(1) delivery of contributions collected by a member of the candidate's committee, such as a block worker or a volunteer who hosts a fundraising event, to the committee's treasurer; and

(2) a delivery made by an individual on behalf of the individual's spouse.

Notwithstanding sections 211A.02, subdivision 3, and 410.21, this section supersedes any home rule charter.

Sec. 2. **[211A.14] CONTRIBUTIONS AND SOLICITATIONS DURING LEGISLATIVE SESSION.**

A legislator or state constitutional officer who is a candidate for a county, city, or town office, the candidate's principal campaign committee, and any other political committee with the candidate's name or title may not solicit or accept a contribution from a political fund or registered lobbyist during a regular session of the legislature.

Sec. 3. **EFFECTIVE DATE.**

This act is effective the day following final enactment.

Presented to the governor May 27, 1997

Signed by the governor May 30, 1997, 1:05 p.m.

CHAPTER 225—S.F.No. 1208

An act relating to health; modifying the MinnesotaCare program; modifying general assistance medical care provisions; modifying loss ratio provisions for health care policies; modifying Medicare supplement plan provisions; modifying the regional coordinating boards; modifying the health technology advisory committee; eliminating the health care commission; modifying mandatory Medicare assignment; modifying MinnesotaCare tax provisions; regulating community purchasing arrangements; modifying disclosure provisions; eliminating integrated service networks; modifying community integrated service network provisions; modifying provisions of the public programs risk adjustment work group; modifying essential community provider provisions; modifying requirements for health plan companies; modifying provisions of the rural physician education account; modifying rural hospital provisions; modifying medical assistance provisions; establishing a senior citizen drug proram; modifying Minnesota comprehensive health association provisions; requiring studies; making technical changes; appropriating money; providing criminal penalties; amending Minnesota Statutes 1996, sections 60A.15, subdivision 1; 60A.951, subdivision 5; 62A.021, subdivision 1, and by adding a subdivision; 62A.316; 62A.61; 62D.02, subdivision 5; 62D.09, subdivision 3; 62E.02, subdivisions 13 and 18; 62E.11, subdivision 5; 62E.13, subdivision 2; 62J.017; 62J.06; 62J.07, subdivisions 1 and 3; 62J.09, subdivision 1; 62J.15, subdivision 1; 62J.152, subdivisions 1, 2, 4, 5, and by adding subdivisions; 62J.17, subdivision 6a; 62J.22; 62J.25; 62J.2914, subdivision 1; 62J.2915; 62J.2916, subdivision 1; 62J.2917, subdivision 2; 62J.2921, subdivision 2; 62J.451, subdivision 6b; 62M.02, subdivision 21; 62N.01, subdivision 1; 62N.22; 62N.23; 62N.25, subdivision 5; 62N.26; 62N.40; 62Q.01, subdivisions 3, 4, and 5; 62Q.03, subdivision 5a; 62Q.106; 62Q.19, subdivision 1; 62Q.33, subdivision 2; 62Q.45, subdivision 2; 136A.1355; 144.147, subdivisions 1, 2, 3, and 4; 144.1484, subdivision 1; 256.01, subdivision 2;

256.045, subdivision 3a; 256.9352, subdivision 3; 256.9353, subdivisions 1, 3, and 7; 256.9354, subdivisions 4, 5, 6, 7, and by adding a subdivision; 256.9355, subdivisions 1, 4, and by adding a subdivision; 256.9357, subdivision 3; 256.9358, subdivision 4; 256.9359, subdivision 2; 256.9362, subdivision 6; 256.9363, subdivisions 1 and 5; 256.9657, subdivision 3; 256B.056, subdivision 8; 256B.0625, subdivisions 13 and 15; 256B.0911, subdivision 2, as amended; 256B.0913, subdivision 16, as added; 256D.03, subdivisions 3 and 3b; 295.50, subdivisions 3, 4, 6, 7, 13, and 14; 295.51, subdivision 1; 295.52, subdivision 4, and by adding subdivisions; 295.53, subdivisions 1, 3, 4, and by adding a subdivision; 295.54, subdivisions 1 and 2; 295.55, subdivision 2; 295.582; S. F. No. 1908, article 1, sections 2; 3, subdivision 2; article 4, sections 70 and 73; and article 9, section 24; proposing coding for new law in Minnesota Statutes, chapters 16A; 62Q; 144; and 256; proposing coding for new law as Minnesota Statutes, chapter 62T; repealing Minnesota Statutes 1996, sections 62E.11, subdivision 12; 62J.03, subdivision 3; 62J.04, subdivisions 4 and 7; 62J.05; 62J.051; 62J.09, subdivision 3a; 62J.37; 62N.01, subdivision 2; 62N.02, subdivisions 2, 3, 4b, 4c, 6, 7, 8, 9, 10, and 12; 62N.03; 62N.04; 62N.05; 62N.06; 62N.065; 62N.071; 62N.072; 62N.073; 62N.074; 62N.076; 62N.077; 62N.078; 62N.10; 62N.11; 62N.12; 62N.13; 62N.14; 62N.15; 62N.17; 62N.18; 62N.24; 62N.38; 62Q.165, subdivision 3; 62Q.25; 62Q.29; 62Q.41; 147.01, subdivision 6; 295.52, subdivision 1b; and 295.53, subdivision 5; Laws 1993, chapter 247, article 4, section 8; Laws 1994, chapter 625, article 5, section 5, as amended; Laws 1995, chapter 96, section 2; Laws 1995, First Special Session chapter 3, article 13, section 2; Laws 1997, chapters 31, article 4; and 84, article 4.

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

ARTICLE 1

MINNESOTACARE PROGRAM/GAMC

Section 1. Minnesota Statutes 1996, 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, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Effective July 1, 1998, adult dental care for nonpreventive services with the exception of orthodontic services is available to persons who qualify under section 256.9354, subdivisions 1 to 5, or 256.9366, with family gross income equal to or less than 175 percent of the federal poverty guidelines. 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 impair-

ment 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. 2. Minnesota Statutes 1996, 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. Prior to July 1, 1997, the inpatient hospital benefit for adult enrollees is subject to an annual benefit limit of $10,000. Effective July 1, 1997, the inpatient hospital benefit for adult enrollees who qualify under section 256.9354, subdivision 5, or who qualify under section 256.9354, subdivisions 1 to 4a, or section 256.9366 with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, is subject to an annual limit of $10,000.

(b) Enrollees who qualify under section 256.9354, subdivision 5, or who qualify under section 256.9354, subdivisions 1 to 4a, or section 256.9366 with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, and are 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 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. 3. Minnesota Statutes 1996, section 256.9353, subdivision 7, is amended to read:

Subd. 7. **COPAYMENTS AND COINSURANCE.** The MinnesotaCare benefit plan shall include the following copayments and coinsurance requirements:

(1) ten percent of the paid charges ~~submitted~~ for inpatient hospital services for adult enrollees not eligible for medical assistance, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

(2) $3 per prescription for adult enrollees; ~~and~~

(3) $25 for eyeglasses for adult enrollees; and

(4) effective July 1, 1998, 50 percent of the fee-for-service rate for adult dental care services other than preventive care services for persons eligible under section 256.9354, subdivisions 1 to 5, or 256.9366, with income equal to or less than 175 percent of the federal poverty guidelines.

Prior to July 1, 1997, enrollees who are not eligible for medical assistance with or without a spenddown shall be financially responsible for the coinsurance amount and amounts which exceed the $10,000 benefit limit. ~~MinnesotaCare shall be financially responsible for the spenddown amount up to the $10,000 benefit limit for enrollees who are eligible for medical assistance with a spenddown; enrollees who are eligible for medical assistance with a spenddown are financially responsible for amounts which exceed the $10,000 benefit limit.~~ Effective July 1, 1997, adult enrollees who qualify under section 256.9354, subdivision 5, or who qualify under section 256.9354, subdivisions 1 to 4a, or section 256.9366 with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, and who are not eligible for medical assistance with or without a spenddown, shall be financially responsible for the coinsurance amount and amounts which exceed the $10,000 inpatient hospital benefit limit.

When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

Sec. 4. Minnesota Statutes 1996, 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 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. 5. Minnesota Statutes 1996, 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" 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) 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.~~

~~(d)~~ (b) Beginning July 1, 1997, the definition of eligible persons is expanded to include all individuals and households with no children who have gross family incomes that are equal to or less than 175 percent of the federal poverty guidelines and who are not eligible for medical assistance without a spenddown under chapter 256B.

(c) 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. 6. Minnesota Statutes 1996, section 256.9354, subdivision 6, is amended to read:

Subd. 6. **APPLICANTS POTENTIALLY ELIGIBLE FOR MEDICAL ASSISTANCE.** Individuals who apply for MinnesotaCare who qualify under section 256.9354, subdivision 5, but who are potentially eligible for medical assistance without a spenddown shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer such individuals to their county social service agency. The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60–day enrollment period. Enrollees who do not apply for and cooperate with medical assistance within the 60–day enrollment period, and their other family members, shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination for the family member or members who were referred to the county agency. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination. The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

Sec. 7. Minnesota Statutes 1996, section 256.9354, subdivision 7, is amended to read:

Subd. 7. **GENERAL ASSISTANCE MEDICAL CARE.** A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same

~~month, except that a MinnesotaCare enrollee may be eligible for retroactive general assistance medical care according to section 256D.03, subdivision 3, paragraph (b).~~

Sec. 8. Minnesota Statutes 1996, section 256.9354, is amended by adding a subdivision to read:

Subd. 9. **MINNESOTACARE OUTREACH.** (a) The commissioner shall award grants to public or private organizations to provide information on the importance of maintaining insurance coverage and on how to obtain coverage through the MinnesotaCare program in areas of the state with high uninsured populations.

(b) In awarding the grants, the commissioner shall consider the following:

(1) geographic areas and populations with high uninsured rates;

(2) the ability to raise matching funds; and

(3) the ability to contact or serve eligible populations.

The commissioner shall monitor the grants and may terminate a grant if the outreach effort does not increase the MinnesotaCare program enrollment.

Sec. 9. Minnesota Statutes 1996, section 256.9355, subdivision 1, is amended to read:

Subdivision 1. **APPLICATION AND INFORMATION AVAILABILITY.** Applications and other information must be made available to provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, and Women, Infants and Children (WIC) program sites. These sites may accept applications~~, collect the enrollment fee or initial premium fee,~~ and forward the forms ~~and fees~~ to the commissioner. Otherwise, applicants may apply directly to the commissioner. Beginning January 1, 2000, MinnesotaCare enrollment sites will be expanded to include local county human services agencies which choose to participate.

Sec. 10. Minnesota Statutes 1996, section 256.9355, subdivision 4, is amended to read:

Subd. 4. **APPLICATION PROCESSING.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the department of human services. ~~This requirement shall be suspended for four months following the dates in which single adults and families without children become eligible for the program.~~ Beginning July 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare.

Sec. 11. Minnesota Statutes 1996, section 256.9355, is amended by adding a subdivision to read:

Subd. 5. **AVAILABILITY OF PRIVATE INSURANCE.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage to all families and individuals enrolled in the MinnesotaCare program whose gross family income is equal to or more than 200 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter.

Sec. 12. Minnesota Statutes 1996, 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 or as required by 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;

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

(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. 13. Minnesota Statutes 1996, 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 family income is greater than ~~125 percent of the federal poverty guidelines~~ the amount specified in section 256.9354, subdivision 5, are ineligible for the plan.

Sec. 14. Minnesota Statutes 1996, section 256.9359, subdivision 2, is amended to read:

Subd. 2. **RESIDENCY REQUIREMENT.** (a) Prior to July 1, 1997, to be eligible for health coverage under the MinnesotaCare program, families and individuals must be permanent residents of Minnesota.

(b) Effective July 1, 1997, to be eligible for health coverage under the MinnesotaCare program, adults without children must be permanent residents of Minnesota.

(c) Effective July 1, 1997, to be eligible for health coverage under the MinnesotaCare program, pregnant women, families, and children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403, except that the provisions of section 256B.056, subdivision 1, shall apply upon receipt of federal approval.

Sec. 15. Minnesota Statutes 1996, section 256.9362, subdivision 6, is amended to read:

Subd. 6. **ENROLLEES 18 OR OLDER.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256.9354, subdivision 5, or who qualify under section 256.9354, subdivisions 1 to 4a, or section 256.9366 with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256.9354, subdivisions 1 to 4a, or section 256.9366, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any copayment required under section 256.9353, subdivision 6, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256.9353, subdivision 3, payment must be the medical assistance rate minus any copayment required under section 256.9353, subdivision 6. The hospital must not seek payment from the enrollee in addition to the copayment. The MinnesotaCare payment plus the copayment must be treated as payment in full.

(b) If the medical assistance rate minus any copayment required under section 256.9353, subdivision 6, is greater than the amount remaining in the enrollee's benefit limit under section 256.9353, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any copayment established under section 256.9353, subdivision 6.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256.9353, subdivision 3, paragraph (c), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring during the period of July 1, 1997, through June 30, 1998, for adults who are not pregnant and are eligible under section 256.9354, subdivisions 1 to 4a, or 256.9366, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits in excess of the $10,000 annual inpatient benefit limit.

Sec. 16. Minnesota Statutes 1996, 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. Effective January 1, 1998, MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (d), must 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 Minne-

sotaCare, and medical assistance and may, at the option of the commissioner of human services, also include general assistance medical care.

Sec. 17. **[256.937] ASSET REQUIREMENT FOR MINNESOTACARE.**

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

(a) "Asset" means cash and other personal property, as well as any real property, that a family or individual owns which has monetary value.

(b) "Homestead" means the home that is owned by, and is the usual residence of, the family or individual, together with the surrounding property which is not separated from the home by intervening property owned by others. Public rights-of-way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. "Usual residence" includes the home from which the family or individual is temporarily absent due to illness, employment, or education, or because the home is temporarily not habitable due to casualty or natural disaster.

(c) "Net asset" means the asset's fair market value minus any encumbrances including, but not limited to, liens and mortgages.

Subd. 2. **LIMIT ON TOTAL ASSETS.** (a) Effective April 1, 1997, or upon federal approval, whichever is later, in order to be eligible for the MinnesotaCare program, a household of two or more persons must not own more than $30,000 in total net assets, and a household of one person must not own more than $15,000 in total net assets.

(b) For purposes of this subdivision, total net assets include all assets, with the following exceptions:

(1) a homestead is not considered;

(2) household goods and personal effects are not considered;

(3) any assets owned by children;

(4) vehicles used for employment;

(5) court ordered settlements up to $10,000;

(6) individual retirement accounts; and

(7) capital and operating assets of a trade or business up to $200,000 in net assets are not considered.

(c) If an asset excluded under paragraph (b) has a negative value, the negative value shall be subtracted from the total net assets under paragraph (a).

Subd. 3. **DOCUMENTATION.** (a) The commissioner of human services shall require individuals and families, at the time of application or renewal, to indicate on a checkoff form developed by the commissioner whether they satisfy the MinnesotaCare asset requirement. This form must include the following or similar language: "To be eligible for MinnesotaCare, individuals and families must not own net assets in excess of $30,000 for a household of two or more persons or $15,000 for a household of one person, not including a homestead, household goods and personal effects, assets owned by children, vehicles used for employment, court ordered settlements up to $10,000, indi-

vidual retirement accounts, and capital and operating assets of a trade or business up to $200,000. Do you and your household own net assets in excess of these limits?"

(b) The commissioner may require individuals and families to provide any information the commissioner determines necessary to verify compliance with the asset requirement, if the commissioner determines that there is reason to believe that an individual or family has assets that exceed the program limit.

Subd. 4. **PENALTIES.** Individuals or families who are found to have knowingly misreported the amount of their assets as described in this section shall be subject to the penalties in section 256.98. The commissioner shall present recommendations on additional penalties to the 1998 legislature.

