# CHAPTER 62N

# MINNESOTA INTEGRATED SERVICE NETWORK ACT



## 62N.01 CITATION AND PURPOSE.

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

Subd. 2. **Purpose.** Sections 62N.01 to 62N.24 allow the creation of integrated service networks that will be responsible for arranging for or delivering a full array of health care services, from routine primary and preventive care through acute inpatient hospital care, to a defined population for a fixed price from a purchaser.

Each integrated service network is accountable to keep its total revenues within the limit of growth set by the commissioner of health under section 62N.05, subdivision 2. Integrated service networks can be formed by health care providers, health maintenance organizations, insurance companies, employers, or other organizations. Competition between integrated service networks on the quality and price of health care services is encouraged.

**History:** *1993 c 345 art 1 s 2; 1Sp1993 c 6 s 36*

## 62N.02 DEFINITIONS.

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

Subd. 2. **Accredited capitated provider.** "Accredited capitated provider" means a financially responsible health care providing entity paid by a network on a capitated basis.

Subd. 3. **Commission.** "Commission" means the health care commission established under section 62J.05.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health or the commissioner's designated representative.

Subd. 5. **Enrollee.** "Enrollee" means an individual, including a member of a group, to whom a network is obligated to provide health services under this chapter.

Subd. 6. **Health care providing entity.** "Health care providing entity" means a participating entity that provides health care to enrollees through an integrated service network.

Subd. 6a. **Health carrier.** "Health carrier" has the meaning given in section 62A.011.

Subd. 7. **Health plan.** "Health plan" means a health plan as defined in section 62A.011 or coverage by an integrated service network.

Subd. 8. **Integrated service network.** "Integrated service network" means a formal arrangement permitted by this chapter and licensed by the commissioner for providing health services under this chapter to enrollees for a fixed payment per time period.

Subd. 9. **Network.** "Network" means an integrated service network as defined in this section.

Subd. 10. **Participating entity.** "Participating entity" means a health care providing entity, a risk-bearing entity, or an entity providing other services through an integrated service network.

Subd. 11. **Price.** "Price" means the actual amount of money paid, after discounts or other adjustments, by the person or organization paying money to buy health care coverage and health care services. "Price" does not mean the cost or costs incurred by a network or other entity to provide health care services to individuals.

Subd. 12. **Risk-bearing entity.** "Risk-bearing entity" means an entity that participates in an integrated service network so as to bear all or part of the risk of loss. "Risk-bearing entity" includes an entity that provides reinsurance, stop-loss, excess-of-loss, and similar coverage.

**History:** *1993 c 345 art 1 s 3*

## 62N.03 APPLICABILITY OF OTHER LAW.

Chapters 60A, 60B, 60G, 61A, 61B, 62A, 62C, 62D, 62E, 62H, 62L, 62M, and 64B do not, except as expressly provided in this chapter or in those other chapters, apply to integrated service networks, or to entities otherwise subject to those chapters, with respect to participation by those entities in integrated service networks. Chapters 72A and 72C apply to integrated service networks, except as otherwise expressly provided in this chapter.

Integrated service networks are in "the business of insurance" for purposes of the federal McCarran-Ferguson Act, United States Code, title 15, section 1012, are "domestic insurance companies" for purposes of the federal Bankruptcy Reform Act of 1978, United States Code, title 11, section 109, and are "insurance" for purposes of the federal Employee Retirement Income Security Act, United States Code, title 29, section 1144.

**History:** *1993 c 345 art 1 s 4*

## 62N.04 REGULATION.

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

**History:** *1993 c 345 art 1 s 5*

## 62N.05 RULES GOVERNING INTEGRATED SERVICE NETWORKS.

Subdivision 1. **Rules.** The commissioner, in consultation with the commission, may adopt emergency and permanent rules to establish more detailed requirements governing integrated service networks in accordance with this chapter.

