# CHAPTER 62Q

# RISK ADJUSTMENT SYSTEM



## 62Q.01 DEFINITIONS.

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

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Health plan.** "Health plan" means a health plan as defined in section 62A.011 or a policy, contract, or certificate issued by a community integrated service network; an integrated service network; or an all-payer insurer as defined in section 62P.02.

Subd. 4. **Health plan company.** "Health plan company" means:

(1) a health carrier as defined under section 62A.011, subdivision 2;

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

(3) an all-payer insurer as defined under section 62P.02; or

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

**History:** *1994 c 625 art 2 s 14*

## 62Q.03 PROCESS FOR DEFINING, DEVELOPING, AND IMPLEMENTING A RISK ADJUSTMENT SYSTEM.

Subdivision 1. **Purpose.** Risk adjustment is a vital element of the state's strategy for achieving a more equitable, efficient system of health care delivery and financing for all state residents. Risk adjustment is needed to: remove current disincentives in the health care system to insure and serve high risk and special needs populations; promote fair competition among health plan companies on the basis of their ability to efficiently and effectively provide services rather than on the health status of those in a given insurance pool; and help assure the viability of all health plan companies, including community integrated service networks. It is the commitment of the state to develop and implement a risk adjustment system by July 1, 1997, and to continue to improve and refine risk adjustment over time. The process for designing and implementing risk adjustment shall be open, explicit, utilize resources and expertise from both the private and public sectors, and include at least the representation described in subdivision 4. The process shall take into account the formative nature of risk adjustment as an emerging science, and shall develop and implement risk adjustment to allow continual modifications, expansions, and refinements over time. The process shall have at least two stages, as described in subdivisions 2 and 3.

Subd. 2. **First stage of risk adjustment development process.** The objective of the

first stage is to report to the legislature by January 15, 1995, with recommendations on the process, organization, resource needs, and specific work plan to define, develop, and implement a risk adjustment mechanism by July 1, 1997, and to continually improve risk adjustment over time. The report shall address the specific issues listed in subdivision 5, and shall also identify any additional policy issues, questions, and concerns that must be addressed to facilitate development and implementation of risk adjustment.

Subd. 3. **Second stage of the risk adjustment development process.** The second stage of the process, following review and any modification by the legislature of the January 15, 1995 report, shall be to carry out the work plan to develop and implement a risk adjustment mechanism by July 1, 1997, and to continue to improve and refine a risk adjustment over time. The second stage of the process shall be carried out by the association created in subdivision 6.

Subd. 4. **Expert panel.** The commissioners of health and commerce shall convene an expert advisory panel comprised of, but not limited to, the board members of the Minnesota risk adjustment association, as described in subdivision 8, and experts from the fields of epidemiology, health services research, and health economics. The commissioners may also convene technical work groups that may include members of the expert advisory panel and other persons, all selected in the sole discretion of the commissioners. The expert advisory panel and the workgroups shall assist and advise the commissioners of health and commerce in preparing the implementation report described in subdivision 5.

Subd. 5. **Implementation report to the legislature.** The commissioners of health and commerce shall submit a report to the legislature by January 15, 1995, with recommendations on the process, organization, resource needs, and specific work plan to define, develop, and implement a risk adjustment system by July 1, 1997, and to continually improve risk adjustment over time. In developing the January 15, 1995 report, the commissioners of commerce and health must consider and describe the following:

(1) the relationship of risk adjustment to the implementation of universal coverage and community rating;

(2) the role of reinsurance in the risk adjustment system, as a short-term alternative in the absence of a risk adjustment methodology;

(3) the relationship of the risk adjustment system to the implementation of reforms in underwriting and rating requirements;

(4) the potential role of the health coverage reinsurance association in the risk adjustment system;

(5) the need for mandatory participation of all health plan companies in the risk adjustment system;

(6) current and emerging applications of risk adjustment methodologies used for reimbursement purposes at the state and national level and the reliability and validity of current risk assessment and risk adjustment methodologies;