Subd. 5. **EXEMPTION.** This section does not apply to pregnant women. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

Sec. 18. **[256.9371] PENALTIES.**

Whoever obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or by the intentional withholding or concealment of a material fact, or by impersonation, or other fraudulent device:

(1) benefits under the MinnesotaCare program to which the person is not entitled; or

(2) benefits under the MinnesotaCare program greater than that to which the person is reasonably entitled;

shall be considered to have violated section 256.98, and shall be subject to both the criminal and civil penalties provided under that section.

Sec. 19. Minnesota Statutes 1996, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **GENERAL ASSISTANCE MEDICAL CARE; ELIGIBILITY.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in clause (4), except as provided in paragraph (b); and:

(1) who is receiving assistance under section 256D.05, ~~or~~ except for families with children who are eligible under Minnesota family investment program–statewide (MFIP–S), who is having a payment made on the person's behalf under sections 256I.01 to 256I.06, or who resides in group residential housing as defined in chapter 256I and can meet a spenddown using the cost of remedial services received through group residential housing; or

(2)(i) who is a resident of Minnesota; and whose equity in assets is not in excess of $1,000 per assistance unit. No asset test shall be applied to children and their parents living in the same household. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in chapter 256B, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; and

(ii) who has countable income not in excess of the assistance standards established in section 256B.056, subdivision 4, or whose excess income is spent down pursuant to section 256B.056, subdivision 5, using a six-month budget period~~, except that a one-month budget period must be used for recipients residing in a long-term care facility~~. The method for calculating earned income disregards and deductions for a person who resides with a dependent child under age 21 shall ~~be as specified in section 256.74, subdivision 1~~ follow section 256B.056, subdivision 1a. However, if a disregard of $30 and one-third of the remainder ~~described in section 256.74, subdivision 1, clause (4),~~ has been applied to the wage earner's income, the disregard shall not be applied again until the wage earner's income has not been considered in an eligibility determination for general assistance, general assistance medical care, medical assistance, or ~~aid to families with dependent children~~ MFIP-S for 12 consecutive months. The earned income and work expense deductions for a person who does not reside with a dependent child under age 21 shall be the same as the method used to determine eligibility for a person under section 256D.06, subdivision 1, except the disregard of the first $50 of earned income is not allowed; or

(3) who would be eligible for medical assistance except that the person resides in a facility that is determined by the commissioner or the federal health care financing administration to be an institution for mental diseases.

(4) Beginning July 1, 1998, applicants or recipients who meet all eligibility requirements of MinnesotaCare as defined in sections 256.9351 to 256.9363 and 256.9366 to 256.9369, and are:

(i) adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines; or

(ii) adults without children with earned income and whose family gross income is between 75 percent of the federal poverty guidelines and the amount set by section 256.9354, subdivision 5, shall be terminated from general assistance medical care upon enrollment in MinnesotaCare.

(b) ~~Eligibility is available for the month of application, and for three months prior to application if the person was eligible in those prior months.~~ For services rendered on or after July 1, 1997, eligibility is limited to one month prior to application if the person is determined eligible in the prior month. A redetermination of eligibility must occur every 12 months. Beginning July 1, 1998, Minnesota health care program applications completed by recipients and applicants who are persons described in paragraph (a), clause (4), may be returned to the county agency to be forwarded to the department of human services or sent directly to the department of human services for enrollment in MinnesotaCare. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which a MinnesotaCare eligibility determination and enrollment are pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraph (d).

(c) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and social security number, signed and dated, to the county agency or the depart-

ment of human services. If the applicant is unable to provide an initial application when health care is delivered due to a medical condition or disability, a health care provider may act on the person's behalf to complete the initial application. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary.

(d) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

~~(c)~~ (e) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

~~(d)~~ (f) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance. General assistance medical care is limited to payment of emergency services only for applicants or recipients as described in paragraph (a), clause (4), whose MinnesotaCare coverage is denied or terminated for nonpayment of premiums as required by sections 256.9356 to 256.9358.

~~(e)~~ (g) In determining the amount of assets of an individual, there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

~~(f)(1)~~ (h) Beginning October 1, 1993, an undocumented alien or a nonimmigrant is ineligible for general assistance medical care other than emergency services. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes

listed in United States Code, title 8, section 1101(a)(15), and an undocumented alien is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

~~(2)~~ (i) This subdivision does not apply to a child under age 18, to a Cuban or Haitian entrant as defined in Public Law Number 96–422, section 501(e)(1) or (2)(a), or to an alien who is aged, blind, or disabled as defined in United States Code, title 42, section 1382c(a)(1).

~~(3)~~ (j) For purposes of ~~paragraph~~ paragraphs (f) and (h), "emergency services" has the meaning given in Code of Federal Regulations, title 42, section 440.255(b)(1), except that it also means services rendered because of suspected or actual pesticide poisoning.

Sec. 20. **TRANSITION PLAN FOR MINNESOTACARE ENROLLEES.**

(a) The commissioner of human services, in consultation with the legislative commission on health care access and the commissioners of employee relations, health, and commerce, shall develop an implementation plan to transition higher–income MinnesotaCare enrollees to private sector or other nonsubsidized coverage. In developing the plan, the commissioner shall examine the feasibility of using the health insurance program for state employees administered by the commissioner of employee relations as a source of coverage, and shall also examine methods to increase the affordability of private sector coverage for individuals and families transitioning off MinnesotaCare. The commissioner shall submit the implementation plan to the legislature by December 15, 1997.

(b) The commissioner of human services shall report to the legislature by January 15, 1998, on the impact of the outreach efforts for the MinnesotaCare program, and on the reasons why enrollees are leaving the MinnesotaCare program, and make recommendations on:

(1) the affordability of the MinnesotaCare premium schedule;

(2) the eligibility income level for the MinnesotaCare program that will result in the greatest number of individuals having health coverage;

(3) what will encourage greater availability of health coverage in the private market;

(4) steps to increase the availability of health coverage in the small employer market;

(5) the need, if any, and the feasibility of increasing the MinnesotaCare program income eligibility level for individuals and households without children; and

(6) the possibility of alternative premium payments and of waiving the premiums for the MinnesotaCare program for certain low–income enrollees.

Sec. 21. **INPATIENT BENEFIT LIMIT PILOT PROJECT.**

The commissioner of human services shall develop a pilot project in a designated area of the state to determine whether the presence of the $10,000 inpatient hospital benefit limit prevents erosion of the private health insurance market by eliminating the $10,000 inpatient benefit limit for that area of the state. The commissioner shall work with the legislative commission on health care access in designing the elements of the pilot project.

Sec. 22. **EFFECTIVE DATE.**

Section 3, subdivision 7, clause (1), is effective July 1, 1998.

ARTICLE 2

MISCELLANEOUS CHANGES TO HEALTH CARE REFORM

Section 1. Minnesota Statutes 1996, section 60A.951, subdivision 5, is amended to read:

Subd. 5. **INSURER.** "Insurer" means insurance company, risk retention group as defined in section 60E.02, service plan corporation as defined in section 62C.02, health maintenance organization as defined in section 62D.02, community integrated service network as defined in section 62N.02, fraternal benefit society regulated under chapter 64B, township mutual company regulated under chapter 67A, joint self-insurance plan or multiple employer trust regulated under chapter 60F, 62H, or section 471.617, subdivision 2, persons administering a self-insurance plan as defined in section 60A.23, subdivision 8, clause (2), paragraphs (a) and (d), and the workers' compensation reinsurance association established in section 79.34.

Sec. 2. Minnesota Statutes 1996, section 62A.021, subdivision 1, is amended to read:

Subdivision 1. **LOSS RATIO STANDARDS.** (a) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and ~~any~~ all types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1,

2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

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

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

(c) A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

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

(e)(1) For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(2) For purposes of this section, ~~(1)~~ (i) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and ~~(2)~~ (ii) "health carrier" has the

meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

(f) The loss ratio phase–in as described in paragraph (a) does not apply to individual policies and small employer policies issued by a health plan company that is assessed less than three percent of the total annual amount assessed by the Minnesota comprehensive health association. These policies must meet a 68 percent loss ratio for individual policies, a 71 percent loss ratio for small employer policies with fewer than ten employees, and a 75 percent loss ratio for all other small employer policies.

(g) The commissioners of commerce and health shall each annually issue a public report listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in this state by the health plan companies that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than June 1 for loss ratios experienced for the preceding calendar year. Health plan companies shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.

Sec. 3. Minnesota Statutes 1996, section 62A.021, is amended by adding a subdivision to read:

Subd. 3. **LOSS RATIO DISCLOSURE.** (a) Each health care policy form or health care certificate form for which subdivision 1 requires compliance with a loss ratio requirement shall prominently display the disclosure provided in paragraph (b) on its declarations sheet if it has one and, if not, on its front page. The disclosure must also be prominently displayed in any marketing materials used in connection with it.

(b) The disclosure must be in the following format:

Notice: This disclosure is required by Minnesota law. This policy or certificate is expected to return on average (fill in anticipated loss ratio approved by the commissioner) percent of your premium dollar for health care. The lowest percentage permitted by state law for this policy or certificate is (fill in applicable minimum loss ratio).

(c) This subdivision applies to policies and certificates issued on or after January 1, 1998.

Sec. 4. Minnesota Statutes 1996, section 62A.316, is amended to read:

62A.316 **BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

(a) The basic Medicare supplement plan must have a level of coverage that will provide:

(1) coverage for all of the Medicare part A inpatient hospital coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare, after satisfying the Medicare part A deductible;

(2) coverage for the daily copayment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the copayment amount of Medicare eligible expenses under Medicare part B regardless of hospital confinement, subject to the Medicare part B deductible amount;

(4) 80 percent of the hospital and medical expenses and supplies incurred during travel outside the United States as a result of a medical emergency;

(5) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations; and

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer screening including mammograms and pap smears.

(b) Only the following optional benefit riders may be added to this plan:

(1) coverage for all of the Medicare part A inpatient hospital deductible amount;

(2) a minimum of 80 percent of eligible medical expenses and supplies not covered by Medicare part B, not to exceed any charge limitation established by the Medicare program or state law;

(3) coverage for all of the Medicare part B annual deductible;

(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses;

(5) coverage for the following preventive health services:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test, administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare–approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for a procedure covered by Medicare;

(6) coverage for services to provide short–term at–home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) For purposes of this benefit, the following definitions apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self–administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aid, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at–home recovery visit" means the period of a visit required to provide at–home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24–hour period of services provided by a care provider is one visit;

(ii) Coverage requirements and limitations:

(A) at–home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at–home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at–home recovery visits certified as necessary by the insured's attending physician. The total number of at–home recovery visits shall not exceed the number of Medicare–approved home care visits under a Medicare–approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at–home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at–home recovery visits received during the period the insured is receiving Medicare–approved home care services or no more than eight weeks after the service date of the last Medicare–approved home health care visit;

(iii) Coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by family members, unpaid volunteers, or providers who are not care providers.;

(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually under this benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4).

Sec. 5. Minnesota Statutes 1996, section 62A.61, is amended to read:

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

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

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

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

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

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

(c) The commissioner of health or the commissioner of commerce, as appropriate, may use to enforce this section any enforcement powers otherwise available to the commissioner with respect to the health carrier. ~~The appropriate commissioner shall enforce compliance with a request made under this section by the Minnesota health care commission, at the request of the commissioner.~~ The commissioner of health or commerce, as appropriate, may require health carriers to provide the information required under this section and may use any powers granted under other laws relating to the regulation of health carriers to enforce compliance.

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

Sec. 6. Minnesota Statutes 1996, section 62D.02, subdivision 5, is amended to read:

Subd. 5. "Evidence of coverage" means any certificate, agreement or contract, and amendments thereto, issued to an enrollee which sets out the coverage to which the enrollee is entitled under the health maintenance contract which covers the enrollee.

Sec. 7. Minnesota Statutes 1996, section 62D.09, subdivision 3, is amended to read:

Subd. 3. Every health maintenance organization or its representative shall annually, before June 1, provide to its enrollees the following: (1) a summary of its most recent annual financial statement including a balance sheet and statement of receipts and disbursements; (2) a description of the health maintenance organization, its health care plan or plans, its facilities and personnel, any material changes therein since the last report; (3)

the current evidence of coverage, or ~~contract~~ amendments thereto; and (4) a statement of consumer information and rights as described in section 62D.07, subdivision 3, paragraph (c). Under clause (3), a health maintenance organization may annually alternate between providing enrollees with amendments and providing current evidence of coverage.

Sec. 8. Minnesota Statutes 1996, section 62E.11, subdivision 5, is amended to read:

Subd. 5. Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contributing member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner. Payments made by the state to a contributing member for medical assistance, MinnesotaCare, or general assistance medical care services according to chapters 256, 256B, and 256D shall be excluded when determining a contributing member's total premium.

Sec. 9. Minnesota Statutes 1996, 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. 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 restructured health care financing and delivery system must be enacted or adopted by January 1, 1996.~~

Sec. 10. Minnesota Statutes 1996, 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 technology advisory committee established under section 62J.15, 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. 11. Minnesota Statutes 1996, section 62J.07, subdivision 1, is amended to read:

Subdivision 1. **LEGISLATIVE OVERSIGHT.** The legislative commission on health care access reviews the activities of the commissioner of health, the ~~state health care commission~~ regional coordinating boards, the health technology advisory committee, and all other state agencies involved in the implementation and administration of this chapter, including efforts to obtain federal approval through waivers and other means.

Sec. 12. Minnesota Statutes 1996, section 62J.07, subdivision 3, is amended to read:

Subd. 3. **REPORTS TO THE COMMISSION.** The commissioner of health ~~and the Minnesota health care commission,~~ the regional coordinating boards, and the health technology advisory committee shall report on their activities ~~and the activities of the regional boards~~ annually and at other times at the request of the legislative commission on health care access. The commissioners of health, commerce, and human services shall provide periodic reports to the legislative commission on the progress of rulemaking that is authorized or required under this act and shall notify members of the commission when a draft of a proposed rule has been completed and scheduled for publication in the State Register. At the request of a member of the commission, a commissioner shall provide a description and a copy of a proposed rule.

Sec. 13. Minnesota Statutes 1996, section 62J.09, subdivision 1, is amended to read:

Subdivision 1. **GENERAL DUTIES.** (a) The commissioner shall divide the state into six regions, one of these regions being the seven-county metropolitan area.

~~The~~ (b) Each region shall establish a locally controlled regional coordinating ~~boards are locally controlled boards~~ board consisting of providers, health plan companies, employers, consumers, and elected officials. Regional coordinating boards may:

(1) undertake voluntary activities to educate consumers, providers, and purchasers about community plans and projects promoting health care cost containment, consumer accountability, access, and quality and efforts to achieve public health goals;

(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. 14. Minnesota Statutes 1996, section 62J.15, subdivision 1, is amended to read:

Subdivision 1. **HEALTH TECHNOLOGY ADVISORY COMMITTEE.** The ~~Minnesota health care commission shall convene~~ legislative commission on health care access may convene or authorize the commissioner of health to convene an advisory committee to conduct evaluations of existing research and technology assessments conducted by other entities of new and existing health care technologies as designated by the

legislative commission on health care access, the commissioner, or the advisory committee. ~~The advisory committee may include members of the state commission and other persons appointed by the commission.~~ The advisory committee must include at least one person representing physicians, at least one person representing hospitals, and at least one person representing the health care technology industry. Health care technologies include high–cost drugs, devices, procedures, or processes applied to human health care, such as high–cost transplants and expensive scanners and imagers. The advisory committee is governed by section 15.0575, subdivision 3, except that members do not receive per diem payments.

