CHAPTER 268—H.F.No. 2762

An act relating to health; regulating coverages; regulating the Minnesota Comprehensive Health Association; providing for the composition of the board; authorizing an enrollee incentive for participation in a disease management program; phasing out Medicare-extended basic supplement plans; providing for high deductible plans; authorizing purchasing alliances to include seasonal employees; regulating trade practices; regulating certain health occupations and professions; requiring certain pharmacy benefit disclosures; providing an effective date for a certain hospital construction moratorium exemption; requiring a study; amending Minnesota Statutes 2002, sections 62A.65, subdivision 5; 62E.10, subdivisions 2, 10; 62L.12, subdivisions 2, 3; 62Q.01, by adding a subdivision; 62T.02, by adding a subdivision; 72A.20, by adding a subdivision; 147.03, subdivision 1; Minnesota Statutes 2003 Supplement, sections 62E.12; 256B.69, subdivision 4; proposing coding for new law in Minnesota Statutes, chapters 62Q; 151.

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

Section 1. Minnesota Statutes 2002, section 62A.65, subdivision 5, is amended to read:

Subd. 5. **PORTABILITY AND CONVERSION OF COVERAGE.** (a) No individual health plan may be offered, sold, issued, or with respect to children age 18 or under renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, unless the limitation or exclusion is permitted under this subdivision and under chapter 62L, provided that, except for children age 18 or under, underwriting restrictions may be retained on individual contracts that are issued without evidence of insurability as a replacement for prior individual coverage that was sold before May 17, 1993. The individual may be subjected to an 18-month preexisting condition limitation, unless the individual has maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. An individual who has maintained continuous coverage may be subjected to a onetime preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage as defined in section 62L.02.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in section 62L.02. If the individual has available any continuation coverage provided under sections 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, the health carrier need not offer coverage under this paragraph until the

individual has exhausted the continuation coverage. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The offer of coverage by the health carrier must inform the individual that the coverage, including what is covered and the health care providers from whom covered care may be obtained, may not be the same as the individual's coverage under the group health plan. The offer of coverage by the health carrier must also inform the individual that the individual, if a Minnesota resident, may be eligible to obtain coverage from (i) other private sources of health coverage, or (ii) the Minnesota Comprehensive Health Association, without a preexisting condition limitation, and must provide the telephone number used by that association for enrollment purposes. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed 100 percent of the premium charged for comparable individual coverage by the Minnesota Comprehensive Health Association, and the premium rate must be less than that amount if necessary to otherwise comply with this section. An individual health plan offered under this paragraph to a person satisfies the health carrier's obligation to offer conversion coverage under section 62E.16, with respect to that person. Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph.

EFFECTIVE DATE. This section is effective January 1, 2005, and applies to conversion coverage offered on or after that date.

Sec. 2. Minnesota Statutes 2002, section 62E.10, subdivision 2, is amended to read:

Subd. 2. **BOARD OF DIRECTORS; ORGANIZATION.** The board of directors of the association shall be made up of ~~nine~~ eleven members as follows: ~~five~~ six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary; ~~four~~ five public directors selected by the commissioner, at least two of whom must be plan enrollees, two of whom must be representatives of employers whose accident and health insurance premiums are part of the association's assessment base, and one of whom must be a licensed insurance agent. At least two of the public directors must reside outside of the seven-county metropolitan area. ~~Public members may include licensed insurance agents.~~ In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, health maintenance contract payment, or community integrated service network payment derived from or on behalf of Minnesota residents in the previous calendar

year, as determined by the commissioner. In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by contributing members may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Sec. 3. Minnesota Statutes 2002, section 62E.10, subdivision 10, is amended to read:

Subd. 10. **COST CONTAINMENT GOALS.** (a) By July 1, 2001, the association shall investigate managed care delivery systems, and if cost effective, enter into contracts with third-party entities as provided in section 62E.101.

(b) By July 1, 2001, the association shall establish a system to annually identify individuals insured by the Minnesota Comprehensive Health Association who may be eligible for private health care coverage, medical assistance, state drug programs, or other state or federal programs and notify them about their eligibility for these programs.

(c) The association shall endeavor to reduce health care costs using additional methods consistent with effective patient care. At a minimum, by July 1, 2001, the association shall:

(1) develop a focused chronic disease management and case management program;

(2) develop a comprehensive program of preventive care; and

(3) implement a total drug formulary program.

The association may establish an enrollee incentive based on enrollee participation in the chronic disease management and case management program developed under this section.