(7) the levels and types of risk to be distributed through the risk adjustment system;

(8) the extent to which prepaid contracting by public programs needs to be addressed by the risk adjustment methodology;

(9) a plan for testing of the risk adjustment options being proposed, including simulations using existing health plan data, and development and testing of models on simulated data to assess the feasibility and efficacy of specific methodologies;

(10) the appropriate role of the state in the supervision of the risk adjustment association created pursuant to subdivision 6;

(11) risk adjustment methodologies that take into account differences among health plan companies due to their relative efficiencies, characteristics, and relative to existing insured contracts, new business, underwriting, or rating restrictions required or permitted by law; and

(12) methods to encourage health plan companies to enroll higher risk populations.

To the extent possible, the implementation report shall identify a specific methodology or methodologies that may serve as a starting point for risk adjustment, explain the advantages and disadvantages of each such methodology, and provide a specific workplan for implementing the methodology.

Subd. 6. **Creation of risk adjustment association.** The Minnesota risk adjustment association is created on July 1, 1994, and may operate as a nonprofit unincorporated association.

Subd. 7. **Purpose of association.** The association is established to carry out the purposes of subdivision 1, as further elaborated on by the implementation report described in subdivision 5 and by legislation enacted in 1995 or subsequently.

Subd. 8. **Governance.** (a) The association shall be governed by an interim 19-member board as follows: one provider member appointed by the Minnesota Hospital Association; one provider member appointed by the Minnesota Medical Association; one provider member appointed by the governor; three members appointed by the Minnesota Council of HMOs to include an HMO with at least 50 percent of total membership enrolled through a public program; three members appointed by Blue Cross and Blue Shield of Minnesota, to include a member from a Blue Cross and Blue Shield of Minnesota affiliated health plan with fewer than 50,000 enrollees and located outside the Minneapolis-St. Paul metropolitan area; two members appointed by the Insurance Federation of Minnesota; one member appointed by the Minnesota Association of Counties; and three public members appointed by the governor, to include at least one representative of a public program. The commissioners of health, commerce, human services, and employee relations shall be nonvoting ex officio members.

(b) The board may elect officers and establish committees as necessary.

(c) A majority of the members of the board constitutes a quorum for the transaction of business.

(d) Approval by a majority of the board members present is required for any action of the board.

(e) Interim board members shall be appointed by July 1, 1994, and shall serve until a new board is elected according to the plan developed by the association.

(f) A member may designate a representative to act as a member of the interim board in the member's absence.

Subd. 9. **Data collection.** The board of the association shall consider antitrust implications and establish procedures to assure that pricing and other competitive information is appropriately shared among competitors in the health care market or members of the board. Any information shared shall be distributed only for the purposes of administering or developing any of the tasks identified in subdivisions 2 and 4. In developing these procedures, the board of the association may consider the identification of a state agency or other appropriate third party to receive information of a confidential or competitive nature.

Subd. 10. **Supervision.** The association's activities shall be supervised by the commissioners of health and commerce.

Subd. 11. **Reporting.** The board of the association shall provide a status report on its activities to the health care commission on a quarterly basis.

**History:** *1994 c 625 art 2 s 15*

## 62Q.07 ACTION PLANS.

Subdivision 1. **Action plans required.** (a) To increase public awareness and accountability of health plan companies, all health plan companies must annually file with the applicable commissioner an action plan that satisfies the requirements of this section beginning July 1, 1994, as a condition of doing business in Minnesota. Each health plan company must also file its action plan with the information clearinghouse. Action plans are required solely to provide information to consumers, purchasers, and the larger community as a first step toward greater accountability of health plan companies. The

sole function of the commissioner in relation to the action plans is to ensure that each health plan company files a complete action plan, that the action plan is truthful and not misleading, and that the action plan is reviewed by appropriate community agencies.

(b) If a commissioner responsible for regulating a health plan company required to file an action plan under this section has reason to believe an action plan is false or misleading, the commissioner may conduct an investigation to determine whether the action plan is truthful and not misleading, and may require the health plan company to submit any information that the commissioner reasonably deems necessary to complete the investigation. If the commissioner determines that an action plan is false or misleading, the commissioner may require the health plan company to file an amended plan or may take any action authorized under chapter 72A.