Sec. 15. Minnesota Statutes 1996, section 62J.152, subdivision 1, is amended to read:

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

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

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

(3) provide the legislature with scientific evaluations of proposed benefit mandates that utilize health care technologies for a specific use and application;

(4) report the results of the evaluations to the commissioner and the ~~Minnesota health care commission~~ legislative commission on health care access; and

~~(4)~~ (5) carry out other duties relating to health technology assigned by the ~~commission~~ legislature or the legislative commission on health care access.

Sec. 16. Minnesota Statutes 1996, section 62J.152, is amended by adding a subdivision to read:

Subd. 1a. **LEGISLATIVE ACTION.** Nothing in subdivision 1 shall be construed to:

(1) require the legislature to postpone hearings or legislative action on a proposed benefit mandate; or

(2) require the legislature to act in accordance with any recommendations of the health technology advisory committee.

Sec. 17. Minnesota Statutes 1996, section 62J.152, subdivision 2, is amended to read:

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

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

(2) the cost implications;

(3) the potential for rapid diffusion;

(4) the impact on a substantial patient population;

(5) the existence of alternative technologies;

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

(7) the public health importance;

(8) the level of public and professional demand;

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

(10) the prevalence of the disease or condition.

The committee may give different weights or attach different importance to each of the criteria, depending on the technology being considered. The committee shall consider any additional criteria approved by the commissioner and the ~~Minnesota health care commission~~ legislative commission on health care access. The committee shall present its list of technologies for evaluation to the legislative commission on health care access for review.

Sec. 18. Minnesota Statutes 1996, section 62J.152, subdivision 4, is amended to read:

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

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

~~final report, its comments and recommendations, and a summary of the public's comments to the commissioner and information clearinghouse.~~

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

Sec. 19. Minnesota Statutes 1996, 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 organizations in the development of practice parameters;

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

(5) by consumers in making decisions about treatment;

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

(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.

Sec. 20. Minnesota Statutes 1996, section 62J.152, is amended by adding a subdivision to read:

Subd. 8. **REPEALER.** This section and sections 62J.15 and 62J.156 are repealed effective July 1, 2001.

Sec. 21. Minnesota Statutes 1996, 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 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 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~~ health technology advisory committee 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) **PENALTIES AND REMEDIES.** The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

Sec. 22. Minnesota Statutes 1996, section 62J.22, is amended to read:

62J.22 **PARTICIPATION OF FEDERAL PROGRAMS.**

The commissioner of health shall seek the full participation of federal health care programs under this chapter, including Medicare, medical assistance, veterans administration programs, and other federal programs. The commissioner of human services shall ~~under the direction of the health care commission~~ submit waiver requests and take other action necessary to obtain federal approval to allow participation of the medical assistance program. ~~Other state agencies shall provide assistance at the request of the commission.~~ If federal approval is not given for one or more federal programs, data on the amount of health care spending that is collected under section 62J.04 shall be adjusted so that state and regional spending limits take into account the failure of the federal program to participate.

Sec. 23. Minnesota Statutes 1996, section 62J.25, is amended to read:

62J.25 **MANDATORY MEDICARE ASSIGNMENT.**

(a) Effective January 1, 1993, a health care provider ~~authorized to participate in the Medicare program~~ shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 115 percent of the Medicare–approved amount for any Medicare–covered service provided.

(b) Effective January 1, 1994, a health care provider ~~authorized to participate in the Medicare program~~ shall not charge to or collect from a Medicare beneficiary who is a

Minnesota resident any amount in excess of 110 percent of the Medicare–approved amount for any Medicare–covered service provided.

(c) Effective January 1, 1995, a health care provider ~~authorized to participate in the Medicare program~~ shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 105 percent of the Medicare–approved amount for any Medicare–covered service provided.

(d) Effective January 1, 1996, a health care provider ~~authorized to participate in the Medicare program~~ shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of the Medicare–approved amount for any Medicare–covered service provided.

(e) This section does not apply to ambulance services as defined in section 144.801, subdivision 4, or medical supplies and equipment.

Sec. 24. Minnesota Statutes 1996, section 62J.2914, subdivision 1, is amended to read:

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

(1) a descriptive title;

(2) a table of contents;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 25. Minnesota Statutes 1996, section 62J.2915, is amended to read:

62J.2915 **NOTICE AND COMMENT.**

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

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

Sec. 26. Minnesota Statutes 1996, section 62J.2916, subdivision 1, is amended to read:

Subdivision 1. **CHOICE OF PROCEDURES.** After the conclusion of the period provided in section 62J.2915, subdivision 2, for the applicant to respond to comments,

the commissioner shall select one of the three procedures provided in subdivision 2. In determining which procedure to use, the commissioner shall consider the following criteria:

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

(2) the complexity of the proposed arrangement;

(3) the novelty of the proposed arrangement;

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

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

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

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

Sec. 27. Minnesota Statutes 1996, section 62J.2917, subdivision 2, is amended to read:

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

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

(2) market structure:

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

(ii) actual and potential consumers;

(iii) geographic market area; and

(iv) entry conditions;

(3) current market conditions;

(4) the historical behavior of the market;

(5) performance of other, similar arrangements;

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

(7) the financial condition of the applicant.

(b) **COST.** The commissioner's analysis of cost must focus on the individual consumer of health care. Cost savings to be realized by providers, health carriers, group purchasers, or other participants in the health care system are relevant only to the extent that

the savings are likely to be passed on to the consumer. However, where an application is submitted by providers or purchasers who are paid primarily by third party payers unaffiliated with the applicant, it is sufficient for the applicant to show that cost savings are likely to be passed on to the unaffiliated third party payers; the applicants do not have the burden of proving that third party payers with whom the applicants are not affiliated will pass on cost savings to individuals receiving coverage through the third party payers. In making determinations as to costs, the commissioner may consider:

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

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

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

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

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

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

(7) likely effectiveness of regulation by the commissioner;

(8) inferences to be drawn from market structure;

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

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

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

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

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

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

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

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

(1) decrease morbidity and mortality;

(2) result in faster convalescence;

(3) result in fewer hospital days;

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

(5) increase patient satisfaction; and

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

Sec. 28. Minnesota Statutes 1996, section 62J.2921, subdivision 2, is amended to read:

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

Sec. 29. Minnesota Statutes 1996, section 62J.451, subdivision 6b, is amended to read:

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.

Sec. 30. Minnesota Statutes 1996, section 62M.02, subdivision 21, is amended to read:

Subd. 21. **UTILIZATION REVIEW ORGANIZATION.** "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network ~~or an integrated service network~~ licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and determines certification of an admission, extension of stay, or other health care services for a Minnesota resident; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state.

Sec. 31. Minnesota Statutes 1996, section 62N.01, subdivision 1, is amended to read:

Subdivision 1. **CITATION.** This chapter may be cited as the "Minnesota community integrated service network act."

Sec. 32. Minnesota Statutes 1996, section 62N.22, is amended to read:

62N.22 **DISCLOSURE OF COMMISSIONS.**

Before selling any coverage or enrollment in a community integrated service network ~~or an integrated service network~~, a person selling the coverage or enrollment shall disclose in writing to the prospective purchaser the amount of any commission or other

compensation the person will receive as a direct result of the sale. The disclosure may be expressed in dollars or as a percentage of the premium. The amount disclosed need not include any anticipated renewal commissions.

Sec. 33. Minnesota Statutes 1996, section 62N.23, is amended to read:

62N.23 **TECHNICAL ASSISTANCE; LOANS.**

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

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

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

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

(b) The commissioner shall grant loans for organizational and start–up expenses to entities forming community integrated service networks ~~or integrated service networks~~, or to networks less than one year old, to the extent of any appropriation for that purpose. The commissioner shall allocate the available funds among applicants based upon the following criteria, as evaluated by the commissioner within the commissioner's discretion:

(1) the applicant's need for the loan;

(2) the likelihood that the loan will foster the formation or growth of a network; and

(3) the likelihood of repayment.

The commissioner shall determine any necessary application deadlines and forms and is exempt from rulemaking in doing so.

Sec. 34. Minnesota Statutes 1996, section 62N.25, subdivision 5, is amended to read:

Subd. 5. **BENEFITS.** Community integrated service networks must offer the health maintenance organization benefit set, as defined in chapter 62D, and other laws applicable to entities regulated under chapter 62D~~, except that the community integrated service network may impose a deductible, not to exceed $1,000 per person per year, provided that out–of–pocket expenses on covered services do not exceed $3,000 per person or $5,000 per family per year. The deductible must not apply to preventive health services as described in Minnesota Rules, part 4685.0801, subpart~~ 8. Community networks and

chemical dependency facilities under contract with a community network shall use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660, when assessing enrollees for chemical dependency treatment.

Sec. 35. Minnesota Statutes 1996, section 62N.26, is amended to read:

62N.26 **SHARED SERVICES COOPERATIVE.**

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

Sec. 36. Minnesota Statutes 1996, section 62N.40, is amended to read:

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. 37. Minnesota Statutes 1996, 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; a policy, contract, or certificate issued by a community integrated service network~~; or an integrated service network~~.

Sec. 38. Minnesota Statutes 1996, 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; or

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

~~(3)~~ a community integrated service network as defined under section 62N.02, subdivision 4a.

Sec. 39. Minnesota Statutes 1996, section 62Q.01, subdivision 5, is amended 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; or (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. 40. Minnesota Statutes 1996, section 62Q.03, subdivision 5a, is amended 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 public programs risk adjustment work group is governed by section 15.059 for purposes of membership terms and removal of members and shall terminate on June 30, 1999. The work group shall meet at the discretion of the commissioners of health and human services. The commissioner of health shall work with the risk adjustment association to ensure coordination between the risk adjustment systems for the public and private sectors. The commissioner of human services shall seek any needed federal approvals necessary for the inclusion of the medical assistance program in the public programs 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. 41. Minnesota Statutes 1996, section 62Q.106, is amended to read:

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~~,~~ or chapter 45, 60A, or 62D.

Sec. 42. Minnesota Statutes 1996, section 62Q.19, subdivision 1, is amended to read:

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;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal government, an Indian health service unit, or a community health board as defined in chapter 145A; ~~or~~

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions; or

(5) a rural hospital that has qualified for a sole community hospital financial assistance grant in the past three years under section 144.1484, subdivision 1. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services.

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.

Sec. 43. Minnesota Statutes 1996, section 62Q.33, subdivision 2, is amended to read:

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

Sec. 44. Minnesota Statutes 1996, section 62Q.45, subdivision 2, is amended to read:

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; or (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. 45. **[62Q.54] REFERRALS FOR RESIDENTS OF HEALTH CARE FACILITIES.**

If an enrollee is a resident of a health care facility licensed under chapter 144A or a housing with services establishment registered under chapter 144D, the enrollee's primary care physician must refer the enrollee to that facility's skilled nursing unit or that facility's appropriate care setting, provided that the health plan company and the provider can best meet the patient's needs in that setting, if the following conditions are met:

(1) the facility agrees to be reimbursed at that health plan company's contract rate negotiated with similar providers for the same services and supplies; and

(2) the facility meets all guidelines established by the health plan company related to quality of care, utilization, referral authorization, risk assumption, use of health plan company network, and other criteria applicable to providers under contract for the same services and supplies.

Sec. 46. **[62Q.65] ACCESS TO PROVIDER DISCOUNTS.**

Subdivision 1. **REQUIREMENT.** A high deductible health plan must, when used in connection with a medical savings account, provide the enrollee access to any discounted provider fees for services covered by the high deductible health plan, regardless of whether the enrollee has satisfied the deductible for the high deductible health plan.

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

(1) "high deductible health plan" has the meaning given under the Internal Revenue Code of 1986, section 220(c)(2);

(2) "medical savings account" has the meaning given under the Internal Revenue Code of 1986, section 220(d)(1); and

(3) "discounted provider fees" means fees contained in a provider agreement entered into by the issuer of the high deductible health plan, or an affiliate of the issuer, for use in connection with the high deductible health plan.

Sec. 47. Minnesota Statutes 1996, section 136A.1355, is amended to read:

136A.1355 **RURAL PHYSICIANS.**

Subdivision 1. **CREATION OF ACCOUNT.** A rural physician education account is established in the health care access fund. The higher education services office shall use money from the account to establish a loan forgiveness program for medical ~~students~~ residents agreeing to practice in designated rural areas, as defined by the commissioner.

Subd. 2. **ELIGIBILITY.** To be eligible to participate in the program, a prospective physician must submit a letter of interest to the higher education services office. A ~~student or~~ resident who is accepted must sign a contract to agree to serve at least three of the first five years following residency in a designated rural area.

Subd. 3. **LOAN FORGIVENESS.** For fiscal years beginning on and after July 1, 1995, the higher education services office may accept up to ~~four applicants who are fourth year medical students, three~~ 12 applicants who are medical residents, four applicants who are pediatric residents, and ~~four~~ six applicants who are family practice resi-

dents, and ~~one applicant who is an~~ two applicants who are internal medicine ~~resident~~ residents, per fiscal year for participation in the loan forgiveness program. If the higher education services office 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~~ 12 resident applicants 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 services office 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.

Subd. 4. **PENALTY FOR NONFULFILLMENT.** If a participant does not fulfill the required three–year minimum commitment of service in a designated rural area, the higher education services office shall collect from the participant the amount paid by the commissioner under the loan forgiveness program. The higher education services office shall deposit the money collected in the rural physician education account established in subdivision 1. The commissioner shall allow waivers of all or part of the money owed the commissioner if emergency circumstances prevented fulfillment of the three–year service commitment.

Subd. 5. **LOAN FORGIVENESS; UNDERSERVED URBAN COMMUNITIES.** For fiscal years beginning on and after July 1, 1995, the higher education services office 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 services office 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 services office 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. 48. Minnesota Statutes 1996, 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~~ 50 or fewer beds; and

(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. 49. Minnesota Statutes 1996, section 144.147, subdivision 2, is amended to read:

Subd. 2. **GRANTS AUTHORIZED.** The commissioner shall establish a program of grants to assist eligible rural hospitals. The commissioner shall award grants to hospitals and communities for the purposes set forth in paragraphs (a) and (b).

(a) Grants may be used by hospitals and their communities to develop strategic plans for preserving or enhancing access to health services. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what health services are needed and desired by the community. The assessment must include interviews with or surveys of area health professionals, local community leaders, and public hearings;

(2) an assessment of the feasibility of providing needed health services that identifies priorities and timeliness for potential changes; and

(3) an implementation plan.

The strategic plan must be developed by a committee that includes representatives from the hospital, local public health agencies, other health providers, and consumers from the community.

(b) The grants may also be used by eligible rural hospitals that have developed strategic plans to implement transition projects to modify the type and extent of services provided, in order to reflect the needs of that plan. Grants may be used by hospitals under this paragraph to develop hospital-based physician practices that integrate hospital and existing medical practice facilities that agree to transfer their practices, equipment, staffing, and administration to the hospital. The grants may also be used by the hospital to establish a health provider cooperative, a telemedicine system, or a rural health care system. Not

more than one-third of any grant shall be used to offset losses incurred by physicians agreeing to transfer their practices to hospitals.

Sec. 50. Minnesota Statutes 1996, section 144.147, subdivision 3, is amended to read:

Subd. 3. **CONSIDERATION OF GRANTS.** In determining which hospitals will receive grants under this section, the commissioner shall take into account:

(1) improving community access to hospital or health services;

(2) changes in service populations;

(3) demand for ambulatory and emergency services;

(4) the extent that the health needs of the community are not currently being met by other providers in the service area;

(5) the need to recruit and retain health professionals;

(6) the ~~involvement and~~ extent of community support ~~of the community and local health care providers; and~~

(7) the coordination with local community organizations, such as community development and public health agencies; and

(8) the financial condition of the hospital.

Sec. 51. Minnesota Statutes 1996, section 144.147, subdivision 4, is amended to read:

Subd. 4. **ALLOCATION OF GRANTS.** (a) Eligible hospitals must apply to the commissioner no later than September 1 of each fiscal year for grants awarded for that fiscal year. A grant may be awarded upon signing of a grant contract.