Subd. 2. **Requirements.** The commissioner shall include in the rules requirements that will ensure that the annual rate of growth of an integrated service network's aggregate total revenues received from purchasers and enrollees, after adjustments for changes in population size and risk, does not exceed the growth limit established in section 62J.04. A network's aggregate total revenues for purposes of these growth limits are net of the contributions, surcharges, taxes, and assessments listed in section 62P.04, subdivision 2, that the network pays. The commissioner may include in the rules the following:

(1) requirements for licensure, including a fee for initial application and an annual fee for renewal;

(2) quality standards;

(3) requirements for availability and comprehensiveness of services;

(4) requirements regarding the defined population to be served by an integrated service network;

(5) requirements for open enrollment;

(6) provisions for incentives for networks to accept as enrollees individuals who have high risks for needing health care services and individuals and groups with special needs;

(7) prohibitions against disenrolling individuals or groups with high risks or special needs;

(8) requirements that an integrated service network provide to its enrollees information on coverage, including any limitations on coverage, deductibles and copayments, optional services available and the price or prices of those services, any restrictions on emergency services and services provided outside of the network's service area, any responsibilities enrollees have, and describing how an enrollee can use the network's enrollee complaint resolution system;

(9) requirements for financial solvency and stability;

(10) a deposit requirement;

(11) financial reporting and examination requirements;

(12) limits on copayments and deductibles;

(13) mechanisms to prevent and remedy unfair competition;

(14) provisions to reduce or eliminate undesirable barriers to the formation of new integrated service networks;

(15) requirements for maintenance and reporting of information on costs, prices, revenues, volume of services, and outcomes and quality of services;

(16) a provision allowing an integrated service network to set credentialing standards for practitioners employed by or under contract with the network;

(17) a requirement that an integrated service network employ or contract with practitioners and other health care providers, and minimum requirements for those contracts if the commissioner deems requirements to be necessary to ensure that each network will be able to control expenditures and revenues or to protect enrollees and potential enrollees;

(18) provisions regarding liability for medical malpractice;

(19) provisions regarding permissible and impermissible underwriting criteria applicable to the standard set of benefits;

(20) a method or methods to facilitate and encourage appropriate provision of services by midlevel practitioners and pharmacists;

(21) a method or methods to assure that all integrated service networks are subject to the same regulatory requirements. All health carriers, including health maintenance organizations, insurers, and nonprofit health service plan corporations shall be regulated under the same rules, to the extent that the health carrier is operating an integrated service network or is a participating entity in an integrated service network;

(22) provisions for appropriate risk adjusters or other methods to prevent or compensate for adverse selection of enrollees into or out of an integrated service network; and

(23) rules prescribing standard measures and methods by which integrated service networks shall determine and disclose their prices, copayments, deductibles, out-of-pocket limits, enrollee satisfaction levels, and anticipated loss ratios.

Subd. 3. **Criteria for rulemaking.** (a) **Applicability.** The commissioner shall adopt rules governing integrated service networks based on the criteria and objectives specified in this subdivision.

(b) **Competition.** The rules must encourage and facilitate competition through the collection and distribution of reliable information on the cost, prices, and quality of each integrated service network in a manner that allows comparisons between networks.

(c) **Flexibility.** The rules must allow significant flexibility in the structure and organization of integrated service networks. The rules must allow and facilitate the formation of networks by providers, employers, and other organizations, in addition to health carriers.

(d) **Expanding access and coverage.** The rules must be designed to expand access to health care services and coverage for all Minnesotans, including individuals and groups who have preexisting health conditions, who represent a higher risk of requiring treatment, who require translation or other special services to facilitate treatment, who face social or cultural barriers to obtaining health care, or who for other reasons face barriers to access to health care and coverage. Enrollment standards must ensure that high risk and special needs populations will be included and growth limits and payment systems must be designed to provide incentives for networks to enroll even the most challenging and costly groups and populations. The rules must be consistent with the principles of health insurance reform that are reflected in Laws 1992, chapter 549.

(e) **Ability to bear financial risk.** The rules must allow a variety of options for integrated service networks to demonstrate their ability to bear the financial risk of serving their enrollees, to facilitate diversity and innovation and the entry into the market of new networks. The rules must allow the phasing in of reserve requirements and other requirements relating to financial solvency.

(f) **Participation of providers.** The rules must not require providers to participate in an integrated service network and must allow providers to participate in more than one network and to serve both patients who are covered by an integrated service network and patients who are not. The rules must allow significant flexibility for an integrated service network and providers to define and negotiate the terms and conditions of provider participation. The rules must encourage and facilitate the participation of midlevel practitioners, allied health care practitioners, and pharmacists, and eliminate inappropriate barriers to their participation. The rules must encourage and facilitate the participation of disproportionate share providers in integrated service networks and eliminate inappropriate barriers to this participation.