Subd. 2. **Contents of action plans.** (a) An action plan must include a detailed description of all of the health plan company's methods and procedures, standards, qualifications, criteria, and credentialing requirements for designating the providers who are eligible to participate in the health plan company's provider network, including any limitations on the numbers of providers to be included in the network. This description must be updated by the health plan company and filed with the applicable agency on a quarterly basis.

(b) An action plan must include the number of full-time equivalent physicians, by specialty, nonphysician providers, and allied health providers used to provide services. The action plan must also describe how the health plan company intends to encourage the use of nonphysician providers, midlevel practitioners, and allied health professionals, through at least consumer education, physician education, and referral and advisement systems. The annual action plan must also include data that is broken down by type of provider, reflecting actual utilization of midlevel practitioners and allied professionals by enrollees of the health plan company during the previous year. Until July 1, 1995, a health plan company may use estimates if actual data is not available. For purposes of this paragraph, "provider" has the meaning given in section 62J.03, subdivision 8.

(c) An action plan must include a description of the health plan company's policy on determining the number and the type of providers that are necessary to deliver cost-effective health care to its enrollees. The action plan must also include the health plan company's strategy, including provider recruitment and retention activities, for ensuring that sufficient providers are available to its enrollees.

(d) An action plan must include a description of actions taken or planned by the health plan company to ensure that information from report cards, outcome studies, and complaints is used internally to improve quality of the services provided by the health plan company.

(e) An action plan must include a detailed description of the health plan company's policies and procedures for enrolling and serving high risk and special needs populations. This description must also include the barriers that are present for the high risk and special needs population and how the health plan company is addressing these barriers in order to provide greater access to these populations. "High risk and special needs populations" includes, but is not limited to, recipients of medical assistance, general assistance medical care, and MinnesotaCare; persons with chronic conditions or disabilities; individuals within certain racial, cultural, and ethnic communities; individuals and families with low income; adolescents; the elderly; individuals with limited or no English language proficiency; persons with high-cost preexisting conditions; homeless persons; chemically dependent persons; persons with serious and persistent mental illness and children with severe emotional disturbance; and persons who are at high risk of requiring treatment. The action plan must also reflect actual utilization of providers by enrollees defined by this section as high risk or special needs populations during the previous year. For purposes of this paragraph, "provider" has the meaning given in section 62J.03, subdivision 8.

(f) An action plan must include a general description of any action the health plan

company has taken and those it intends to take to offer health coverage options to rural communities and other communities not currently served by the health plan company.

(g) A health plan company other than a large managed care plan company may satisfy any of the requirements of the action plan in paragraphs (a) to (f) by stating that it has no policies, procedures, practices, or requirements, either written or unwritten, or formal or informal, and has undertaken no activities or plans on the issues required to be addressed in the action plan, provided that the statement is truthful and not misleading. For purposes of this paragraph, "large managed care plan company" means a health maintenance organization, integrated service network, or other health plan company that employs or contracts with health care providers, that has more than 50,000 enrollees in this state. If a health plan company employs or contracts with providers for some of its health plans and does not do so for other health plans that it offers, the health plan company is a large managed care plan company if it has more than 50,000 enrollees in this state in health plans for which it does employ or contract with providers.

**History:** *1994 c 625 art 2 s 16*

## 62Q.075 LOCAL PUBLIC ACCOUNTABILITY AND COLLABORATION PLAN.

Subdivision 1. **Definition.** For purposes of this section, "managed care organization" means a health maintenance organization, community integrated service network, or integrated service network.