(b) The commissioner must make a final decision on the funding of each application within 60 days of the deadline for receiving applications.

(c) Each relevant community health board has 30 days in which to review and comment to the commissioner on grant applications from hospitals in their community health service area.

(d) In determining which hospitals will receive grants under this section, the commissioner shall consider the following factors:

(1) Description of the problem, description of the project, and the likelihood of successful outcome of the project. The applicant must explain clearly the nature of the health services problems in their service area, how the grant funds will be used, what will be accomplished, and the results expected. The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations.

(2) The extent of community support for the hospital and this proposed project. The applicant should demonstrate support for the hospital and for the proposed project from other local health service providers and from local community and government leaders. Evidence of such support may include past commitments of financial support from local individuals, organizations, or government entities; and commitment of financial support, in-kind services or cash, for this project.

(3) The comments, if any, resulting from a review of the application by the community health board in whose community health service area the hospital is located.

(e) In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning the maximum of 70 points for an applicant's understanding of the problem, description of the project, and likelihood of successful outcome of the project; and a maximum of 30 points for the extent of community support for the hospital and this project. The commissioner may also take into account other relevant factors.

(f) A grant to a hospital, including hospitals that submit applications as consortia, may not exceed ~~$37,500~~ $50,000 a year and may not exceed a term of two years. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one–half of the amount, which may include in–kind services, is available for the same purposes from nonstate sources. A hospital receiving a grant under this section may use the grant for any expenses incurred in the development of strategic plans or the implementation of transition projects with respect to which the grant is made. Project grants may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

(g) The commissioner may adopt rules to implement this section.

Sec. 52. **[144.1475] RURAL HOSPITAL DEMONSTRATION PROJECT.**

Subdivision 1. **ESTABLISHMENT.** The commissioner of health, for the biennium ending June 30, 1999, shall establish at least three demonstration projects per fiscal year to assist rural hospitals in the planning and implementation process to either consolidate or cooperate with another existing hospital in its service area to provide better quality health care to its community. A demonstration project must include at least two eligible hospitals. For purposes of this section, an "eligible hospital" means a hospital that:

(1) is located outside the seven–county metropolitan area;

(2) has 50 or fewer licensed beds; and

(3) is located within a 25–mile radius of another hospital.

At least one of the eligible hospitals in a demonstration project must have had a negative operating margin during one of the two years prior to application.

Subd. 2. **APPLICATION.** (a) An eligible hospital seeking to be a participant in a demonstration project must submit an application to the commissioner of health detailing the hospital's efforts to consolidate health care delivery in its service area, cooperate with another hospital in the delivery of health care, or both consolidate and cooperate. Applications must be submitted by October 15 of each fiscal year for grants awarded for that fiscal year.

(b) Applications must:

(1) describe the problem that the proposed consolidation or cooperation will address, the consolidation or cooperation project, how the grant funds will be used, what will be accomplished, and the results expected;

(2) describe achievable objectives, a timetable, and the roles and capabilities of responsible individuals and organizations;

(3) include written commitments from the applicant hospital and at least one other hospital that will participate in the consolidation or cooperation demonstration project, that specify the activities the organization will undertake during the project, the resources the organization will contribute to the demonstration project, and the expected role and nature of the organization's involvement in proposed consolidation or cooperation activities; and

(4) provide evidence of support for the proposed project from other local health service providers and from local community and government leaders.

Subd. 3. **GRANTS.** The commissioner of health shall allocate a grant of up to $100,000 to the highest scoring applicants each year until available funding is expended. Grants may be used by eligible hospitals to:

(1) conduct consolidation or cooperation negotiations;

(2) develop consolidation or cooperation plans, including financial plans and architectural designs;

(3) seek community input and conduct community education on proposed or planned consolidations or cooperative activities; and

(4) implement consolidation or cooperation plans.

Subd. 4. **CONSIDERATION OF GRANTS.** In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning: a maximum of 40 points for an applicant's understanding of the problem, description of the project, and likelihood of successful outcome of the project; a maximum of 30 points for explicit and unequivocal written commitments from organizations participating in the project; a maximum of 20 points for matching funds or in-kind services committed by the applicant or others to the project; and a maximum of ten points for the extent of community support for the project. The commissioner shall consider the comments, if any, resulting from a review of the application by the community health board in whose community health service area the applicant is located. The commissioner may also take into account other relevant factors.

Subd. 5. **EVALUATION.** The commissioner of health shall evaluate the overall effectiveness of the demonstration projects and report to the legislature by September 1, 2000. The commissioner may collect, from the hospitals receiving grants, any information necessary to evaluate the demonstration project.

Sec. 53. **[144.148] RURAL HOSPITAL CAPITAL IMPROVEMENT GRANT AND LOAN PROGRAM.**

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

(b) "Eligible rural hospital" means a hospital that:

(1) is located outside the seven-county metropolitan area;

(2) has 50 or fewer licensed hospital beds with a net hospital operating margin not greater than two percent in the two fiscal years prior to application; and

(3) is 25 miles or more from another hospital.

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital.

Subd. 2. **PROGRAM.** The commissioner of health shall award rural hospital capital improvement grants or loans to eligible rural hospitals. A grant or loan shall not exceed $1,500,000 per hospital. Grants or loans shall be interest free. An eligible rural hospital may apply the funds retroactively to capital improvements made during the two fiscal years preceding the fiscal year in which the grant or loan was received, provided the hospital met the eligibility criteria during that time period.

Subd. 3. **APPLICATIONS.** Eligible hospitals seeking a grant or loan shall apply to the commissioner. Applications must include a description of the problem that the proposed project will address, a description of the project including construction and remodeling drawings or specifications, sources of funds for the project, uses of funds for the project, the results expected, and a plan to maintain or operate any facility or equipment included in the project. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organization. Applicants must submit to the commissioner evidence that competitive bidding was used to select contractors for the project.

Subd. 4. **CONSIDERATION OF APPLICATIONS.** The commissioner shall review each application to determine whether or not the hospital's application is complete and whether the hospital and the project are eligible for a grant or loan. In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning: a maximum of 40 points for an applicant's clarity and thoroughness in describing the problem and the project; a maximum of 40 points for the extent to which the applicant has demonstrated that it has made adequate provisions to assure proper and efficient operation of the facility once the project is completed; and a maximum of 20 points for the extent to which the proposed project is consistent with the hospital's capital improvement plan or strategic plan. The commissioner may also take into account other relevant factors. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies a loan applicant.

Subd. 5. **PROGRAM OVERSIGHT.** The commissioner of health shall review audited financial information of the hospital to assess eligibility. The commissioner shall determine the amount of a grant or loan to be given to an eligible rural hospital based on the relative score of each eligible hospital's application and the funds available to the commissioner. The grant or loan shall be used to update, remodel, or replace aging facilities and equipment necessary to maintain the operations of the hospital.

Subd. 6. **LOAN PAYMENT.** Loans shall be repaid as provided in this subdivision over a period of 15 years. In those years when an eligible rural hospital experiences a positive net operating margin in excess of two percent, the eligible rural hospital shall pay to the state one–half of the excess above two percent, up to the yearly payment amount based upon a loan period of 15 years. If the amount paid back in any year is less than the yearly payment amount, or if no payment is required because the eligible rural hospital does not experience a positive net operating margin in excess of two percent, the amount unpaid for that year shall be forgiven by the state without any financial penalty. As a condition of receiving an award through this program, eligible hospitals must agree to

any and all collection activities the commissioner finds necessary to collect loan payments in those years a payment is due.

Subd. 7. **ACCOUNTING TREATMENT.** The commissioner of finance shall record as grants in the state accounting system funds obligated by this section. Loan payments received under this section shall be deposited in the health care access fund.

Subd. 8. **EXPIRATION.** This section expires June 30, 1999.

Sec. 54. Minnesota Statutes 1996, 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 operating income losses in ~~the~~ two of the previous three 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 operating loss margin (total operating losses as a percentage of total operating revenue) for ~~the~~ two of the previous three most recent consecutive fiscal years for which audited financial information is available and the total amount of funding available. For purposes of calculating a hospital's operating loss margin, total operating revenue does not include grant funding provided under this subdivision. One hundred percent of the available funds will be disbursed proportionately based on the operating loss margins of the eligible hospitals.

Sec. 55. Minnesota Statutes 1996, section 256.045, subdivision 3a, is amended to read:

Subd. 3a. **PREPAID HEALTH PLAN APPEALS.** (a) All prepaid health plans under contract to the commissioner under chapter 256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). When a complaint is filed, the prepaid health plan must notify the ombudsman within three working days. Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health

plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services referee shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

Sec. 56. Minnesota Statutes 1996, section 256.9363, subdivision 1, is amended to read:

Subdivision 1. **SELECTION OF VENDORS.** In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. ~~Managed care plans may include integrated service networks as defined in section 62N.02.~~

Sec. 57. Minnesota Statutes 1996, section 256.9657, subdivision 3, is amended to read:

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

(b) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization, ~~integrated service network,~~ or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wrap–around subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization, ~~an integrated service network,~~ or a community integrated service network and the health care financing administration of the federal Department of Health and Human Services, for services to a Medicare beneficiary; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization, ~~integrated service network,~~ or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization, ~~integrated service network,~~ or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

(c) When a health maintenance organization or ~~an integrated service network or~~ community integrated service network merges or consolidates with or is acquired by another health maintenance organization, ~~integrated service network,~~ or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(d) Effective July 1 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the second previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

(e) When a health maintenance organization, ~~integrated service network,~~ or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization, ~~integrated service network,~~ or community integrated service network.

(f) In the event a health maintenance organization, ~~integrated service network,~~ or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(g) The surcharge assessed to a health maintenance organization~~, integrated service network,~~ or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

Sec. 58. **MEIP STUDY.**

The commissioner of employee relations shall study the current Minnesota employees insurance program (MEIP) and report to the legislature by January 15, 1998, on recommendations on whether this program provides greater accessibility to small employers for purchasing health insurance and on the continued viability of the program, including whether the program could be modified in terms of underwriting, marketing, and advertising to create a program that would provide a cost incentive for small employers to purchase health coverage through this program.

Sec. 59. **MCHA STANDARDS STUDY.**

The commissioner of commerce, in consultation with the commissioner of health, shall study and make recommendations regarding the feasibility of establishing a comprehensive set of eligibility standards for coverage under the Minnesota comprehensive health association and on guaranteed issuance in the individual market for individuals who do not meet the eligibility standards for coverage under the Minnesota comprehensive health association. The recommendations shall be reported to the legislature by January 15, 1998.

Sec. 60. **PRESCRIPTION DRUG INSURANCE PROGRAM.**

The commissioner of commerce shall study the feasibility of providing an insurance program to provide prescription drugs to Minnesotans who are 65 and older. The program shall be administered by the Minnesota comprehensive health association, but shall be separate from the health coverage programs operated by the association under Minnesota Statutes, chapter 62E. In studying the feasibility of the program, the commissioner shall incorporate, to the extent feasible, the administrative procedures and health care delivery methods used by the association under Minnesota Statutes, chapter 62E. The commissioner shall study the program based upon independent actuarial analysis, and shall present recommendations to the legislature by December 15, 1997.

Sec. 61. **PUBLIC PROGRAMS RATE SETTING AND RISK ADJUSTMENT.**

The commissioners of health and of human services shall submit a coordinated report on rate setting and risk adjustment methods to the legislature by February 1, 1998. An interim report shall be provided to the legislative commission on health care access to facilitate a public hearing and testimony prior to the 1998 legislative session. Changes in the rate setting and risk adjustment methods shall not be implemented until after the 1998 legislative session.

Sec. 62. **REVISOR INSTRUCTIONS.**

The revisor of statutes shall delete references to "integrated service network," but not "community integrated service network," wherever it appears in Minnesota Statutes and make conforming changes as necessary.

Sec. 63. **REPEALER.**

(a) Minnesota Statutes 1996, sections 62E.11, subdivision 12; 62J.03, subdivision 3; 62J.04, subdivisions 4 and 7; 62J.05; 62J.051; 62J.09, subdivision 3a; 62J.37; 62N.01, subdivision 2; 62N.02, subdivisions 2, 3, 4b, 4c, 6, 7, 8, 9, 10, and 12; 62N.03; 62N.04; 62N.05; 62N.06; 62N.065; 62N.071; 62N.072; 62N.073; 62N.074; 62N.076; 62N.077; 62N.078; 62N.10; 62N.11; 62N.12; 62N.13; 62N.14; 62N.15; 62N.17; 62N.18; 62N.24; 62N.38; 62Q.165, subdivision 3; 62Q.25; 62Q.29; 62Q.41 and 147.01, subdivision 6, are repealed.

(b) Laws 1993, chapter 247, article 4, section 8; Laws 1995, chapter 96, section 2; and Laws 1995, First Special Session chapter 3, article 13, section 2, are repealed.

(c) Laws 1994, chapter 625, article 5, section 5, as amended by Laws 1995, chapter 234, article 3, section 8, is repealed.

Sec. 64. **EFFECTIVE DATE.**

Section 23 is effective the day following final enactment. Section 46 is effective January 1, 1998, and applies to high deductible health plans issued or renewed on or after that date.

ARTICLE 3

MINNESOTACARE TAXES

Section 1. **[16A.76] FEDERAL RESERVE; HEALTH CARE ACCESS FUND.**

Subdivision 1. **ESTABLISH RESERVE.** The federal contingency reserve is established within the health care access fund for uses necessary to preserve access to basic health care services when federal funding is significantly reduced.

Subd. 2. **RESERVE FINANCING.** The funds in reserve shall be equal to the amount of federal financial participation received since July 1, 1995, for services and administrative activities funded by the health care access fund up to a reserve limit of $150,000,000. Investment income attributed to the federal contingency reserve balances shall also be included in the total reserve amount.

Subd. 3. **PERMITTED USE.** The federal contingency reserve is established to protect access to basic health care services that are publicly funded. Funds held in the federal contingency reserve are available for appropriation in the event that federal funds for basic health care services are significantly reduced such as under federal reform or other significant changes to federal law.

Subd. 4. **LIMITS ON USE.** The federal contingency reserve is not available for supplementing reductions in federal funding resulting from application of current federal law funding formulas, for funding long–term care services, or for replacing existing general fund commitments.

Sec. 2. Minnesota Statutes 1996, section 60A.15, subdivision 1, is amended to read:

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

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

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

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

(e) For purposes of computing installments for town and farmers' mutual insurance companies and for mutual property casualty companies with total assets on December 31, 1989, of $1,600,000,000 or less, the following rates apply:

(1) for all life insurance, two percent;

(2) for town and farmers' mutual insurance companies and for mutual property and casualty companies with total assets of $5,000,000 or less, on all other coverages, one percent; and

(3) for mutual property and casualty companies with total assets on December 31, 1989, of $1,600,000,000 or less, on all other coverages, 1.26 percent.

(f) Premiums under medical assistance, general assistance medical care, the MinnesotaCare program, and the Minnesota comprehensive health insurance plan and all payments, revenues, and reimbursements received from the federal government for Medicare–related coverage as defined in section 62A.31, subdivision 3, paragraph (e), are not subject to tax under this section.

(g) For calendar years 1998 and 1999, the installments for health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations must be based on an amount equal to one percent of premiums described under paragraph (b). Health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations that have met the cost containment goals established under section 62J.04 in the individual and small employer market for calendar year 1996 are exempt from payment of the tax imposed under this section for

premiums paid after March 30, 1997, and before April 1, 1998. Health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations that have met the cost containment goals established under section 62J.04 in the individual and small employer market for calendar year 1997 are exempt from payment of the tax imposed under this section for premiums paid after March 30, 1998, and before April 1, 1999.