Sec. 4. Minnesota Statutes 2003 Supplement, section 62E.12, is amended to read:

62E.12 **MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN.**

(a) The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan and a number two qualified plan, except that the maximum lifetime benefit on these plans shall be $2,800,000; and an extended basic Medicare supplement plan and a basic Medicare supplement plan as described in sections 62A.31 to 62A.44. The association may also offer a plan that is identical to a number one and number two qualified plan except that it has a $2,000 annual deductible and a $2,800,000 maximum lifetime benefit. The association, subject to the approval of the commissioner, may also offer plans that are identical to the number one or number two qualified plan, except that they have annual deductibles of $5,000 and $10,000, respectively; have limitations on total annual

out-of-pocket expenses equal to those annual deductibles and therefore cover 100 percent of the allowable cost of covered services in excess of those annual deductibles; and have a $2,800,000 maximum lifetime benefit. As of January 1, 2006, the association shall no longer be required to offer an extended basic Medicare supplement plan.

(b) The requirement that a policy issued by the association must be a qualified plan is satisfied if the association contracts with a preferred provider network and the level of benefits for services provided within the network satisfies the requirements of a qualified plan. If the association uses a preferred provider network, payments to nonparticipating providers must meet the minimum requirements of section 72A.20, subdivision 15.

(c) The association shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

(d) Notwithstanding the provisions of section 62E.06 and unless those charges are billed by a provider that is part of the association's preferred provider network, the state plan shall exclude coverage of services of a private duty nurse other than on an inpatient basis and any charges for treatment in a hospital located outside of the state of Minnesota in which the covered person is receiving treatment for a mental or nervous disorder, unless similar treatment for the mental or nervous disorder is medically necessary, unavailable in Minnesota and provided upon referral by a licensed Minnesota medical practitioner.

Sec. 5. Minnesota Statutes 2002, section 62L.12, subdivision 2, is amended to read:

Subd. 2. **EXCEPTIONS.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees as required.

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to substitute individual health plans for a group health plan nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

(h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.31 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., as amended.

(i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

(j) A health carrier may offer, issue, sell, or renew an individual health plan to persons eligible for an employer group health plan, if the individual health plan is a high deductible health plan for use in connection with an existing health savings account, in compliance with the Internal Revenue Code, section 223. In that situation, the same or a different health carrier may offer, issue, sell, or renew a group health plan to cover the other eligible employees in the group.

EFFECTIVE DATE. This section is effective January 1, 2004.

Sec. 6. Minnesota Statutes 2002, section 62L.12, subdivision 3, is amended to read:

Subd. 3. **AGENT'S LICENSURE.** An agent licensed under chapter 60K or section 62C.17 who knowingly and willfully breaks apart a small group for the purpose of selling individual health plans to eligible employees and dependents of a small employer that meets the participation and contribution requirements of section 62L.03, subdivision 3, is guilty of an unfair trade practice and subject to disciplinary action, including the revocation or suspension of license, under section 60K.43 or 62C.17. The action must be by order and subject to the notice, hearing, and appeal procedures specified in section 60K.43. The action of the commissioner is subject to judicial review as provided under chapter 14. This section does not apply to any action performed by an agent that would be permitted for a health carrier under subdivision 2.

EFFECTIVE DATE. This section is effective January 1, 2004.

Sec. 7. Minnesota Statutes 2002, section 62Q.01, is amended by adding a subdivision to read:

Subd. 4a. **HIGH DEDUCTIBLE HEALTH PLANS.** "High deductible health plans" means those health coverage plans issued by a health plan company as defined under the provisions of sections 220 and 223 of the Internal Revenue Code of 1986, and implementing regulations.

EFFECTIVE DATE. This section is effective January 1, 2004.

Sec. 8. **[62Q.025] PRODUCT APPROVALS.**

Subdivision 1. **QUALIFIED PLAN.** A high deductible health plan shall be deemed a qualified plan under sections 62E.06 and 62E.12. The plan must meet all other requirements of state law except those that are inconsistent with a high deductible health plan as defined in sections 220 and 223 of the Internal Revenue Code and supporting regulations.

Subd. 2. **AUTHORIZATION.** Notwithstanding any other law of this state, any health plan company defined in section 62Q.01, subdivision 4, is permitted to offer high deductible health plans.

EFFECTIVE DATE. This section is effective January 1, 2004.

Sec. 9. **[62Q.182] SHORT-TERM COVERAGE; APPLICABILITY.**

Notwithstanding section 62A.65, subdivision 3, paragraph (g), and subdivision 7, paragraph (c), short-term coverage is not subject to section 62A.021.

Sec. 10. Minnesota Statutes 2002, section 62T.02, is amended by adding a subdivision to read:

Subd. 3. **SEASONAL EMPLOYEES.** A purchasing alliance may define eligible employees to include seasonal employees. For purposes of this chapter, "seasonal employee" means an employee who is employed on a full-time basis for at least six months during the calendar year and is unemployed for no longer than four months during the calendar year. If seasonal employees are included:

(1) the alliance must not show bias in the selection of members based on the percentage of seasonal employees employed by an employer member;

(2) prior to issuance or renewal, the employer must inform the alliance that it will include seasonal employees;

(3) the employer must cover seasonal employees for the entire term of its plan year; and

(4) the purchasing alliance may require an employer-member contribution of at least 50 percent of the cost of employee coverage during the months the seasonal employee is unemployed.