Subd. 2. **Requirement.** Beginning July 1, 1995, all managed care organizations shall annually file with the action plans required under section 62Q.07 a plan describing the actions the managed care organization has taken and those it intends to take to contribute to achieving public health goals for each service area in which an enrollee of the managed care organization resides. This plan must be jointly developed in collaboration with the local public health units, appropriate regional coordinating boards, and other community organizations providing health services within the same service area as the managed care organization. Local government units with responsibilities and authority defined under chapters 145A and 256E may designate individuals to participate in the collaborative planning with the managed care organization to provide expertise and represent community needs and goals as identified under chapters 145A and 256E.

Subd. 3. **Contents.** The plan must address the following:

(a) specific measurement strategies and a description of any activities which contribute to public health goals and needs of high risk and special needs populations as defined and developed under chapters 145A and 256E;

(b) description of the process by which the managed care organization will coordinate its activities with the community health boards, regional coordinating boards, and other relevant community organizations servicing the same area;

(c) documentation indicating that local public health units and local government unit designees were involved in the development of the plan;

(d) documentation of compliance with the plan filed the previous year, including data on the previously identified progress measures.

Subd. 4. **Review.** Upon receipt of the plan, the appropriate commissioner shall provide a copy to the regional coordinating boards, local community health boards, and other relevant community organizations within the managed care organization's service area. After reviewing the plan, these community groups may submit written comments on the plan to either the commissioner of health or commerce, as applicable, and may advise the commissioner of the managed care organization's effectiveness in assisting to achieve regional public health goals. The plan may be reviewed by the county boards, or city councils acting as a local board of health in accordance with chapter 145A, within the managed care organization's service area to determine whether the plan is consistent with the goals and objectives of the plans required under chapters 145A and 256E and whether the plan meets the needs of the community. The county

board, or applicable city council, may also review and make recommendations on the availability and accessibility of services provided by the managed care organization. The county board, or applicable city council, may submit written comments to the appropriate commissioner, and may advise the commissioner of the managed care organization's effectiveness in assisting to meet the needs and goals as defined under the responsibilities of chapters 145A and 256E. Copies of these written comments must be provided to the managed care organization. The plan and any comments submitted must be filed with the information clearinghouse to be distributed to the public.

**History:** *1994 c 625 art 7 s 1*

## 62Q.09 PROHIBITION ON EXCLUSIVE RELATIONSHIPS.

Subdivision 1. **Prohibition on exclusive contracts.** No provider or health plan company shall restrict any person's right to provide health services or procedures to another provider or health plan company, unless the person is an employee.

Subd. 2. **Prohibition on restrictive contract terms.** No provider or person providing goods or health services to a provider shall enter into any contract or subcontract with any health plan company on terms that require the provider or person not to contract with any other health plan company, unless the provider or person is an employee.

Subd. 3. **Enforcement.** Either the commissioner of health or commerce shall periodically review contracts among health care providing entities and health plan companies to determine compliance with this section. Any provider may submit a contract to the commissioner for review if the provider believes this section has been violated. Any provision of a contract found to violate this section is null and void, and the commissioner may seek civil penalties in an amount not to exceed $25,000 for each such contract.

Subd. 4. **Application; voluntary renewal.** This section applies to contracts entered into on or after the effective date of this section. This section does not prohibit the voluntary renewal of exclusive contracts entered into prior to the effective date of this section.

Subd. 5. **Sunset.** This section expires January 1, 1997.

**History:** *1994 c 625 art 2 s 17*

## 62Q.095 EXPANDED PROVIDER NETWORKS.

Subdivision 1. **Provider acceptance required.** Each health plan company, with the exception of any health plan company with 50,000 or fewer enrollees and health plan companies that are exempt under subdivision 6, shall establish an expanded network of allied independent health providers, in addition to a preferred network. A health plan company shall accept as a provider in the expanded network any allied independent health provider who: (1) meets the health plan company's credentialing standards; (2) agrees to the terms of the health plan company's provider contract; and (3) agrees to comply with all managed care protocols of the health plan company. A preferred network shall be considered an expanded network if all allied independent health providers who meet the requirements of clauses (1), (2), and (3) are accepted into the preferred network. A community integrated service network may offer to its enrollees an expanded network of allied independent health providers as described under this section.