(h) For calendar years after 1999, the commissioner of finance shall determine the balance of the health care access fund on September 1 of each year beginning September 1, 1999. If the commissioner determines that there is no structural deficit for the next fiscal year, no tax shall be imposed under paragraph (d) for the following calendar year. If the commissioner determines that there will be a structural deficit in the fund for the following fiscal year, then the commissioner, in consultation with the commissioner of revenue, shall determine the amount needed to eliminate the structural deficit and a tax shall be imposed under paragraph (d) for the following calendar year. The commissioner shall determine the rate of the tax as either one–quarter of one percent, one–half of one percent, three–quarters of one percent, or one percent of premiums described in paragraph (b), whichever is the lowest of those rates that the commissioner determines will produce sufficient revenue to eliminate the projected structural deficit. The commissioner of finance shall publish in the State Register by October 1 of each year the amount of tax to be imposed for the following calendar year.

(i) In approving the premium rates as required in sections 62L.08, subdivision 8, and 62A.65, subdivision 3, the commissioners of health and commerce shall ensure that any exemption from the tax as described in paragraphs (g) and (h) is reflected in the premium rate.

Sec. 3. Minnesota Statutes 1996, 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~~ in accordance with section 16A.76. The commissioner must make a quarterly assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including ~~minimum~~ the reserve requirements described in section 16A.76, 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, 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 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 en-

rolled 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 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 (c), for fiscal year 1997.~~

~~(c) Notwithstanding 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 (b).~~

Sec. 4. Minnesota Statutes 1996, 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 hospital for patient services;

(2) a surgical center for patient services;

(3) a health care provider, other than a staff model health carrier, for patient services;

(4) 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; and

(5) 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~~; and~~

~~(6) a pharmacy for medical supplies, appliances, and equipment.~~

Sec. 5. Minnesota Statutes 1996, section 295.50, subdivision 4, is amended to read:

Subd. 4. **HEALTH CARE PROVIDER.** (a) "Health care provider" means:

(1) a person whose health care occupation is regulated or required to be regulated by the state of Minnesota 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~~; (2) a person who provides goods and services not listed ~~above~~ in clause (1) that qualify 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)~~ (3) a staff model health plan company; ~~or~~

~~(3)~~ (4) an ambulance service required to be licensed; or

(5) a person who sells or repairs hearing aids and related equipment or prescription eyewear.

(b) Health care provider does not include hospitals, medical supplies distributors, except as specified under paragraph (a), clause (5); nursing homes licensed under chapter 144A or licensed in any other jurisdiction; pharmacies; surgical centers; bus and taxicab transportation, or any other providers of transportation services other than ambulance services required to be licensed; supervised living facilities for persons with mental retardation or related conditions, licensed under Minnesota Rules, parts 4665.0100 to 4665.9900; 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 157.17 to provide supportive services or health supervision services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training and habilitation services for adults with mental retardation and related conditions as defined in section 252.41, subdivision 3; and boarding care homes, as defined in Minnesota Rules, part 4655.0100.

(c) For purposes of this subdivision, "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.

Sec. 6. Minnesota Statutes 1996, section 295.50, subdivision 6, is amended to read:

Subd. 6. **HOME HEALTH CARE SERVICES.** "Home health care services" are services:

(1) defined under the state medical assistance program as home health agency services provided by a home health agency, personal care services and supervision of personal care services, private duty nursing services, and waivered services or services by home care providers required to be licensed under chapter 144A; and

(2) provided at a recipient's residence, if the recipient does not live in a hospital, nursing facility, as defined in section 62A.46, subdivision 3, or intermediate care facility for persons with mental retardation as defined in section 256B.055, subdivision 12, paragraph (d).

Sec. 7. Minnesota Statutes 1996, section 295.50, subdivision 7, is amended to read:

Subd. 7. **HOSPITAL.** "Hospital" means a hospital licensed under chapter 144, or a hospital licensed by any other ~~state or province or territory of Canada~~ jurisdiction.

Sec. 8. Minnesota Statutes 1996, section 295.50, subdivision 13, is amended to read:

Subd. 13. **SURGICAL CENTER.** "Surgical center" is an outpatient surgical center as defined in Minnesota Rules, chapter 4675 or a similar facility located in any other ~~state or province or territory of Canada~~ jurisdiction.

Sec. 9. Minnesota Statutes 1996, section 295.50, subdivision 14, is amended to read:

Subd. 14. **WHOLESALE DRUG DISTRIBUTOR.** "Wholesale drug distributor" means a wholesale drug distributor required to be licensed under sections 151.42 to 151.51 ~~or a nonresident pharmacy required to be registered under section 151.19~~.

Sec. 10. Minnesota Statutes 1996, section 295.51, subdivision 1, is amended to read:

Subdivision 1. **BUSINESS TRANSACTIONS IN MINNESOTA.** A hospital, surgical center, ~~pharmacy,~~ or health care provider is subject to tax under sections 295.50 to 295.59 if it is "transacting business in Minnesota." A hospital, surgical center, ~~pharmacy,~~ or health care provider is transacting business in Minnesota if it maintains contacts with or presence in the state of Minnesota sufficient to permit taxation of gross revenues received for patient services under the United States Constitution.

Sec. 11. Minnesota Statutes 1996, section 295.52, subdivision 4, is amended to read:

Subd. 4. **USE TAX; PRESCRIPTION DRUGS.** A person that receives prescription drugs for resale or use in Minnesota, other than from a wholesale drug distributor that paid the tax under subdivision 3, is subject to a tax equal to ~~two percent of~~ the price paid multiplied by the tax percentage specified in this section. Liability for the tax is incurred when prescription drugs are received or delivered in Minnesota by the person.

Sec. 12. Minnesota Statutes 1996, section 295.52, is amended by adding a subdivision to read:

Subd. 6. **HEARING AIDS AND PRESCRIPTION EYEWEAR.** The tax liability of a person who meets the definition of a health care provider solely because the person sells or repairs hearing aids and related equipment or prescription eyewear is limited to the gross revenues received from the sale or repair of these items.

Sec. 13. Minnesota Statutes 1996, section 295.52, is amended by adding a subdivision to read:

Subd. 7. **TAX REDUCTION.** Notwithstanding subdivisions 1, 1a, 2, 3, and 4, the tax imposed under this section for calendar years 1998 and 1999 shall be equal to 1.5 percent of the gross revenues received on or after January 1, 1998, and before January 1, 2000. The commissioner shall extend the reduced tax rate of 1.5 percent for gross revenues received on or after January 1, 2000, and before January 1, 2002, if the commissioner of finance determines that the health care access fund structural balance projected for fiscal year 2001 will remain positive, prior to any increase of the one percent premium tax under section 60A.15, subdivision 1, paragraph (h), and prior to any tax expenditures related to the increase in the maximum tax credit for research expenses under section 295.53, subdivision 4, as amended by this act.

Sec. 14. Minnesota Statutes 1996, 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 Medicare enrollee or by 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 this chapter 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 who is subject to tax under section 295.52, subdivision 3, 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 health care provider or the wholly owned subsidiary of a 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 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 health care provider for ~~medical supplies, appliances, and equipment~~ hearing aids and related equipment or prescription eyewear delivered outside of Minnesota;

(18) 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

(19) payments received for services provided by: assisted living programs and congregate housing programs.

(b) Payments received by wholesale drug distributors for ~~prescription~~ legend 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. 15. Minnesota Statutes 1996, section 295.53, subdivision 3, is amended to read:

Subd. 3. **SEPARATE STATEMENT OF TAX.** A hospital, surgical center, ~~pharmacy,~~ or health care provider must not state the tax obligation under section 295.52 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 multiplied by the tax percentage specified in section 295.52. Pharmacies must not state the tax obligation ~~as two percent of~~ based on 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. 16. Minnesota Statutes 1996, 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 au-~~

~~thority 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 qualifying research conducted by an allowable research ~~programs~~ program.

(b) For purposes of this subdivision, the following requirements apply:

(1) expenditures ~~for allowable research programs are the direct and general~~ must be for program costs ~~for activities which are part~~ of qualifying research conducted by an allowable research program;

(2) an allowable research program must be 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. Allowable~~ conducted by an entity 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;

(3) qualifying research must:

(A) be approved in writing by the governing body of the hospital or health care provider which is taking the deduction under this subdivision;

~~(1)~~ (B) 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)~~ (C) be subject to review 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)~~ (D) be subject to review and supervision by an institutional review board operating in conformity with federal regulations 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 sec-

tion 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 tax percentage specified in section 295.52. The commissioner shall pay the refund no later than May 15 of the calendar year.

(e) This subdivision expires January 1, 2000.

Sec. 17. Minnesota Statutes 1996, section 295.53, is amended by adding a subdivision to read:

Subd. 4a. **CREDIT FOR RESEARCH.** (a) In addition to the exemptions allowed under subdivision 1, a hospital or health care provider may claim an annual credit against the total amount of tax, if any, the hospital or health care provider owes for that calendar year under sections 295.50 to 295.57. The credit shall equal 2.5 percent of revenues for patient services used to fund expenditures for qualifying research conducted by an allowable research program. The amount of the credit shall not exceed the tax liability of the hospital or health care provider under sections 295.50 to 295.57.

(b) For purposes of this subdivision, the following requirements apply:

(1) expenditures must be for program costs of qualifying research conducted by an allowable research program;

(2) an allowable research program must be a formal program of medical and health care research conducted by an entity 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;

(3) qualifying research must:

(A) be approved in writing by the governing body of the hospital or health care provider which is taking the deduction under this subdivision;

(B) 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;

(C) be subject to review 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

(D) be subject to review and supervision by an institutional review board operating in conformity with federal regulations 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 credit 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.

(d) The taxpayer shall apply for the credit under this section on the annual return under section 295.55, subdivision 5.

(e) Beginning September 1, 2000, if the actual or estimated amount paid under this section for the calendar year exceeds $2,500,000, the commissioner of finance shall determine the rate of the research credit for the following calendar year to the nearest one-half percent so that refunds paid under this section will most closely equal $2,500,000. The commissioner of finance shall publish in the State Register by October 1 of each year the rate of the credit for the following calendar year. A determination under this section is not subject to the rulemaking provisions of chapter 14.

Sec. 18. Minnesota Statutes 1996, section 295.54, subdivision 1, is amended to read:

Subdivision 1. **TAXES PAID TO ANOTHER STATE.** A hospital, surgical center, ~~pharmacy,~~ or health care provider that has paid taxes to another ~~state or province or territory of Canada~~ jurisdiction measured by gross revenues and is subject to tax under sections 295.52 to 295.59 on the same gross revenues is entitled to a credit for the tax legally due and paid to another ~~state or province or territory of Canada~~ jurisdiction to the extent of the lesser of (1) the tax actually paid to the other ~~state or province or territory of Canada~~ jurisdiction, or (2) the amount of tax imposed by Minnesota on the gross revenues subject to tax in the other taxing jurisdictions.

Sec. 19. Minnesota Statutes 1996, section 295.54, subdivision 2, is amended to read:

Subd. 2. **PHARMACY ~~CREDIT~~ REFUND.** A pharmacy may claim ~~a quarterly credit~~ an annual refund against the total amount of tax, if any, the pharmacy owes during that ~~quarter~~ calendar year under section 295.52, subdivision ~~1b, as provided in this subdivision~~ 2. The ~~credit~~ refund shall equal ~~two percent of~~ the amount paid by the pharmacy to a wholesale drug distributor subject to tax under section 295.52, subdivision 3, for legend drugs delivered by the pharmacy outside of Minnesota, multiplied by the tax percentage specified in section 295.52. If the amount of the ~~credit~~ refund exceeds the tax liability of the pharmacy under section 295.52, subdivision 1b, the commissioner shall provide the pharmacy with a refund equal to the excess amount. Each qualifying pharmacy must apply for the refund on the annual return as provided under section 295.55, subdivision 5. The refund must be claimed within one year of the due date of the return. Interest on refunds paid under this subdivision will begin to accrue 60 days after the date a claim for refund is filed. For purposes of this subdivision, the date a claim is filed is the due date of the return or the date of the actual claim for refund, whichever is later.

Sec. 20. Minnesota Statutes 1996, section 295.55, subdivision 2, is amended to read:

Subd. 2. **ESTIMATED TAX; HOSPITALS; SURGICAL CENTERS.** (a) Each hospital or surgical center must make estimated payments of the taxes for the calendar year in monthly installments to the commissioner within ~~ten~~ 15 days after the end of the month.

(b) Estimated tax payments are not required of hospitals or surgical centers if the tax for the calendar year is less than $500 or if a hospital has been allowed a grant under section 144.1484, subdivision 2, for the year.

(c) Underpayment of estimated installments bear interest at the rate specified in section 270.75, from the due date of the payment until paid or until the due date of the annual return at the rate specified in section 270.75. An underpayment of an estimated installment is the difference between the amount paid and the lesser of (1) 90 percent of one–twelfth of the tax for the calendar year or (2) the tax for the actual gross revenues received during the month.

Sec. 21. Minnesota Statutes 1996, 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 tax percentage specified in section 295.52 multiplied against the gross revenues received under the third–party contract, and ~~two percent of~~ the tax percentage specified in section 295.52 multiplied against 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).

(c) Any hospital, surgical center, or health care provider 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 file a complaint with the commissioner responsible for regulating the third–party purchaser if at any time the third–party purchaser fails to comply with paragraph (a).

(d) 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 take enforcement action against a third–party purchaser which is subject to

the commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center, pharmacy, or provider to pass–through the tax. 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 if the commissioner finds that the third–party purchaser has not complied with this section. The third–party purchaser may appeal the commissioner's order through a contested case hearing in accordance with chapter 14.

Sec. 22. **MCHA ASSESSMENT OFFSET.**

In approving the premium rates as required in Minnesota Statutes, sections 62A.65, subdivision 3, and 62L.08, subdivision 8, the commissioners of health and commerce shall ensure that any appropriation to reduce the annual assessment made on the contributing members to cover the costs of the Minnesota comprehensive health insurance plan as required under Minnesota Statutes, section 62E.11, is reflected in the premium rate of each contributing member.

Sec. 23. **REPEALER.**

(a) Minnesota Statutes 1996, sections 295.52, subdivision 1b; and 295.53, subdivision 5, are repealed.

(b) Laws 1997, chapters 31, article 4; and 84, article 4, are repealed. Notwithstanding Minnesota Statutes, section 645.34, the sections of statutes amended by the laws repealed under this paragraph remain in effect as if not so amended.

Sec. 24. **EFFECTIVE DATES.**

Section 2, subdivision 1, paragraph (f), is effective for payments, revenues, and reimbursements received from the federal government on or after December 31, 1996.

Sections 1 and 3 are effective July 1, 1997.

Sections 4, 5, 6, 9 to 13, 15, and 19 are effective for gross revenues received after December 31, 1997.

Section 14, subdivision 1, paragraph (a), clause (6), and paragraph (b) are effective the day following final enactment. Section 14, paragraph (a), clause (17), is effective for gross revenues received for hearing aids and related equipment or prescription eyewear after December 31, 1997.

Section 18 is effective January 1, 1998. Section 21, paragraph (a), is effective January 1, 1998.

Section 20 is effective for estimated payments due after July 1, 1997.

Sections 7, 8, and 21, paragraphs (c) and (d), are effective the day following final enactment.

Section 16 is effective for research expenditures incurred after December 31, 1995. Section 17 is effective for research expenditures incurred after December 31, 1999.

Section 23 is effective January 1, 1998.