(g) **Rural communities.** The rules must permit a variety of forms of integrated service networks to be developed in rural areas in response to the needs, preferences, and conditions of rural communities, utilizing to the greatest extent possible current existing health care providers and hospitals.

(h) **Limits on growth.** The rules must include provisions to enable the commissioner to enforce the limits on growth in health care total revenues for each integrated service network and for the entire system of integrated service networks.

(i) **Standard benefit set.** The commission shall make recommendations to the commissioner regarding a standard benefit set.

(j) **Conflict of interest.** The rules shall include provisions the commissioner deems necessary and appropriate to address integrated service networks' and participating providers' relationship to section 62J.23 or other laws relating to provider conflicts of interest.

**History:** *1993 c 345 art 1 s 6*

## 62N.06 AUTHORIZED ENTITIES.

Subdivision 1. **Authorized entities.** (a) An integrated service network may be organized as a separate nonprofit corporation under chapter 317A or as a cooperative under chapter 308A.

(b) A nonprofit health carrier, as defined in section 62A.011, may establish and operate one or more integrated service networks without forming a separate corporation or cooperative, but only if all of the following conditions are met:

(i) a contract between the health carrier and a health care provider, for a term of less than seven years, that was executed before June 1, 1993, does not bind the health carrier or provider as applied to integrated service network services, except with the mutual consent of the health carrier and provider entered into on or after June 1, 1993. This clause does not apply to contracts between a health carrier and its salaried employees;

(ii) the health carrier shall not apply toward the net worth, working capital, or deposit requirements of this chapter any assets used to satisfy net worth, working capital, deposit, or other financial requirements under any other chapter of Minnesota law;

(iii) the health carrier shall not include in its premiums for health coverage provided under any other chapter of Minnesota law, an assessment or surcharge relating to net worth, working capital, or deposit requirements imposed upon the integrated service network under this chapter; and

(iv) the health carrier shall not include in its premiums for integrated service network coverage under this chapter an assessment or surcharge relating to net worth working capital or deposit requirements imposed upon health coverage offered under any other chapter of Minnesota law.

Subd. 2. **Separate accounting required.** Any entity operating one or more integrated service networks shall maintain separate accounting and record keeping procedures, acceptable to the commissioner, for each integrated service network.

Subd. 3. **Governmental subdivision.** A political subdivision may establish and operate an integrated service network directly, without forming a separate entity. Unless otherwise specified, a network authorized under this subdivision must comply with all other provisions governing networks.

**History:** *1993 c 345 art 1 s 7*

## 62N.065 ADMINISTRATIVE COST CONTAINMENT.

Subdivision 1. **Unreasonable expenses.** No integrated service network shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62N.01 to 62N.24; in order to safeguard the underlying nonprofit status of integrated service networks; and to ensure that payment of integrated service network money to any person or organization results in a corresponding benefit to the integrated service network and its enrollees; when determining whether an integrated service network has incurred an unreasonable expense in relation to payments made to a person or organization, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the integrated service network have acted with good faith and in the best interests of the integrated service network in entering into, and performing under, a contract under which the integrated service network has incurred an expense. In addition to the compliance powers under subdivision 3, the commissioner has standing to sue, on behalf of an integrated service network, officers or trustees of the integrated service network who have breached their fiduciary duty in entering into and performing such contracts.

Subd. 2. **Data on contracts.** Integrated service networks shall keep on file in the offices of the integrated service network copies of all contracts regulated under subdivision 1, and data on the payments, salaries, and other remuneration paid to for-profit firms, affiliates, or to persons for administrative expenses, service contracts, and management of the integrated service network, and shall make these records available to the commissioner upon request.

Subd. 3. **Compliance authority.** The commissioner may review any contract, arrangement, or agreement to determine whether it complies with the provisions contained in subdivision 1. The commissioner may suspend any provision that does not comply with subdivision 1 and may require the integrated service network to replace those provisions with provisions that do comply.

**History:** *1993 c 345 art 1 s 8; 1Sp1993 c 6 s 37*

## 62N.07 PURPOSE.

The legislature finds that previous cost containment efforts have focused on reducing benefits and services, eliminating access to certain provider groups, and otherwise reducing the level of care available. Under a system of overall spending controls, these cost containment approaches will, in the absence of controls on cost shifting, shift costs from the payer to the consumer, to government programs, and to providers in the form

of uncompensated care. The legislature further finds that the integrated service network benefit package should be designed to promote coordinated, cost-effective delivery of all health services an enrollee needs without cost shifting. The legislature further finds that affordability of health coverage is a high priority and that lower cost coverage options should be made available through the use of copayments, coinsurance, and deductibles to reduce premium costs rather than through the exclusion of services or providers.

