SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 301

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DATE	D-PG	OFFICIAL STATUS
01/23/2017	380	Introduction and first reading Referred to Health and Human Services Finance and Policy

A bill for an act

relating to health; establishing a waiver dispute process for waiver requests requested by health carriers or preferred provider organizations on provider geographic accessibility requirements; amending Minnesota Statutes 2016, section 62K.10, subdivision 5.

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

Section 1. Minnesota Statutes 2016, section 62K.10, subdivision 5, is amended to read:

Subd. 5. **Waiver.** (a) A health carrier or preferred provider organization may apply to the commissioner of health for a waiver of the requirements in subdivision 2 or 3 if it is unable to meet the statutory requirements. A waiver application must be submitted on a form provided by the commissioner at least 90 days prior to the annual open enrollment period established for the individual market under section 62K.15 and must:

(1) demonstrate with specific data that the requirement of subdivision 2 or 3 is not feasible in a particular service area or part of a service area because:

(i) the health carrier or preferred provider organization conducted a good-faith search for providers and there were no providers physically present in the service area; or

(ii) the providers physically present in the service area do not meet the health carrier's or the preferred provider organization's credentialing requirements; and

(2) include information as to the steps that were and will be taken to address the network inadequacy.

(b) A health carrier or preferred provider organization's contract with an exclusive provider, such as an accountable care organization or other entity operating a health care delivery system, is not by itself a basis for a waiver from the requirements of this section.

(c) The commissioner shall post each waiver submitted under this section on the department's Web site upon receipt of the waiver request. Within 30 days of posting, an affected provider or enrollee may dispute the waiver by filing a form provided by the commissioner. For purposes of this subdivision, "affected" means an enrollee as defined under section 62K.03, subdivision 4, who is a resident of the county, or a provider operating within the county for which a waiver request was submitted. The affected provider or enrollee shall:

(1) provide written documentation that the health carrier or preferred provider organization that submitted the waiver has failed to take adequate actions to address the network adequacy requirements of subdivisions 2 to 4; or

(2) provide written documentation that the health carrier or preferred provider organization that submitted the waiver misrepresented the actions taken to address network adequacy in its waiver application.

(d) The commissioner shall render a decision in any waiver submitted within 60 days of receipt of the waiver request. The commissioner's decision is a final agency action. The affected enrollee or provider aggrieved by a waiver may appeal the commissioner's decision to grant the waiver to the district court of their county of residence.

(e) The waiver shall automatically expire after four years. If a renewal of the waiver is sought, the commissioner of health shall take into consideration steps that have been taken to address network adequacy.

Sec. 2. **EFFECTIVE DATE.**

Section 1 is effective the day following final enactment and applies to health plans with an effective date on or after January 1, 2018.