ARTICLE 4

SENIOR CITIZEN DRUG PROGRAM

Section 1. Minnesota Statutes 1996, section 256.01, subdivision 2, is amended to read:

Subd. 2. **SPECIFIC POWERS.** Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall:

(1) Administer and supervise all forms of public assistance provided for by state law and other welfare activities or services as are vested in the commissioner. Administration and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

(a) require county agency participation in training and technical assistance programs to promote compliance with statutes, rules, federal laws, regulations, and policies governing human services;

(b) monitor, on an ongoing basis, the performance of county agencies in the operation and administration of human services, enforce compliance with statutes, rules, federal laws, regulations, and policies governing welfare services and promote excellence of administration and program operation;

(c) develop a quality control program or other monitoring program to review county performance and accuracy of benefit determinations;

(d) require county agencies to make an adjustment to the public assistance benefits issued to any individual consistent with federal law and regulation and state law and rule and to issue or recover benefits as appropriate;

(e) delay or deny payment of all or part of the state and federal share of benefits and administrative reimbursement according to the procedures set forth in section 256.017; and

(f) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using appropriated funds.

(2) Inform county agencies, on a timely basis, of changes in statute, rule, federal law, regulation, and policy necessary to county agency administration of the programs.

(3) Administer and supervise all child welfare activities; promote the enforcement of laws protecting handicapped, dependent, neglected and delinquent children, and children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child–caring and child–placing agencies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the state board of control.

(4) Administer and supervise all noninstitutional service to handicapped persons, including those who are visually impaired, hearing impaired, or physically impaired or

otherwise handicapped. The commissioner may provide and contract for the care and treatment of qualified indigent children in facilities other than those located and available at state hospitals when it is not feasible to provide the service in state hospitals.

(5) Assist and actively cooperate with other departments, agencies and institutions, local, state, and federal, by performing services in conformity with the purposes of Laws 1939, chapter 431.

(6) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

(7) Establish and maintain any administrative units reasonably necessary for the performance of administrative functions common to all divisions of the department.

(8) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as mentally retarded.

(9) Act as coordinating referral and informational center on requests for service for newly arrived immigrants coming to Minnesota.

(10) The specific enumeration of powers and duties as hereinabove set forth shall in no way be construed to be a limitation upon the general transfer of powers herein contained.

(11) Establish county, regional, or statewide schedules of maximum fees and charges which may be paid by county agencies for medical, dental, surgical, hospital, nursing and nursing home care and medicine and medical supplies under all programs of medical care provided by the state and for congregate living care under the income maintenance programs.

(12) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

(a) The proposed comprehensive plan, including estimated project costs and the proposed order establishing the waiver, shall be filed with the secretary of the senate and chief clerk of the house of representatives at least 60 days prior to its effective date.

(b) The secretary of health, education, and welfare of the United States has agreed, for the same project, to waive state plan requirements relative to statewide uniformity.

(c) A comprehensive plan, including estimated project costs, shall be approved by the legislative advisory commission and filed with the commissioner of administration.

(13) In accordance with federal requirements, establish procedures to be followed by local welfare boards in creating citizen advisory committees, including procedures for selection of committee members.

(14) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for the aid to families with dependent children, medical assistance, or food stamp program in the following manner:

(a) One–half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and AFDC programs, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due.

(b) Notwithstanding the provisions of paragraph (a), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in paragraph (a), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to paragraph (a).

(15) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited in the state treasury and credited to a special account until the balance in the account reaches $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

(16) Have the authority to make direct payments to facilities providing shelter to women and their children pursuant to section 256D.05, subdivision 3. Upon the written request of a shelter facility that has been denied payments under section 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make a determination within 30 days of the request for review regarding issuance of direct payments to the shel-

ter facility. Failure to act within 30 days shall be considered a determination not to issue direct payments.

(17) Have the authority to establish and enforce the following county reporting requirements:

(a) The commissioner shall establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for human services programs. When establishing financial and statistical reporting requirements, the commissioner shall evaluate all reports, in consultation with the counties, to determine if the reports can be simplified or the number of reports can be reduced.

(b) The county board shall submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format shall be accepted by the commissioner.

(c) If the required reports are not received by the deadlines established in clause (b), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received.

(d) A county board that submits reports that are late, illegible, incomplete, or not in the required format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner shall notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county board plans to correct the problem. The corrective action plan must be submitted to the commissioner within 45 days after the date the county board received notice of noncompliance.

(e) The final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the report for that reporting period and the county board must repay any funds associated with the report received for that reporting period.

(f) The commissioner may not delay payments, withhold funds, or require repayment under paragraph (c) or (e) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the commissioner under paragraph (c) or (e), the county board may appeal the action according to sections 14.57 to 14.69.

(g) Counties subject to withholding of funds under paragraph (c) or forfeiture or repayment of funds under paragraph (e) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under paragraph (c) or (e).

(18) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample for the foster care program under title IV–E of the Social Security Act, United States Code, title 42, in direct proportion to each county's title IV–E foster care maintenance claim for that period.

(19) Have the authority to administer a drug rebate program for drugs purchased pursuant to the senior citizen drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. For each drug, the amount of the rebate shall be equal to the basic rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r–8(c)(1). This basic rebate shall be applied to single–source and multiple–source drugs. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

Sec. 2. **[256.955] SENIOR CITIZEN DRUG PROGRAM.**

Subdivision 1. **ESTABLISHMENT.** The commissioner of human services shall establish and administer a senior citizen drug program. Qualified senior citizens shall be eligible for prescription drug coverage under the program beginning no later than January 1, 1999.

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

(b) "Health plan" has the meaning provided in section 62Q.01, subdivision 3.

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

(d) "Qualified senior citizen" means an individual age 65 or older who:

(1) is eligible as a qualified Medicare beneficiary according to section 256B.057, subdivision 3 or 3a, or is eligible under section 256B.057, subdivision 3 or 3a, and is also eligible for medical assistance or general assistance medical care with a spenddown as defined in section 256B.056, subdivision 5. Persons who are determined eligible for medical assistance according to section 256B.0575, who are eligible for medical assistance or general assistance medical care without a spenddown, or who are enrolled in MinnesotaCare, are not eligible for this program;

(2) is not enrolled in prescription drug coverage under a health plan;

(3) is not enrolled in prescription drug coverage 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 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended;

(4) has not had coverage described in clauses (2) and (3) for at least four months prior to application for the program; and

(5) is a permanent resident of Minnesota as defined in section 256.9359.

Subd. 3. **PRESCRIPTION DRUG COVERAGE.** Coverage under the program is limited to prescription drugs covered under the medical assistance program as described in section 256B.0625, subdivision 13, subject to a maximum deductible of $300 annually, except drugs cleared by the FDA shall be available to qualified senior citizens enrolled in the program without restriction when prescribed for medically accepted indication as defined in the federal rebate program under section 1927 of title XIX of the federal Social Security Act.

Subd. 4. **APPLICATION PROCEDURES AND COORDINATION WITH MEDICAL ASSISTANCE.** Applications and information on the program must be made available at county social service agencies, health care provider offices, and agencies and organizations serving senior citizens. Senior citizens shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the county social service agencies:

(1) beginning January 1, 1999, the county social service agency shall determine medical assistance spenddown eligibility of individuals who qualify for the senior citizen drug program of individuals; and

(2) program payments will be used to reduce the spenddown obligations of individuals who are determined to be eligible for medical assistance with a spenddown as defined in section 256B.056, subdivision 5.

Seniors who are eligible for medical assistance with a spenddown shall be financially responsible for the deductible amount up to the satisfaction of the spenddown. No deductible applies once the spenddown has been met. Payments to providers for prescription drugs for persons eligible under this subdivision shall be reduced by the deductible.

County social service agencies shall determine an applicant's eligibility for the program within 30 days from the date the application is received.

Subd. 5. **DRUG UTILIZATION REVIEW PROGRAM.** The commissioner shall utilize the drug utilization review program as described in section 256B.0625, subdivision 13a.

Subd. 6. **PHARMACY REIMBURSEMENT.** The commissioner shall reimburse participating pharmacies for drug and dispensing costs at the medical assistance reimbursement level, minus the deductible required under subdivision 7.

Subd. 7. **COST SHARING.** (a) Enrollees shall pay an annual premium of $120.

(b) Program enrollees must satisfy a $300 annual deductible, based upon expenditures for prescription drugs, to be paid as follows:

(1) $25 monthly deductible for persons with a monthly spenddown; or

(2) $150 biannual deductible for persons with a six-month spenddown.

The commissioner may adjust the annual deductible amount to stay within the program's appropriation.

Subd. 8. **REPORT.** The commissioner shall annually report to the legislature on the senior citizen drug program. The report must include demographic information on en-

rollees, per–prescription expenditures, total program expenditures, hospital and nursing home costs avoided by enrollees, any savings to medical assistance and Medicare resulting from the provision of prescription drug coverage under Medicare by health maintenance organizations, other public and private options for drug assistance to the senior population, any hardships caused by the annual premium and deductible, and any recommendations for changes in the senior drug program.

Subd. 9. **PROGRAM LIMITATION.** This section shall be repealed upon federal approval of the waiver to allow the commissioner to provide prescription drug coverage for qualified Medicare beneficiaries whose income is less than 150 percent of the federal poverty guidelines.

Sec. 3. Minnesota Statutes 1996, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **DRUGS.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control. The commissioner, after receiving recommendations from professional medical associations and professional pharmacist associations, shall designate a formulary committee to advise the commissioner on the names of drugs for which payment is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve three–year terms and shall serve without compensation. Members may be reappointed once.

(b) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the administrative procedure act, but the formulary committee shall review and comment on the formulary contents. The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; and

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include:

(i) drugs or products for which there is no federal funding;

(ii) over–the–counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, and vitamins for children under the age of seven and pregnant or nursing women;

(iii) any other over–the–counter drug identified by the commissioner, in consultation with the drug formulary committee, as necessary, appropriate, and cost–effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14;

(iv) anorectics; ~~and~~

(v) drugs for which medical value has not been established; and

(vi) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act and who have not signed an agreement with the state for drugs purchased pursuant to the senior citizen drug program established under section 256.955.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The pharmacy dispensing fee shall be $3.85. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third–party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the administrative procedure act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long–term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30–day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible

for reuse. Over–the–counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30–day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written – brand necessary" on the prescription as required by section 151.21, subdivision 2.

Sec. 4. **SENIOR DRUG PROGRAM.**

The commissioner shall administer the senior drug program so that the costs to the state total no more than $4,000,000 plus the amount of the rebate. The commissioner is authorized to discontinue enrollment in order to meet this level of funding.

The commissioner shall report to the legislature the estimated costs of the senior drug program without funding caps. The report shall be included as part of the November and February forecasts.

The commissioner of finance shall annually reimburse the general fund with health care access funds for the estimated increased costs in the QMB/SLMB program directly associated with the senior drug program. This reimbursement shall sunset June 30, 2001.

Sec. 5. **STUDY ON DUAL PRESCRIPTION DRUG COVERAGE.**

The commissioner of human services shall study the implications to the senior citizen drug program if a health plan company offers within the state a product that provides a prescription drug benefit as part of the standard coverage for Medicare enrollees and shall make recommendations on how to address this issue to the legislature by January 15, 1998.

ARTICLE 5

COMMUNITY PURCHASING ARRANGEMENTS

Section 1. **[62T.01] DEFINITIONS.**

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

Subd. 2. **HEALTH CARE PURCHASING ALLIANCE.** "Health care purchasing alliance" means a business organization created under this chapter to negotiate the purchase of health care services for employers. Nothing in this chapter shall be deemed to regulate or impose any requirements on a self–insured employer or labor union. A health care purchasing alliance may include a grouping of:

(1) businesses, including small businesses with one employee. The businesses may or may not be organized under section 62Q.17, as a purchasing pool;

(2) trade association members or church organizations under section 60A.02, or union members who are not in a self–insured benefit plan;

(3) multiple employer welfare associations under chapter 62H;

(4) municipalities, townships, or counties;

(5) other government entities; or

(6) any combination of clauses (1) to (5).

The alliance may determine the definition of a business of one employee, but must adhere to its definition and show no bias in selection of members, based on that definition.

Subd. 3. **ACCOUNTABLE PROVIDER NETWORK.** "Accountable provider network" means a group of health care providers organized to market health care services on a risk–sharing or nonrisk–sharing basis with a health care purchasing alliance. Accountable provider networks shall operate as not–for–profit entities or as health care cooperatives, as allowed under chapter 62R. This chapter applies only when an accountable provider network is marketing and selling services and benefits to the employees of businesses as authorized in section 62T.05.

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

Sec. 2. **[62T.02] PURCHASING ALLIANCES.**

Subdivision 1. **REGISTRATION.** Purchasing alliances must register prior to offering coverage, and annually on July 1 thereafter, with the commissioner on a form prescribed by the commissioner.

Subd. 2. **COMMON FACTORS.** All participants in a purchasing alliance must live within a common geographic region, be employed in a similar occupation, or share some other common factor as approved by the commissioner. 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. 3. **[62T.03] APPLICATION OF OTHER LAWS.**

An accountable provider network is subject to all requirements applicable to a health plan company licensed in the state, except as otherwise noted in this chapter. An accountable provider network and a health care purchasing alliance must comply with all requirements of chapter 62L. A contracting arrangement between a health care purchasing alliance and an accountable provider network for provision of health care benefits must provide consumer protection functions comparable to those currently required of a health plan company licensed under section 62N.25, and other statutes referenced in that section, except for modifications and waivers permitted under this chapter.

Sec. 4. **[62T.04] COMPLAINT SYSTEM.**

Accountable provider networks must establish and maintain an enrollee complaint system as required under section 62Q.105. The accountable provider network may contract with the health care purchasing alliance or a vendor for operation of this system.

Sec. 5. **[62T.05] BENEFITS.**

An accountable provider network may offer and sell any benefits permitted to be offered and sold by health plan companies under Minnesota law.

Sec. 6. **[62T.06] WAIVERS.**

Subdivision 1. **AUTHORIZATION.** The commissioner may grant waivers from the requirements of law for the contracting arrangement between a health care purchasing alliance and an accountable provider network in the areas listed in subdivisions 2 to 4. The commissioner may not waive the following state consumer protection and quality assurance laws:

(1) laws requiring that enrollees be informed of any restrictions, requirements, or limitations on coverage, services, or access to specialists and other providers;

(2) laws allowing consumers to complain to or appeal to a state regulatory agency if denied benefits or services;

(3) laws prohibiting gag clauses and other restrictions on communication between a patient and their physician or provider;

(4) laws allowing consumers to obtain information on provider financial incentives, which may affect treatment;

(5) laws requiring the submission of information needed to monitor quality of care and enrollee rights;

(6) laws protecting enrollee privacy and confidentiality of records;

(7) minimum standards for adequate provider network capacity and geographic access to services;

(8) laws assuring continuity of care when a patient must change providers;

(9) laws governing coverage of emergency services;

(10) laws prohibiting excessive or unreasonable administrative fees or expenses; and

(11) other laws or rules that are directly related to quality of care, consumer protection, and due process rights.

Subd. 2. **SOLVENCY PROTECTION.** (a) The commissioner may waive the requirements of sections 62N.27 to 62N.32, and may substitute capital and surplus requirements that are reduced from the levels required of other risk–bearing entities in order to reflect its reduced risk exposure. If risk is being underwritten, the underwriter cannot have more than 25 percent of the representation on the governing board of the accountable provider network. The reduced requirements must include at least the following levels of capital and surplus: (i) a deposit of $500,000 plus (ii) the greater of an estimated 15 percent of gross premium revenues or twice the net retained annual risk up to $750,000 on a single enrollee. Net retained annual risk may be, for example, the lowest annual deductible under a provider stop–loss insurance policy that covers all costs above the deductible. Assets supporting the deposit must meet the standards for deposits referenced in section 62N.32. Assets supporting the capital must meet the investment guidelines referenced in section 62N.27.

(b) An accountable provider network may propose a method of reporting income, expenses, claims payments, and other financial information in a manner which adequately demonstrates ongoing compliance with the standards for capital, surplus, and claims reserves agreed to under this waiver.

