the fiscal year beginning July 1, 1996, is to match federal funding received through the area health education center grant applied for under Minnesota Statutes, section 137.42. This appropriation is available to the board of regents only if the University of Minnesota-Duluth School of Medicine receives a federal area health education center grant. This appropriation shall not become part of the base for the fiscal year 1998-1999 biennium.

PHYSICIAN SUBSTITUTE DEMONSTRATION PROJECT. Of this appropriation, $85,000 for the fiscal year beginning July 1, 1995, is for costs incurred by the academic health center in credentialing physician substitutes and employing physician substitutes as temporary clinical faculty under Minnesota Statutes, section 137.43. The academic health center must report to the House MinnesotaCare Finance Division and the Senate Health Care Committee by February 15, 1996, on progress in credentially and employing physician substitutes under Minnesota Statutes, section 137.43. Unspent funds may be carried forward to the fiscal year beginning July 1. 1996.

PRIMARY CARE TRAINING INITIATIVE. Of this appropriation, $125,000 for the fiscal year beginning

July 1, 1995, and $125,000 for the fiscal year beginning July 1, 1996, is for increasing the number of primary care physicians in Minnesota as requested in Minnesota Statutes, section 137.38, subdivision 3. This appropriation is available only if the University can provide evidence of matching funding. This appropriation shall not become part of the base for the fiscal year 1998-1999 biennium.

INDIGENT DENTAL CARE. Of this appropriation, $300,000 for the fiscal year beginning July 1, 1995, and $300,000 for the fiscal year beginning July 1, 1996, is to cover the cost of indigent care at the University of Minnesota Dental School. This appropriation shall not become part of the base for the fiscal year 1998-1999 biennium.* **(The preceding paragraph beginning "INDIGENT DENTAL CARE." was vetoed by the governor.)**

UMD MEDICAL SCHOOL. Of this appropriation, $200,000 for the fiscal year beginning July 1, 1996, is for the University of Minnesota-Duluth. This appropriation shall not become part of the base for the fiscal year 1998-1999 biennium.* **(The preceding paragraph beginning "UMD MEDICAL SCHOOL." was vetoed by the governor.)**

Subd. 5. Department of Revenue			
Health Care Access Fund	1,375,000	1,381,000	2,756,000
Subd. 6. Department of Commerce			
Health Care Access Fund	26,000	26,000	52,000
Subd. 7. Legislative Coordinating Commission			
Health Care Access Fund	175,000	125,000	300,000

Presented to the governor May 23, 1995

Signed by the governor May 25, 1995, 2:32 p.m.

CHAPTER 235—S.F.No. 579

An act relating to commerce; regulating charitable organizations; regulating filing statement; appropriating money; amending Minnesota Statutes 1994, sections 309.501, subdivision 1; 309.52, subdivisions 2 and 7; 309.53, subdivisions 1, 2, 3, and 8; 309.531, subdivisions 1 and 4; 309.54, subdivision 1; 309.556, subdivision 1; 501B.36; 501B.37, subdivision 2, and by adding a subdivision; and 501B.38; repealing Minnesota Statutes 1994, section 309.53, subdivision 1a.

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

Section 1. Minnesota Statutes 1994, section 309.501, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** (a) As used in this section, the following terms have the meanings given them.

(b) "Registered combined charitable organization" means a federated funding organization:

(1) which is tax exempt under section 501(c)3 of the Internal Revenue Code of 1986, as amended through December 31, 1992 (hereinafter "Internal Revenue Code"), and to which contributions are deductible under section 170 of the Internal Revenue Code;

(2) which exists for purposes other than solely fundraising;

(3) which secures funds for distribution to 14 or more affiliated agencies in a single, annual consolidated effort;

(4) which is governed either by a local, independent, voluntary board of directors which represents the broad interests of the public and 90 percent of the directors of the governing board live or work in the community or surrounding area or, if the charitable agencies are solely educational institutions which meet the requirements of paragraph (c), by a national board of directors that has a local advisory board composed of members who live or work in the community or surrounding area;

(5) which distributes at least 70 percent of its total campaign income and revenue, plus donor designated amounts raised to its affiliated agencies and to the designated agencies it supports and expends no more than 30 percent of its total income and revenue, plus donor designated amounts raised for management and general costs and fund raising costs;