CHAPTER 62P

REGULATED ALL-PAYER SYSTEM

62P.01 REGULATED ALL-PAYER SYSTEM.

The regulated all-payer system established under this chapter governs all health care services that are provided outside of an integrated service network. The regulated all-payer system is designed to control costs, prices, and utilization of all health care services not provided through an integrated service network while maintaining or improving the quality of services. The commissioner of health shall adopt rules establishing controls within the system to ensure that the rate of growth in spending in the system, after adjustments for population size and risk, remains within the limits set by the commissioner under section 62J.04. All providers that serve Minnesota residents and all health carriers that cover Minnesota residents shall comply with the requirements and rules established under this chapter for all health care services or coverage provided to Minnesota residents.

History: *1993 c 345 art 2 s 2*

62P.03 IMPLEMENTATION.

(a) By January 1, 1994, the commissioner of health, in consultation with the Minnesota health care commission, shall report to the legislature recommendations for the design and implementation of the all-payer system. The commissioner may use a consultant or other technical assistance to develop a design for the all-payer system. The commissioner's recommendations shall include the following:

(1) methods for controlling payments to providers such as uniform fee schedules or rate limits to be applied to all health plans and health care providers with independent billing rights;

(2) methods for controlling utilization of services such as the application of standardized utilization review criteria, incentives based on setting and achieving volume targets, recovery of excess spending due to overutilization, or required use of practice parameters;

(3) methods for monitoring quality of care and mechanisms to enforce the quality of care standards;

(4) requirements for maintaining and reporting data on costs, prices, revenues, expenditures, utilization, quality of services, and outcomes;

(5) measures to prevent or discourage adverse risk selection between the regulated all-payer system and integrated service networks;

(6) measures to coordinate the regulated all-payer system with integrated service networks to minimize or eliminate barriers to access to health care services that might otherwise result;

(7) an appeals process;

(8) measures to encourage and facilitate appropriate use of midlevel practitioners and eliminate undesirable barriers to their participation in providing services;

(9) measures to assure appropriate use of technology and to manage introduction of new technology;

(10) consequences to be imposed on providers whose expenditures have exceeded the limits established by the commissioner; and

(11) restrictions on provider conflicts of interest.

(b) On July 1, 1994, the regulated all-payer system shall begin to be phased in with full implementation by July 1, 1996. During the transition period, expenditure limits

for health carriers shall be established in accordance with section 62P.04 and health care provider revenue limits shall be established in accordance with section 62P.05.

History: *1993 c 345 art 2 s 3*

62P.04 EXPENDITURE LIMITS FOR HEALTH CARRIERS.

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

(b) "Health carrier" has the definition provided in section 62A.011.

(c) "Total expenditures" mean incurred claims or expenditures on health care services, administrative expenses, charitable contributions, and all other payments made by health carriers out of premium revenues, except taxes and assessments, and payments or allocations made to establish or maintain reserves. Total expenditures are equivalent to the amount of total revenues minus taxes and assessments. Taxes and assessments means payments for taxes, contributions to the Minnesota comprehensive health association, the provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the health coverage reinsurance association, assessments by the Minnesota life and health insurance guaranty association, and any new assessments imposed by federal or state law.

Subd. 2. **Establishment.** The commissioner of health shall establish limits on the increase in total expenditures by each health carrier for calendar years 1994 and 1995. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). Health carriers that are affiliates may elect to meet one combined expenditure limit.

Subd. 3. **Determination of expenditures.** Health carriers shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993, and by April 1, 1995, for calendar year 1994, all information the commissioner determines to be necessary to implement and enforce this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health carriers. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health carrier to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments and the election to meet one expenditure limit for affiliated health carriers must be submitted to the commissioner by September 1, 1993.

Subd. 4. **Monitoring of reserves.** (a) The commissioner of health shall monitor health carrier reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, to ensure that savings resulting from the establishment of expenditure limits are passed on to consumers in the form of lower premium rates.