(c) An accountable provider network may demonstrate ability to continue to deliver the contracted health care services to the purchasing alliance through arrangements which ensure that, subject to 60 days' notice of intent to discontinue the contracting arrangement, provider participants will continue to meet their obligation to provide health care services to enrollees for a period of 60 days.

Subd. 3. **MARKETING AND DISCLOSURE.** The accountable provider network, in conjunction with the health care purchasing alliance, may propose alternative methods to present marketing and disclosure information which assure the accountability to consumers who are offered and who receive their services.

Subd. 4. **QUALITY ASSURANCE.** The accountable provider network may propose an alternative quality assurance program which incorporates effective methods for reviewing and evaluating data related to quality of care and ways to identify and correct quality problems.

Sec. 7. **[62T.07] CRITERIA FOR GRANTING WAIVERS.**

The commissioner may approve a request for waiver under section 62T.06 if the applicant demonstrates that the contracting arrangement between a health care purchasing alliance and an accountable provider network will meet the following criteria:

(a) The arrangement would be likely to result in:

(1) more choice in benefits and prices;

(2) lower costs;

(3) increased access to health care coverage by small businesses;

(4) increased access to providers who have demonstrated a long-term commitment to the community being serviced; or

(5) increased quality of health care than would otherwise occur under the existing market conditions. In the event that a proposed arrangement appears likely to improve one or two of the criteria at the expense of another one or two of the criteria, the commissioner shall not approve the waiver.

(b) The proposed alternative methods would provide equal or improved results in consumer protection than would result under the existing consumer protections requirements.

Sec. 8. **[62T.08] SUPERVISION AND REVOCATION OF WAIVERS.**

(a) The commissioner shall appropriately supervise and monitor approved waivers.

(b) The commissioner may revoke approval of a waiver if the contracting arrangement no longer satisfies the criteria in section 62T.07, paragraphs (a) and (b).

Sec. 9. **[62T.09] MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION.**

A health care purchasing alliance must pay the assessment required of contributing members pursuant to section 62E.11.

Sec. 10. **[62T.10] MINNESOTACARE TAX.**

An accountable provider network is subject to the premium tax established in section 60A.15 and must pay installments as described in section 60A.15, subdivision 1, paragraph (d).

Sec. 11. **[62T.11] DUTIES OF COMMISSIONER.**

(a) By July 1, 1997, the commissioner shall make available application forms for licensure as an accountable provider network. The accountable provider network may begin doing business after application has been approved.

(b) Upon receipt of an application for a certificate of authority, the commissioner shall grant or deny licensure and waivers requested within 90 days of receipt of a complete application if all requirements are substantially met. For a period of one year after the effective date of this chapter, the commissioner may approve up to five applications, none of which may be from health plan companies. If no written response has been received within 90 days, the application is approved. When the commissioner denies an application or waiver request, the commissioner shall notify the applicant in writing specifically stating the grounds for the denial and specific suggestions for how to remedy the denial. The commissioner will entertain reconsiderations. Within 90 days after the denial, the applicant may file a written request for an administrative hearing and review of the commissioner's determination. The hearing is subject to judicial review as provided by chapter 14.

(c) All monitoring, enforcement, and rulemaking powers available under chapter 62N are granted to the commissioner to assure continued compliance with provisions of this chapter.

(d) The commissioner may contract with other entities as necessary to carry out the responsibilities in this chapter.

Sec. 12. **[62T.12] FEES.**

Every accountable provider network subject to this chapter shall pay to the commissioner fees as prescribed by the commissioner pursuant to section 144.122. The initial fees are:

(1) filing an application for licensure, $500;

(2) filing an amendment to a license, $90;

(3) filing an annual report, $200;

(4) filing of renewal of licensure based on a fee of $1,000 per 1,000 enrollees, with renewal every three years; and

(5) other filing fees as specified by rule.

Sec. 13. **[62T.13] ENROLLMENT.**

An accountable provider network created under this chapter is limited to a maximum enrollment of 30,000 persons.

ARTICLE 6

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

Section 1. Minnesota Statutes 1996, section 62E.02, subdivision 13, is amended to read:

Subd. 13. **ELIGIBLE PERSON.** (a) "Eligible person" means an individual who:

(1) is currently and has been a resident of Minnesota for the six months immediately preceding the date of receipt by the association or its writing carrier of a completed certificate of eligibility ~~and who~~;

(2) meets the enrollment requirements of section 62E.14; and

(3) is not otherwise ineligible under this subdivision.

(b) No individual is eligible for coverage under a qualified or a Medicare supplement plan issued by the association for whom a premium is paid or reimbursed by the medical assistance program or general assistance medical care program as of the first day of any term for which a premium amount is paid or reimbursed.

Sec. 2. Minnesota Statutes 1996, section 62E.02, subdivision 18, is amended to read:

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

Sec. 3. Minnesota Statutes 1996, section 62E.13, subdivision 2, is amended to read:

Subd. 2. The association may select policies and contracts, or parts thereof, submitted by a member or members of the association, or by the association or others, to develop specifications for bids from any ~~members~~ entity which ~~wish~~ wishes to be selected as a writing carrier to administer the state plan. The selection of the writing carrier shall be based upon criteria ~~including~~ established by the board of directors of the association and approved by the commissioner. The criteria shall outline specific qualifications that an entity must satisfy in order to be selected and, at a minimum, shall include the ~~member's~~ entity's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract.

Sec. 4. Minnesota Statutes 1996, section 256B.056, subdivision 8, is amended to read:

Subd. 8. **COOPERATION.** To be eligible for medical assistance, applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payers and assist the state in obtaining third party payments, unless good cause for noncooperation is determined according to Code of Federal Regulations, title 42, part 433.147. "Cooperation" includes identifying any third party who may be liable

for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. Cooperation also includes providing information about a group health plan for which the person may be eligible and if the plan is determined cost–effective by the state agency and premiums are paid by the local agency or there is no cost to the recipient, they must enroll or remain enrolled with the group. For purposes of this subdivision, coverage provided by the Minnesota comprehensive health association under chapter 62E shall not be considered group health plan coverage or cost–effective by the state and local agency. Cost–effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to section 256B.19.

Sec. 5. Minnesota Statutes 1996, section 256B.0625, subdivision 15, is amended to read:

Subd. 15. **HEALTH PLAN PREMIUMS AND COPAYMENTS.** (a) Medical assistance covers health care prepayment plan premiums, insurance premiums, and copayments if determined to be cost–effective by the commissioner. For purposes of obtaining Medicare part A and part B, and copayments, expenditures may be made even if federal funding is not available.

(b) Effective for all premiums due on or after June 30, 1997, medical assistance does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota comprehensive health association. Medical assistance shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota comprehensive health association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

Sec. 6. Minnesota Statutes 1996, section 256D.03, subdivision 3b, is amended to read:

Subd. 3b. **COOPERATION.** (a) General assistance or general assistance medical care applicants and recipients must cooperate with the state and local agency to identify potentially liable third–party payors and assist the state in obtaining third–party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. General assistance medical care applicants and recipients must cooperate by providing information about any group health plan in which they may be eligible to enroll. They must cooperate with the state and local agency in determining if the plan is cost–effective. For purposes of this subdivision, coverage provided by the Minnesota comprehensive health association under chapter 62E shall not be considered group health plan coverage or cost–effective by the state and local agency. If the plan is determined cost–effective and the premium will be paid by the state or local agency or is available at no cost to the person, they must enroll or remain enrolled in the group health plan. Cost–effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to subdivision 6.

(b) Effective for all premiums due on or after June 30, 1997, general assistance medical care does not cover premiums that a recipient is required to pay under a qualified or

Medicare supplement plan issued by the Minnesota comprehensive health association. General assistance medical care shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota comprehensive health association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

Sec. 7. **MCHA TERMINATION NOTICE.**

The Minnesota comprehensive health association, in consultation with the commissioner of human services, shall provide written notice to all persons whose coverage under the comprehensive health insurance plan terminates due to the change in policy described in Minnesota Statutes, sections 256B.056, subdivision 15, and 256D.03, subdivision 3b.

The notice must include the following information:

(1) the reason for termination;

(2) a description of the eligibility requirements for the comprehensive health insurance plan;

(3) a description of medical assistance and general assistance medical care eligibility categories;

(4) a description of the participation requirement to the prepaid medical assistance program, prepaid general assistance medical care, and exemptions from participation due to disability as determined by the social security administration; and

(5) a telephone number for the department of human services for specific questions regarding the medical assistance and general assistance medical care program.

Notice must be given at least six months before coverage is terminated.

The commissioner of human services shall release to the association any data necessary to provide the notice required in this section.

Sec. 8. **SUNSET.**

The amendments made in this article to Minnesota Statutes, sections 62E.02, subdivision 13; 256B.056, subdivision 8; 256B.0625, subdivision 15; and 256D.03, subdivision 3b, expire June 30, 1999.

Sec. 9. **EFFECTIVE DATE.**

Sections 2 to 8 are effective the day following final enactment. Section 1 is effective for coverage provided by the comprehensive health association on or after January 1, 1998, subject to the right to retain coverage for six months after receipt of notice of termination under sections 5 and 6.

ARTICLE 7

APPROPRIATIONS

Section 1. **APPROPRIATIONS; SUMMARY.**

Except as otherwise provided in this act, the sums set forth in the columns designated "fiscal year 1998" and "fiscal year 1999" 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, 1998, and June 30, 1999.

Sec. 2. APPROPRIATIONS

SUMMARY BY FUND

	1998	1999	TOTAL
Health Care Access Fund	$ 130,613,000	$ 161,364,000	$ 291,977,000
General Fund	1,357,000	6,127,000	7,484,000
State Government Special Revenue Fund	21,000	37,000	58,000
Subdivision 1. Department of Human Services			
Health Care Access Fund	99,052,000	129,761,000	228,813,000
General Fund	1,357,000	6,127,000	7,484,000

MEDICAL EDUCATION. Of the fiscal year 1998 health care access fund appropriation, $3,500,000 is for medical education research costs. This appropriation, plus the federal financial participation amount shall be distributed to medical assistance providers according to the distribution methodology of the medical education research trust fund established under Minnesota Statutes, section 62J.69. Any unspent funds in this appropriation do not cancel but may carry forward and be available in fiscal year 1999.

GENERAL FUND APPROPRIATION. The general fund appropriation is for costs associated with the senior drug program, the QMB/SLMB cost increases resulting from the senior drug program, and the discontinuation of the MCHA premium payments for MA and GAMC recipients. The health care access fund shall reimburse the general fund

for the QMB/SLMB cost and the GAMC and MA costs.

ADMINISTRATIVE COSTS. Of the health care access appropriation, $342,000 in fiscal year 1998 and $1,536,000 in fiscal year 1999 is for administrative costs associated with moving parents and working adults GAMC into the MinnesotaCare program. Of this appropriation, only $300,000 shall become part of the base for the fiscal 2000–2001 biennium.

SERVICE CHARGES. For fiscal years 1998 and 1999, the department of human services is exempt from service charges imposed by other state agencies when those charges exceed the base appropriation provided to the department for the particular service.

DENTAL SERVICES REIMBURSEMENT INCREASE. Notwithstanding statutory provisions to the contrary, the commissioner shall increase reimbursement rates by 15 percent for dental services covered under the MinnesotaCare program and rendered on or after July 1, 1997. The commissioner shall increase the prepaid capitation rates as appropriate to reflect this rate increase. Notwithstanding section 5, this paragraph does not expire.

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.

MINNESOTA OUTREACH. Of the health care access fund appropriation, $750,000 each year shall be disbursed for grants to public and private organizations to provide outreach for the MinnesotaCare program in

areas of the state with high uninsured populations.

Subd. 2. Department of Health

Health Care Access Fund	10,653,000	12,248,000	22,901,000
State Government Special Revenue Fund	21,000	37,000	58,000

Health care access fund appropriations for student loan forgiveness programs for health care providers are available for either year of the biennium.

RURAL HOSPITAL CAPITAL GRANTS. Of this appropriation, $3,000,000 in fiscal year 1998 and $4,500,000 in fiscal year 1999 shall be disbursed for rural hospital capital improvement grants or loans. Any unspent funds may be used for rural hospital planning and transition grant programs. This appropriation shall not become part of the base for the fiscal year 2000–2001 biennium.

RURAL HOSPITAL DEMONSTRATION PROJECTS. Of this appropriation, $300,000 in each fiscal year shall be disbursed for rural hospital demonstration projects. This appropriation shall not become part of the base for the fiscal year 2000–2001 biennium.

ADMINISTRATIVE COSTS. The base for administrative costs shall be reduced by $450,000 for fiscal years 2000 and 2001. The commissioner shall examine general fund resources to replace this reduction.

Subd. 3. University of Minnesota

Health Care Access Fund	2,537,000	2,537,000	5,074,000

PRIMARY CARE EDUCATION INITIATIVES. Of this appropriation, $180,000 in each fiscal year shall be disbursed to the board of regents for primary care physician education and training under Minnesota Statutes, sections 137.38 to 137.40. This appropriation is available only if matched by $1 for each $1 of the appropriation. This ap-

propriation is in addition to the current base appropriation for these activities and shall become part of the base appropriation for the fiscal year 2000–2001 biennium.

Subd. 4. Department of Revenue

Health Care Access Fund	3,121,000	1,668,000	4,789,000

RESEARCH DEDUCTION. Of this appropriation, $1,500,000 shall be disbursed in fiscal year 1998 to be used for research deduction claims filed by hospitals and health care providers under Minnesota Statutes, section 295.53, subdivision 4, for research expenditures incurred in calendar year 1996. These claims must be filed by August 1, 1997, and the commissioner must pay the refund no later than October 1, 1997.

Subd. 5. Department of Commerce

Health Care Access Fund	15,100,000	15,000,000	30,100,000

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION ASSESSMENT OFFSET. Of this appropriation, $15,000,000 in fiscal year 1998 and $15,000,000 in fiscal year 1999 is for a grant to the Minnesota Comprehensive Health Association and shall be made available on January 1 of each fiscal year to be used to offset the annual assessments for calendar years 1998 and 1999 that are required to be paid by each contributing member in accordance with Minnesota Statutes, section 62E.11. This appropriation shall not become part of the base for the fiscal year 2000–2001 biennium.

Subd. 6. Legislative Coordinating Commission

Health Care Access Fund	150,000	150,000	300,000

Sec. 3. TRANSFERS

$4,112,000 in fiscal year 1998 and $4,104,000 in fiscal year 1999 are transferred from the health care access fund to the general fund to replace the revenue lost due to the repeal of the $400 physician surcharge.

Sec. 4. CARRYOVER

None of the appropriations in this act which are allowed to be carried forward from fiscal year 1998 to fiscal year 1999 shall become part of the base level funding for the 2000–2001 biennial budget, unless specifically directed by the legislature.

Sec. 5. SUNSET

All uncodified language contained in this article expires on June 30, 1999, unless a different expiration is explicit.

ARTICLE 8

HEALTH AND HUMAN SERVICES TECHNICAL CORRECTIONS

Section 1. S. F. No. 1908, article 1, section 2, if enacted, is amended by adding a subdivision to read:

Subd. 10a. Visitation Access Funds

FEDERAL FUNDS FOR VISITATION ACCESS. The commissioner may accept on behalf of the state any federal funding for the purpose of financing visitation access programs, and may expend these funds on services described in Public Law Number 104–193.

Sec. 2. S. F. No. 1908, article 1, section 3, subdivision 2, if enacted, is amended to read:

Subd. 2. Health Systems and Special Populations		48,517,000	48,233,000
	Summary by Fund		
General	39,295,000	38,998,000	
State Government Special Revenue	9,222,000	9,235,000	

FEES; DRUG AND ALCOHOL COUNSELOR LICENSE. When setting fees for the drug and alcohol counselor license, the department is exempt from Minnesota Statutes, section 16A.1285, subdivision 2.