Subd. 2. **Managed care.** The managed care protocols used by the health plan company may include: (1) a requirement that an enrollee obtain a referral from the health plan company before obtaining services from an allied independent health provider in the expanded network; (2) limits on the number and length of visits to allied independent health providers in the expanded network allowed by each referral, as long as the number and length of visits allowed is not less than the number and length allowed for comparable referrals to allied independent health providers in the preferred network; and (3) ongoing management and review by the health plan company of the care provided by an allied independent health provider in the expanded network after a referral is made.

Subd. 3. **Mandatory offering to enrollees.** Each health plan company shall offer to enrollees the option of receiving covered services through the expanded network of allied independent health providers established under subdivisions 1 and 2. This expanded network option may be offered as a separate health plan. The network may establish separate premium rates and cost-sharing requirements for this expanded network plan, as long as these premium rates and cost-sharing requirements are actuarially justified and approved by the commissioner. This subdivision does not apply to Medicare, medical assistance, general assistance medical care, and MinnesotaCare. This subdivision is effective January 1, 1995, and applies to health plans issued or renewed, or offers of health plans to be issued or renewed, on or after January 1, 1995, except that this subdivision is effective January 1, 1996, for collective bargaining agreements of the department of employee relations and the University of Minnesota.

Subd. 4. **Provider reimbursement.** A health plan company shall pay each allied independent health provider in the expanded network the same rate per unit of service as paid to allied independent health providers in the preferred network.

Subd. 5. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Allied independent health provider" means an independently enrolled audiologist, chiropractor, dietitian, home health care provider, licensed marriage and family therapist, nurse practitioner or advanced practice nurse, occupational therapist, optometrist, optician, outpatient chemical dependency counselor, pharmacist who is not employed by and based on the premises of a health plan company, physical therapist, podiatrist, licensed psychologist, psychological practitioner, licensed social worker, or speech therapist.

(c) "Home health care provider" means a provider of personal care assistance, home health aide, homemaker, respite care, adult day care, or home therapies and home health nursing services.

(d) "Independently enrolled" means that a provider can bill, and receive direct payment for services from, a third-party payer or patient.

Subd. 6. **Exemption.** A health plan company, to the extent that it operates as a staff model health plan company as defined in section 295.50, subdivision 12b, by employing allied independent health care providers to deliver health care services to enrollees, is exempt from this section.

**History:** *1994 c 625 art 1 s 6,18*

## 62Q.10 NONDISCRIMINATION.

If a health plan company, with the exception of a community integrated service network or an indemnity insurer licensed under chapter 60A who does not offer a product through a preferred provider network, offers coverage of a health care service as part of its plan, it may not deny provider network status to a qualified health care provider type who meets the credentialing requirements of the health plan company solely because the provider is an allied independent health care provider as defined in section 62Q.095.

**History:** *1994 c 625 art 1 s 18; art 2 s 18*

## 62Q.11 DISPUTE RESOLUTION.

Subdivision 1. **Established.** The commissioners of health and commerce shall make dispute resolution processes available to encourage early settlement of disputes in order to avoid the time and cost associated with litigation and other formal adversarial hearings. For purposes of this section, "dispute resolution" means the use of negotiation, mediation, arbitration, mediation-arbitration, neutral fact finding, and minitrials. These processes shall be nonbinding unless otherwise agreed to by all parties to the dispute.

Subd. 2. **Requirements.** (a) If an enrollee, health care provider, or applicant for network provider status chooses to use a dispute resolution process prior to the filing of a formal claim or of a lawsuit, the health plan company must participate.

(b) If an enrollee, health care provider, or applicant for network provider status chooses to use a dispute resolution process after the filing of a lawsuit, the health plan company must participate in dispute resolution, including, but not limited to, alternative dispute resolution under rule 114 of the Minnesota general rules of practice.

(c) The commissioners of health and commerce shall inform and educate health plan companies' enrollees about dispute resolution and its benefits.

(d) A health plan company may encourage but not require an enrollee to submit a complaint to alternative dispute resolution.