(b) Health carriers shall fully reflect in the premium rates the savings generated by the expenditure limits and the health care provider revenue limits. No premium rate increase may be approved for those health carriers unless the health carrier establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

Subd. 5. **Notice.** The commissioner of health shall publish in the State Register and make available to the public by July 1, 1995, a list of all health carriers that exceeded their expenditure target for the 1994 calendar year. The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health carriers that exceeded their combined expenditure limit for calendar years 1994 and 1995. The commissioner shall notify each health carrier that the commissioner has determined that the carrier exceeded its expenditure limit, at least 30 days before pub-

lishing the list, and shall provide each carrier with ten days to provide an explanation for exceeding the expenditure target. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. **Assistance by the commissioner of commerce.** The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health carriers regulated by the commissioner of commerce. The commissioner of commerce, in consultation with the commissioner of health, shall enforce compliance by those health carriers.

Subd. 7. **Enforcement.** The commissioners of health and commerce shall enforce the reserve limits referenced in subdivision 4, with respect to the health carriers that each commissioner respectively regulates. Each commissioner shall require health carriers under the commissioner's jurisdiction to submit plans of corrective action when the reserve requirement is not met. Each commissioner may adopt rules necessary to enforce this section. Carriers that exceed the expenditure limits based on two-year average expenditure data or whose reserves exceed the limits referenced in subdivision 4 shall be required by the appropriate commissioner to pay back the amount overspent through an assessment on the carrier. The appropriate commissioner may approve a different repayment method to take into account the carrier's financial condition.

History: *1993 c 345 art 2 s 4*

62P.05 HEALTH CARE PROVIDER REVENUE LIMITS.

Subdivision 1. **Definition.** For purposes of this section, "health care provider" has the definition given in section 62J.03, subdivision 8.

Subd. 2. **Establishment.** The commissioner of health shall establish limits on the increase in revenue for each health care provider, for calendar years 1994 and 1995. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). The commissioner may adjust final revenue figures for case mix complexity, inpatient to outpatient conversion, payer mix, out-of-period settlements, taxes, donations, grants, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health care provider to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments must be submitted to the commissioner by September 1, 1993. A health care provider's revenues for purposes of these growth limits are net of the contributions, surcharges, taxes, and assessments listed in section 62P.04, subdivision 1, that the health care provider pays.

Subd. 3. **Monitoring of revenue.** The commissioner of health shall monitor health care provider revenue, to ensure that savings resulting from the establishment of revenue limits are passed on to consumers in the form of lower charges. The commissioner shall monitor hospital revenue by examining net patient revenue per adjusted admission. The commissioner shall monitor the revenue of physicians and other health care providers by examining revenue per patient per year or revenue per encounter. If this information is not available, the commissioner may enforce an annual limit on the rate of growth of the provider's current fees based on the limits on the rate of growth established for calendar years 1994 and 1995.

Subd. 4. **Monitoring and enforcement.** Health care providers shall submit to the commissioner of health, in the form and at the times required by the commissioner, all information the commissioner determines to be necessary to implement and enforce this section. Health care providers shall submit to audits conducted by the commissioner. The commissioner shall regularly audit all health clinics employing or contracting with over 100 physicians. The commissioner shall also audit, at times and in a manner that does not interfere with delivery of patient care, a sample of smaller clinics, hospitals, and other health care providers. Providers that exceed revenue limits based on two-year average revenue data shall be required by the commissioner to pay back the amount overspent during the following calendar year. The commissioner may

approve a different repayment schedule for a health care provider that takes into account the provider's financial condition. For those providers subject to fee limits established by the commissioner, the commissioner may adjust the percentage increase in the fee schedule to account for changes in utilization. The commissioner may adopt rules in order to enforce this section.

History: *1993 c 345 art 2 s 5; 1Sp1993 c 6 s 38*