Sec. 11. Minnesota Statutes 2002, section 72A.20, is amended by adding a subdivision to read:

Subd. 37. **ELECTRONIC TRANSMISSION OF REQUIRED INFORMATION.** A health carrier, as defined in section 62A.011, subdivision 2, is not in violation of this chapter for electronically transmitting or electronically making available information otherwise required to be delivered in writing under chapters 62A to 62Q and 72A to an enrollee as defined in section 62Q.01, subdivision 2a, and with the requirements of those chapters if the following conditions are met:

(1) the health carrier informs the enrollee that electronic transmission or access is available and, at the discretion of the health carrier, the enrollee is given one of the following options:

(i) electronic transmission or access will occur only if the enrollee affirmatively requests to the health carrier that the required information be electronically transmitted or available and a record of that request is retained by the health carrier; or

(ii) electronic transmission or access will automatically occur if the enrollee has not opted out of that manner of transmission by request to the health carrier and requested that the information be provided in writing. If the enrollee opts out of electronic transmission, a record of that request must be retained by the health carrier;

(2) the enrollee is allowed to withdraw the request at any time;

(3) if the information transmitted electronically contains individually identifiable data, it must be transmitted to a secured mailbox. If the information made available electronically contains individually identifiable data, it must be made available at a password-protected secured Web site;

(4) the enrollee is provided a customer service number on the enrollee's member card that may be called to request a written copy of the document; and

(5) the electronic transmission or electronic availability meets all other requirements of this chapter including, but not limited to, size of the typeface and any required time frames for distribution.

Sec. 12. Minnesota Statutes 2002, section 147.03, subdivision 1, is amended to read:

Subdivision 1. **ENDORSEMENT; RECIPROCITY.** (a) The board may issue a license to practice medicine to any person who satisfies the requirements in paragraphs (b) to (f).

(b) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (b), (d), (e), and (f).

(c) The applicant shall:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the National Board of Medical Examiners, or the United States Medical Licensing Examination program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2); the National Board of Osteopathic Examiners; or the Medical Council of Canada; and

(2) have a current license from the equivalent licensing agency in another state or Canada and, if the examination in clause (1) was passed more than ten years ago, either:

(i) pass the Special Purpose Examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(ii) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association Bureau of Professional Education, or of the Royal College of Physicians and Surgeons of Canada.

(d) The applicant shall pay a fee established by the board by rule. The fee may not be refunded.

(e) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(f) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (e). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

(g) Upon the request of an applicant, the board may conduct the final interview of the applicant by teleconference.

Sec. 13. **[151.214] PAYMENT DISCLOSURE.**

Subdivision 1. **EXPLANATION OF PHARMACY BENEFITS.** A pharmacist licensed under this chapter must provide to a patient, for each prescription dispensed where part or all of the cost of the prescription is being paid or reimbursed by an employer-sponsored plan or health plan company, or its contracted pharmacy benefit manager, the patient's co-payment amount and the usual and customary price of the prescription or the amount the pharmacy will be paid for the prescription drug by the patient's employer-sponsored plan or health plan company, or its contracted pharmacy benefit manager.

Subd. 2. **NO PROHIBITION ON DISCLOSURE.** No contracting agreement between an employer-sponsored health plan or health plan company, or its contracted pharmacy benefit manager, and a resident or nonresident pharmacy registered under this chapter, may prohibit the pharmacy from disclosing to patients information a pharmacy is required or given the option to provide under subdivision 1.

Sec. 14. Minnesota Statutes 2003 Supplement, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **LIMITATION OF CHOICE.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in an individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for

medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

EFFECTIVE DATE. This section is effective July 1, 2004, or upon federal approval, whichever is later.

Sec. 15. **HOSPITAL CONSTRUCTION MORATORIUM EXEMPTION; EFFECTIVE DATE.**

Laws 2004, chapter 187, is effective July 1, 2004.

EFFECTIVE DATE. This section is effective July 1, 2004.

Sec. 16. **PRESUMPTIVE CONDITIONS STUDY.**

The commissioner of commerce, in consultation with the Minnesota Comprehensive Health Association, shall contract with an independent entity to conduct an analysis of the eligibility standards used for enrollment for coverage under the Minnesota Comprehensive Health Association in terms of the use of presumptive conditions for automatic eligibility and the underwriting practices for the individual market regarding the denial or limitations of coverage due to preexisting conditions. The analysis must compare the Minnesota Comprehensive Health Association's practices with that of other states' high-risk pools and examine the basis for denials within the individual market. The analysis must also determine whether there should be additional guidelines or standards in place before the existence of a specific condition or diagnosis is denied coverage in the individual market or deemed automatically eligible for coverage under the Minnesota Comprehensive Health Association.

The commissioner of commerce shall submit the results of the study and any recommendations to the legislature by January 15, 2005.

Presented to the governor May 18, 2004

Signed by the governor May 29, 2004, 2:25 p.m.