**History:** *1994 c 625 art 2 s 19*

### 62Q.12 DENIAL OF ACCESS.

No health plan company may deny access to a covered health care service unless the denial is made by, or under the direction of, or subject to the review of a health care professional licensed to provide the service in question.

**History:** *1994 c 625 art 2 s 20*

### 62Q.135 CONTRACTING FOR CHEMICAL DEPENDENCY SERVICES.

No health plan company shall contract with a chemical dependency treatment program, unless the program participates in the chemical dependency treatment accountability plan established by the commissioner of human services. The commissioner of human services shall make data on chemical dependency services and outcomes collected through this program available to health plan companies.

**History:** *1994 c 625 art 2 s 21*

### 62Q.14 RESTRICTIONS ON ENROLLEE SERVICES.

No health plan company may restrict the choice of an enrollee as to where the enrollee receives services related to:

(1) the voluntary planning of the conception and bearing of children, provided that this clause does not refer to abortion services;

(2) the diagnosis of infertility;

(3) the testing and treatment of a sexually transmitted disease; and

(4) the testing for AIDS or other HIV-related conditions.

**History:** *1994 c 625 art 2 s 22*

### 62Q.16 MIDMONTH TERMINATION PROHIBITED.

The termination of a person's coverage under any health plan as defined in section 62A.011, subdivision 3, with the exception of individual health plans, issued or renewed on or after January 1, 1995, must provide coverage until the end of the month in which coverage was terminated.

**History:** *1994 c 625 art 2 s 23*

### 62Q.165 UNIVERSAL COVERAGE.

It is the commitment of the state to achieve universal health coverage for all Minnesotans by July 1, 1997. In order to achieve this commitment, the following goals must be met:

(1) every Minnesotan shall have health coverage and shall contribute to the costs of coverage based on ability to pay;

(2) no Minnesotan shall be denied coverage or forced to pay more because of health status;

(3) quality health care services must be accessible to all Minnesotans;

(4) all health care purchasers must be placed on an equal footing in the health care marketplace; and

(5) a comprehensive and affordable health plan must be available to all Minnesotans.

**History:** *1994 c 625 art 6 s 1*

## 62Q.17 VOLUNTARY PURCHASING POOLS.

Subdivision 1. **Permission to form.** Notwithstanding section 62A.10, employers, groups, and individuals may voluntarily form purchasing pools, solely for the purpose of negotiating and purchasing health plan coverage from health plan companies for members of the pool.

Subd. 2. **Common factors.** All participants in a purchasing pool must live within a common geographic region, be employed in a similar occupation, or share some common factor as approved by the commissioner.

Subd. 3. **Governing structure.** Each pool must have a governing structure controlled by its members. The governing structure of the pool is responsible for administration of the pool. The governing structure shall review and evaluate all bids for coverage from health plan companies, shall determine criteria for joining and leaving the pool, and may design incentives for healthy lifestyles and health promotion programs. The governing structure may design uniform entrance standards for all employers, except small employers as defined under section 62L.02. Small employers must be permitted to enter any pool if the small employer meets the pool's membership requirements. Pools must provide as much choice in health plans to members as is financially possible. The governing structure may charge all members a fee for administrative purposes.

Subd. 4. **Enrollment.** Pools must have an annual open enrollment period of not less than 15 days, during which all individuals or groups that qualify for membership may enter the pool without any preexisting condition limitations or exclusions or exclusionary riders, except those permitted under chapter 62L for groups or section 62A.65 for individuals. Pools must reach and maintain an enrolled population of at least 1,000 members within six months of formation. If a pool fails to reach or maintain the minimum enrollment, all coverage subsequently purchased through the purchasing pool must be regulated through existing applicable laws and forego all advantages under this section.

Subd. 5. **Members.** The governing structure of the pool shall set a minimum time period for membership. Members must stay in the purchasing pool for the entire minimum period to avoid paying a penalty. Penalties for early withdrawal from the purchasing pool shall be established by the governing structure.