STATE VITAL STATISTICS REDESIGN PROJECT ACCOUNT. The amount

appropriated from the state government special revenue fund for the vital records redesign project shall be available until expended for development and implementation.

WIC PROGRAM. Of this appropriation, $650,000 in 1998 is provided to maintain services of the program, $700,000 in 1998 and $700,000 in 1999 is added to the base level funding for the WIC food program in order to maintain the existing level of the program, and $100,000 in 1998 is for the commissioner to develop and implement an outreach program to apprise potential recipients of the WIC food program of the importance of good nutrition and the availability of the program.

WIC TRANSFERS. General fund appropriations for the women, infants, and children (WIC) food supplement program are available for either year of the biennium. Transfers of appropriations between fiscal years must be for the purpose of maximizing federal funds or minimizing fluctuations in the number of participants.

LOCAL PUBLIC HEALTH FINANCING. Of the general fund appropriation, $5,000,000 each year shall be disbursed for local public health financing and shall be distributed according to the community health service subsidy formula in Minnesota Statutes, section 145A.13.

MINNESOTA CHILDREN WITH SPECIAL HEALTH NEEDS CARRYOVER. General fund appropriations for treatment services in the services for children with special health care needs program are available for either year of the biennium.

HEALTH CARE ASSISTANCE FOR DISABLED CHILDREN INELIGIBLE FOR SSI. Notwithstanding the requirements of Minnesota Rules, part 4705.0100, subpart 14, children who: (a) are eligible for medical assistance as of June 30, 1997, and become ineligible for medical assistance due to changes in supplemental security income disability standards for children enacted in

(PRWORA) Public Law Number 104–193; and (b) are not eligible for MinnesotaCare, are eligible for health care services through Minnesota services for children with special health care needs under Minnesota Rules, parts 4705.0100 to 4705.1600 for the fiscal year ending June 30, 1998, until eligibility for medical assistance is reestablished. The commissioner of health shall report to the legislature by March 1, 1998, on the number of children eligible under this provision, their health care needs, family income as a percentage of the federal poverty level, the extent to which families have employer–based health coverage, and recommendations on how to meet the future needs of children eligible under this provision.

AMERICAN INDIAN DIABETES. Of this appropriation, $90,000 each year shall be disbursed for a comprehensive school–based intervention program designed to reduce the risk factors associated with diabetes among American Indian school children in grades 1 through 4. The appropriation for 1998 may be carried forward to 1999. The appropriation for fiscal year 1999 is available only if matched by $1 of nonstate money for each $1 of the appropriation and may be expended in either year of the biennium. The commissioner shall convene an American Indian diabetes prevention advisory task force. The task force must include representatives from the American Indian tribes located in the state and urban American Indian representatives. The task force shall advise the commissioner on the adaptation of curricula and the dissemination of information designed to reduce the risk factors associated with diabetes among American Indian school children in grades 1 through 4. The curricula and information must be sensitive to traditional American Indian values and culture and must encourage full participation by the American Indian community.

HOME VISITING PROGRAMS. (a) Of this appropriation, $140,000 in 1998 and $870,000 in 1999 is for the home visiting

programs for infant care under Minnesota Statutes, section 145A.16. These amounts are available until June 30, 1999.

(b) Of this appropriation, $225,000 in 1998 and $180,000 in 1999 is to continue funding the home visiting programs that received one–year funding under Laws 1995, chapter 480, article 1, section 9. This amount is available until expended.

FETAL ALCOHOL SYNDROME. Of the general fund appropriation, $625,000 each year of the biennium shall be disbursed to prevent and reduce harm from fetal alcohol syndrome and fetal alcohol effect.

COMPLAINT INVESTIGATIONS. Of the appropriation, $127,000 each year from the state government special revenue fund, and $75,000 each year from the general fund, is for the commissioner to conduct complaint investigations of nursing facilities, hospitals and home health care providers.

COMPLEMENTARY MEDICINE STUDY. (a) Of the general fund appropriation, $20,000 in fiscal year 1998 shall be disbursed for the commissioner of health, in consultation with the commissioner of commerce, to conduct a study based on existing literature, information, and data on the scope of complementary medicine offered in this state. The commissioner shall:

(1) include the types of complementary medicine therapies available in this state;

(2) contact national and state complementary medicine associations for literature, information, and data;

(3) conduct a general literary review for information and data on complementary medicine;

(4) contact the departments of commerce and human services for information on existing registrations, licenses, certificates, credentials, policies, and regulations; and

(5) determine by sample, if complementary medicine is currently covered by health plan companies and the extent of the coverage.

In conducting this review, the commissioner shall consult with the office of alternative medicine through the National Institute of Health.

(b) The commissioner shall, in consultation with the advisory committee, report the study findings to the legislature by January 15, 1998. As part of the report, the commissioner shall make recommendations on whether the state should credential or regulate any of the complementary medicine providers.

(c) The commissioner shall appoint an advisory committee to provide expertise and advice on the study. The committee must include representation from the following groups: health care providers, including providers of complementary medicine; health plan companies; and consumers. The advisory committee is governed by Minnesota Statutes, section 15.059, for membership terms and removal of members.

(d) For purposes of this study, the term "complementary medicine" includes, but is not limited to, acupuncture, homeopathy, manual healing, macrobiotics, naturopathy, biofeedback, mind/body control therapies, traditional and ethnomedicine therapies, structural manipulations and energetic therapies, bioelectromagnetic therapies, and herbal medicine.

~~DOWN'S~~ DOWN SYNDROME. Of the general fund appropriation, $15,000 in fiscal year 1998 shall be disbursed for a grant to a nonprofit organization that provides support to individuals with ~~Down's~~ Down Syndrome and their families, for the purpose of providing all obstetricians, certified nurse–midwives, and family physicians licensed to practice in this state with informational packets on ~~Down's~~ Down Syndrome. The packets must include, at a minimum, a fact sheet on ~~Down's~~ Down Syndrome, a list of counseling and support groups for families with children with ~~Down's~~ Down Syndrome, and a list of special needs adoption re-

sources. The informational packets must be made available to any pregnant patient who has tested positive for ~~Down's~~ Down Syndrome, either through a screening test or amniocentesis.

NEWBORN SCREENING FOR HEARING LOSS PROGRAM IMPLEMENTATION PLAN. (a) Of the general fund appropriation, $18,000 in fiscal year 1998 shall be disbursed to pay the costs of coordinating with hospitals, the medical community, audiologists, insurance companies, parents, and deaf and hard–of–hearing citizens to establish and implement a voluntary plan for hospitals and other health care facilities to screen all infants for hearing loss.

(b) The plan to achieve universal screening of infants for hearing loss on a voluntary basis shall be formulated by a department work group, including the following representatives:

(1) a representative of the health insurance industry designated by the health insurance industry;

(2) a representative of the Minnesota Hospital and Healthcare Partnership;

(3) a total of two representatives from the following physician groups designated by the Minnesota Medical Association: pediatrics, family practice, and ENT;

(4) two audiologists designated by the Minnesota Speech–Language–Hearing Association and the Minnesota Academy of Audiology;

(5) a representative of hospital neonatal nurseries;

(6) a representative of part H (IDEA) early childhood special education;

(7) the commissioner of health or a designee;

(8) a representative of the department of human services;

(9) a public health nurse;

(10) a parent of a deaf or hard–of–hearing child;

(11) a deaf or hard–of–hearing person; and

(12) a representative of the Minnesota commission serving deaf and hard–of–hearing people.

Members of the work group shall not collect a per diem or compensation as provided in Minnesota Statutes, section 15.0575.

(c) The plan shall include measurable goals and timetables for the achievement of universal screening of infants for hearing loss throughout the state and shall include the design and implementation of needed training to assist hospitals and other health care facilities screen infants for hearing loss according to recognized standards of care.

(d) The work group shall report to the legislature by January 15, 1998, concerning progress toward the achievement of universal screening of infants in Minnesota for the purpose of assisting the legislature to determine whether this goal can be accomplished on a voluntary basis.

INFANT HEARING SCREENING PROGRAM. Of the general fund appropriation, $25,000 in fiscal year 1998 shall be disbursed for a grant to a hospital in Staples, Minnesota, for the infant hearing screening program.

NURSING HOMES DAMAGED BY FLOODS. The commissioner shall conduct an expedited process under Minnesota Statutes, section 144A.073, solely to review nursing home moratorium exceptions necessary to repair or replace nursing facilities damaged by spring flooding in 1997. The commissioner may not issue a request for proposals for moratorium projects not related to spring flooding until this expedited process is completed. For facilities that require total replacement and the relocation of residents to other facilities during construction, the operating cost payment rates for the new facility shall be determined using the in-

terim and settle–up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of Minnesota Statutes, section 256B.431, except that subdivision ~~25~~ 26, paragraphs (a) and (b), ~~clause (3), and (d),~~ shall not apply until the second rate year after the settle–up cost report is filed. Property–related reimbursement rates shall be determined under Minnesota ~~Rules, chapter 9549~~ Statutes, section 256B.431, taking into account any federal or state flood–related loans or grants provided to a facility. The medical assistance costs of this paragraph shall be paid from the amount made available in section 2 of this article for moratorium exceptions. This paragraph is effective the day following final enactment and is not subject to section 13 of this article.

Sec. 3. Minnesota Statutes 1996, section 256B.0913, subdivision 16, as added by S. F. No. 1908, article 4, section 39, if enacted, is amended to read:

Subd. 16. **CONVERSION OF ENROLLMENT.** Upon approval of the elderly waiver amendments described in section ~~42~~ 41, persons currently receiving services shall have their eligibility for the elderly waiver program determined under section 256B.0915. Persons currently receiving alternative care services whose income is under the special income standard according to Code of Federal Regulations, title 42, section 435.236, who are eligible for the elderly waiver program shall be transferred to that program and shall receive priority access to elderly waiver slots for six months after implementation of this subdivision. Persons currently enrolled in the alternative care program who are not eligible for the elderly waiver program shall continue to be eligible for the alternative care program as long as continuous eligibility is maintained. Continued eligibility for the alternative care program shall be reviewed every six months. Persons who apply for the alternative care program after approval of the elderly waiver amendments in section ~~42~~ 41 are not eligible for alternative care if they would qualify for the elderly waiver, with or without a spenddown.

Sec. 4. S. F. No. 1908, article 4, section 70, if enacted, is amended to read:

Sec. 70. **WAIVER MODIFICATION.**

The commissioner of human services shall seek federal approval for any modifications to the health care reform waiver necessary to implement the asset standard changes in sections ~~21 to 23~~ 22 to 24, and ~~28~~ 73, paragraph (a).

Sec. 5. S. F. No. 1908, article 4, section 73, if enacted, is amended to read:

Sec. 73. **REPEALER.**

(a) Minnesota Statutes 1996, sections 256B.057, subdivisions 2a and 2b; and 469.154, subdivision 6, are repealed.

(b) Minnesota Statutes 1996, section 256B.0625, subdivision 13b, is repealed the day following final enactment.

(c) Minnesota Rules, ~~part~~ parts 9505.1000 to 9505.1040, ~~is~~ are repealed.

Sec. 6. Minnesota Statutes 1996, section 256B.0911, subdivision 2, as amended by S. F. No. 1908, article 9, section 10, if enacted, is amended to read:

Subd. 2. **PERSONS REQUIRED TO BE SCREENED; EXEMPTIONS.** All applicants to Medicaid certified nursing facilities must be screened prior to admission, regardless of income, assets, or funding sources, except the following:

(1) patients who, having entered acute care facilities from certified nursing facilities, are returning to a certified nursing facility;

(2) residents transferred from other certified nursing facilities located within the state of Minnesota;

(3) individuals who have a contractual right to have their nursing facility care paid for indefinitely by the veteran's administration;

(4) individuals who are enrolled in the Ebenezer/Group Health social health maintenance organization project, or enrolled in a demonstration project under section 256B.69, subdivision 18, at the time of application to a nursing home;

(5) individuals previously screened and currently being served under the alternative care program or under a home and community–based services waiver authorized under section 1915(c) of the Social Security Act; or

(6) individuals who are admitted to a certified nursing facility for a short–term stay, which, based upon a physician's certification, is expected to be 14 days or less in duration, and who have been screened and approved for nursing facility admission within the previous six months. This exemption applies only if the screener determines at the time of the initial screening of the six–month period that it is appropriate to use the nursing facility for short–term stays and that there is an adequate plan of care for return to the home or community–based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. Payment limitations in subdivision 7 will apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

Regardless of the exemptions in clauses (2) to (6), persons who have a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must receive a preadmission screening before admission unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 101–508.

Before admission to a Medicaid certified nursing home or boarding care home, all persons must be screened and approved for admission through an assessment process. The nursing facility is authorized to conduct case mix assessments which are not conducted by the county public health nurse under Minnesota Rules, part 9549.0059. The designated county agency is responsible for distributing the quality assurance and review form for all new applicants to nursing homes.

Other persons who are not applicants to nursing facilities must be screened if a request is made for a screening.

Sec. 7. S. F. No. 1908, article 9, section 24, if enacted, is amended to read:

Sec. 24. **EFFECTIVE DATE.**

~~Section~~ Sections 14 and 16, amending Minnesota Statutes 1996, section 518.17, subdivision 1, ~~is~~ are effective the day following final enactment.

Sec. 8. **EFFECTIVE DATE.**

Section 7 is effective the day following final enactment.

Presented to the governor May 29, 1997

Signed by the governor June 2, 1997, 2:14 p.m.

CHAPTER 226—S.F.No. 254

An act relating to natural resources; modifying fish habitat, harvest, and propagation provisions; authorizing the commissioner to establish special hunts for youth; permitting youth residents to hunt deer without a license tag; authorizing the commissioner to sell merchandise; modifying watercraft provisions; modifying trapping provisions; modifying stamp provisions; modifying the procedure for vacating or modifying a state game refuge; defining terms; modifying hunting provisions; modifying license provisions; modifying recreational motor vehicle provisions; modifying special license plate provisions; modifying provisions relating to personal flotation devices; establishing firearms safety pilot program; requiring reports; providing civil penalties; appropriating money; amending Minnesota Statutes 1996, sections 17.4982, by adding subdivisions; 17.4983, by adding a subdivision; 17.4998; 84.0855; 84.82, subdivision 2; 84.87, subdivision 2; 84.872, by adding a subdivision; 84.873; 86B.201, by adding a subdivision; 97A.015, subdivisions 49, 53, and by adding a subdivision; 97A.045, subdivision 7; 97A.075, subdivision 3; 97A.085, subdivision 8; 97A.101, by adding a subdivision; 97A.411, subdivisions 1 and 3; 97A.421, subdivision 1; 97A.465, subdivision 4; 97A.475, subdivisions 2 and 3; 97A.485, subdivisions 6, 9, and by adding a subdivision; 97B.055, subdivision 2; 97B.075; 97B.211, subdivision 1; 97B.301, subdivision 6; 97B.655, subdivision 1; 97C.035, subdivision 1; 97C.211, subdivision 1, and by adding a subdivision; 97C.321, subdivision 1; 97C.505, by adding a subdivision; 97C.801, subdivision 2; 168.1291; 168.1296, subdivision 1; and 609.487, by adding a subdivision; Laws 1993, chapter 273, as amended; Laws 1996, chapter 410, section 56; proposing coding for new law in Minnesota Statutes, chapter 97B; repealing Minnesota Statutes 1996, sections 97A.111; and 97C.801, subdivision 1.

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

Section 1. Minnesota Statutes 1996, section 17.4982, is amended by adding a subdivision to read:

Subd. 18a. **NONINDIGENOUS SPECIES.** "Nonindigenous species" means a species of fish or other aquatic life that is:

(1) not known to have been historically present in the state;

(2) not known to be naturally occurring in a particular part of the state; or

(3) designated by rule as a prohibited or restricted exotic species.