**History:** *1993 c 345 art 1 s 9*

## 62N.075 COVERED SERVICES.

(a) An integrated service network must provide to each person enrolled a set of appropriate and necessary health services. For purposes of this chapter, "appropriate and necessary" means services needed to maintain the enrollee in good health including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, outpatient health services, preventive health services. The commissioner may modify this definition to reflect changes in community standards, development of practice parameters, new technology assessments, and other medical innovations. These services must be delivered by authorized practitioners acting within their scope of practice. An integrated service network is not responsible for health services that are not appropriate and necessary.

(b) A network may define benefit levels through the use of consumer cost sharing but remains financially accountable for the cost of the set of required health services.

(c) A network may offer any Medicare supplement, Medicare select, or other Medicare-related product otherwise permitted for any type of health carrier in this state. Each Medicare-related product may be offered only in full compliance with the requirements in chapters 62A, 62D, and 62E that apply to that category of product.

(d) Networks must comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(e) Networks must comply with sections 62A.047, 62A.27, and any other coverage of newborn infants, dependent children who do not reside with a covered person, handicapped children and dependents, and adopted children. A network providing dependent coverage must comply with section 62A.302.

(f) Networks must comply with the equal access requirements of section 62A.15, subdivision 2.

**History:** *1993 c 345 art 1 s 10*

## 62N.08 AVAILABILITY OF SERVICES.

(a) An integrated service network is financially responsible to provide to each person enrolled all appropriate and necessary health services required by statute, by the contract of coverage, or otherwise required under sections 62N.075 to 62N.085.

(b) The commissioner shall require that networks provide all appropriate and necessary health services within a reasonable geographic distance for enrollees. The commissioner may adopt rules providing a more detailed requirement, consistent with this paragraph.

**History:** *1993 c 345 art 1 s 11*

## 62N.085 ESTABLISHMENT OF STANDARDIZED BENEFIT PLANS.

(a) The commissioner of health shall adopt permanent rules and may adopt emergency rules to establish not more than five standardized benefit plans which must be offered by integrated service networks. The plans must comply with the requirements of sections 62N.07 to 62N.08 and the other requirements of this chapter. The plans must vary only on the basis of enrollee cost sharing and encompass a range of cost sharing options from (1) lower premium costs combined with higher enrollee cost sharing, to (2) higher premium costs combined with lower enrollee cost sharing.

(b) The purposes of this section, "consumer cost sharing" or "cost sharing" means copayments, deductibles, coinsurance, and other out-of-pocket expenses paid by the individual consumer of health care services.

(c) The commissioner shall consider whether the following principles should apply to cost sharing in an integrated service network:

(1) consumers must have a wide choice of cost sharing arrangement;

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

(3) cost sharing must be based on income and an enrollee's ability to pay for services and should not create a barrier to access to appropriate and effective services;

(4) cost sharing must be capped at a predetermined annual limit to protect individuals and families from financial catastrophe and to protect individuals with substantial health care needs;

(5) child health supervision services, immunizations, prenatal care, and other prevention services must not be subjected to cost sharing;

(6) additional requirements for networks should be established to assist enrollees for whom an inducement in addition to the elimination of cost sharing is necessary in order to encourage them to use cost-effective preventive services. These requirements may include the provision of educational information, assistance or guidance, and opportunities for responsible decision making by enrollees that minimize potential out-of-pocket costs;

(7) cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services; and

(8) cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

**History:** *1993 c 345 art 1 s 12*

## 62N.10 LICENSING.

Subdivision 1. **Requirements.** All integrated service networks must be licensed by the commissioner. Licensure requirements are:

(1) the ability to be responsible for the full continuum of required health care and related costs for the defined population that the integrated service network will serve;

(2) the ability to satisfy standards for quality of care;

(3) financial solvency; and

(4) the ability to fully comply with this chapter and all other applicable law.

The commissioner may adopt rules to specify licensure requirements for integrated service networks in greater detail, consistent with this subdivision.