Subd. 6. **Employer-based purchasing pools.** Employer-based purchasing pools must, with respect to small employers as defined in section 62L.02, meet all the requirements of chapter 62L. The experience of the pool must be pooled and the rates blended across all groups. Pools may decide to create tiers within the pool, based on experience of group members. These tiers must be designed within the requirements of section 62L.08. The governing structure may establish criteria limiting movement between tiers. Tiers must be phased out within two years of the pool's creation.

Subd. 7. **Individual members.** Purchasing pools that contain individual members must meet all of the underwriting and rate restrictions found in the individual health plan market.

Subd. 8. **Reports.** Prior to the initial effective date of coverage, and annually thereafter, each pool shall file a report with the information clearinghouse. The information clearinghouse must use the report to promote the purchasing pools. The annual report must contain the following information:

(1) the number of lives in the pool;

(2) the geographic area the pool intends to cover;

(3) the number of health plans offered;

(4) a description of the benefits under each plan;

(5) a description of the premium structure, including any copayments or deductibles, of each plan offered;

(6) evidence of compliance with chapter 62L;

(7) a sample of marketing information, including a phone number where the pool may be contacted; and

(8) a list of all administrative fees charged.

**History:** *1994 c 625 art 6 s 2*

## 62Q.18 UNIVERSAL COVERAGE; INSURANCE REFORMS.

Subdivision 1. **Definition.** For purposes of this section,

(1) "continuous coverage" has the meaning given in section 62L.02;

(2) "guaranteed issue" means:

(i) for individual health plans, that a health plan company shall not decline an application by an individual for any individual health plan offered by that health plan company, including coverage for a dependent of the individual to whom the health plan has been or would be issued; and

(ii) for group health plans, that a health plan company shall not decline an application by a group for any group health plan offered by that health plan company and shall not decline to cover under the group health plan any person eligible for coverage under the group's eligibility requirements, including persons who become eligible after initial issuance of the group health plan;

(3) "qualifying coverage" has the meaning given in section 62L.02; and

(4) "underwriting restrictions" has the meaning given in section 62L.03, subdivision 4.

Subd. 2. **Individual mandate.** Effective July 1, 1997, each Minnesota resident shall obtain and maintain qualifying coverage.

Subd. 3. **Guaranteed issue.** (a) Effective July 1, 1997, each health plan company shall offer, sell, issue, or renew each of its individual health plan forms on a guaranteed issue basis to any Minnesota resident.

(b) Effective July 1, 1997, each health plan company shall offer, sell, issue, or renew each of its group health plan forms to any employer that has its principal place of business in this state on a guaranteed issue basis, provided that the guaranteed issue requirement does not apply to employees, dependents, or other persons to be covered, who are not residents of this state.

Subd. 4. **Underwriting restrictions limited.** Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan that has underwriting restrictions that apply to a Minnesota resident, except as expressly permitted under this section.

Subd. 5. **Preexisting condition limitations.** Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan that contains a preexisting condition limitation or exclusion or exclusionary rider that applies to a Minnesota resident, except a limitation which is no longer than 12 months and applies only to a person who has not maintained continuous coverage. An unexpired preexisting condition limitation from previous qualifying coverage may be carried over to new coverage under a health plan, if the unexpired condition is one permitted under this section. A Minnesota resident who has not maintained continuous coverage may be subjected to a new 12-month preexisting condition limitation after each break in continuous coverage.

Subd. 6. **Limits on premium rate variations.** (a) Effective July 1, 1995, the premium rate variations permitted under sections 62A.65 and 62L.08 become:

(1) for factors other than age and geography, 12.5 percent of the index rate; and

(2) for age, 25 percent of the index rate.

(b) Effective July 1, 1996, the premium variations permitted under sections 62A.65 and 62L.08 become:

(1) for factors other than age and geography, 7.5 percent of the index rate; and

(2) for age, 15 percent of the index rate.