Subd. 2. **Fees.** Licensees shall pay an initial fee and a renewal fee each following year to be established by the commissioner of health.

Subd. 3. **Loss of license.** The commissioner may fine a licensee or suspend or revoke a license for violations of rules or statutes pertaining to integrated service networks.

Subd. 4. **Participation; government programs.** Integrated service networks shall, as a condition of licensure, participate in the medical assistance, general assistance medical care, and MinnesotaCare programs. The commissioner shall adopt rules specifying

the participation required of the networks. The rules must be consistent with Minnesota Rules, parts 9505.5200 to 9505.5260, governing participation by health maintenance organizations in public health care programs.

Subd. 5. **Application.** Each application for an integrated service network license must be in a form prescribed by the commissioner.

Subd. 6. **Documents on file.** A network shall agree to retain in its files any documents specified by the commissioner. A network shall permit the commissioner to examine those documents at any time and shall promptly provide copies of any of them to the commissioner upon request.

**History:** *1993 c 345 art 1 s 13*

## 62N.11 EVIDENCE OF COVERAGE.

Subdivision 1. **Applicability.** Every integrated service network enrollee residing in this state is entitled to evidence of coverage or contract. The integrated service network or its designated representative shall issue the evidence of coverage or contract. The commissioner shall adopt rules specifying the requirements for contracts and evidence of coverage. "Evidence of coverage" means evidence that an enrollee is covered by a group contract issued to the group.

Subd. 2. **Filing.** No evidence of coverage or contract or amendment of coverage or contract shall be issued or delivered to any individual in this state until a copy of the form of the evidence of coverage or contract or amendment of coverage or contract has been filed with and approved by the commissioner.

**History:** *1993 c 345 art 1 s 14*

## 62N.12 ENROLLEE RIGHTS.

The cover page of the evidence of coverage and contract must contain a clear and complete statement of an enrollee's rights as a consumer. The commissioner shall adopt rules specifying enrollee rights and required disclosures to enrollees.

**History:** *1993 c 345 art 1 s 15*

## 62N.13 ENROLLEE COMPLAINT SYSTEM.

Every integrated service network must establish and maintain an enrollee complaint system, including an impartial arbitration provision, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services. The commissioner shall adopt rules specifying requirements relating to enrollee complaints.

**History:** *1993 c 345 art 1 s 16*

## 62N.16 UNDERWRITING AND RATING.

Subdivision 1. **Applicability.** Except as provided in subdivision 3, this section applies to the standard benefit plans under section 62N.085 and does not apply to additional benefits. This section does not require coverage by an integrated service network of any group or individual residing outside of the network's service area. A network's service area is a geographic service region agreed to by the commissioner and the network at the time of licensure. This section does not apply to any group that the commissioner determines is organized or functions primarily to provide coverage to one or more high risk individuals. The commissioner may adopt rules specifying other types of groups to which this section does not apply.

Subd. 2. **Group members.** Integrated service networks shall charge the same rate for each individual in a group, except as appropriate to provide dependent or family coverage. Rates for managed care plans as described in section 256.9363 shall be determined through contract between the department of human services and the integrated service network.

Subd. 3. **Small employers.** To provide services to employees of a small employer

as defined in section 62L.02, integrated service networks shall comply with chapter 62L.

**History:** *1993 c 345 art 1 s 17*

## 62N.22 DISCLOSURE OF COMMISSIONS.

Before selling, or offering to sell, any coverage or enrollment in an integrated service network, a person selling the coverage or enrollment shall disclose 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.

**History:** *1993 c 345 art 1 s 18*

## 62N.23 TECHNICAL ASSISTANCE; LOANS.

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

The technical assistance program shall offer seminars on the establishment and operation of 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 an integrated service network. The guide must provide basic instructions for parties wishing to establish 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 an integrated service network.

(b) The commissioner, in consultation with the commission, shall provide recommendations for the creation of a loan program that would provide loans or grants to entities forming integrated service networks or to networks less than one year old. The commissioner shall propose criteria for the loan program.

**History:** *1993 c 345 art 1 s 19*

## 62N.24 REVIEW OF RULES.

The commissioner of health shall mail copies of all proposed emergency and permanent rules that are being promulgated under this chapter to each member of the legislative commission on health care access prior to final adoption by the commissioner.

**History:** *1993 c 345 art 1 s 20*