(c) Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan, that is subject to section 62A.65 or 62L.08, for which the premium rate varies between covered persons on the basis of any factor other than:

(1) for individual health plans, differences in benefits or benefit design, and for group health plans, actuarially valid differences in benefits or benefit design;

(2) the number of persons to be covered by the health plan;

(3) actuarially valid differences in expected costs between adults and children;

(4) healthy lifestyle discounts authorized by statute; and

(5) for individual health plans, geographic variations permitted under section 62A.65, and for group health plans, geographic variations permitted under section 62L.08.

(d) All premium rate variations permitted under paragraph (c) are subject to the approval of the commissioner.

(e) Notwithstanding paragraphs (a), (b), and (c), no health plan company shall renew any individual or group health plan, except in compliance with this paragraph. No premium rate for any policy holder or contract holder shall increase or decrease upon renewal, as a result of this subdivision, by more than 15 percent per year. The increase or decrease described in this paragraph is in addition to any premium increase or decrease caused by legally permissible factors other than this subdivision. If a premium increase or decrease is constrained by this paragraph, the health plan company may implement the remaining portion of the increase or decrease at the time of subsequent annual renewals, but never to exceed 15 percent per year for paragraphs (a), (b), and (c) combined.

Subd. 7. **Portability of coverage.** (a) Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew any group or individual health plan that does not provide for guaranteed issue, with full credit for previous qualifying coverage against any preexisting condition limitation that would otherwise apply under subdivision 5. No health plan shall be subject to any other type of underwriting restriction.

(b) Effective July 1, 1995, no health plan company shall offer, sell, issue, or renew any group or individual health plan that does not, with respect to individuals who maintain continuous coverage and whose immediately preceding qualifying coverage is a health plan issued by medical assistance under chapter 256B, general assistance medical care under chapter 256D, or the MinnesotaCare program established under section 256.9352,

(1) make coverage available on a guaranteed issue basis; and

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or exclusion.

(c) Paragraph (b) applies to individuals whose immediately preceding qualifying coverage is medical assistance under chapter 256B, general assistance medical care under chapter 256D, or the MinnesotaCare program established under section 256.9352, only if the individual has disenrolled from the public program or will disenroll upon issuance of the new coverage. Paragraph (b) does not apply if the public program uses or will use public funds to pay the premiums for an individual who remains or will remain enrolled in the public program. No public funds may be used to purchase private coverage available under this paragraph. This paragraph does not prohibit public payment of premiums to continue private sector coverage originally obtained prior to enrollment in the public program, where otherwise permitted by state or federal law. Portability coverage under this paragraph is subject to the provisions of section 62A.65, subdivision 5, clause (b).

(d) Effective July 1, 1994, no health plan company shall offer, sell, issue, or renew any group health plan that does not, with respect to individuals who maintain continuous coverage:

(1) make coverage available on a guaranteed issue basis; and

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or exclusion.

To the extent that this paragraph conflicts with chapter 62L, with respect to small employers as defined in section 62L.02, chapter 62L governs.

Subd. 8. **Comprehensive health association.** Effective July 1, 1997, the comprehensive health association created in section 62E.10 shall not accept new applicants for enrollment, except for Medicare-related coverage described in section 62E.12 and for coverage described in section 62E.18.

Subd. 9. **Contingency; future legislation.** This section, except for subdivision 7, paragraphs (b), (c), and (d), is not intended to be implemented prior to legislation enacted to achieve the objectives of section 62Q.165 and Laws 1994, chapter 625, article 6, sections 5, 6, and 7. Subdivision 6 is not effective until an effective date is specified in 1995 legislation.

**History:** *1994 c 625 art 6 s 3; art 8 s 72*

## 62Q.19 ESSENTIAL COMMUNITY PROVIDERS.

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; or

(3) status as a local government or community health board as defined in chapter 145A.

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.

Subd. 2. **Application.** Any provider may apply to the commissioner for designation as an essential community provider within two years after the effective date of the rules adopted by the commissioner to implement this section.

Subd. 3. **Health plan company affiliation.** A health plan company must offer a provider contract to any designated essential community provider located within the area served by the health plan company. A health plan company shall not restrict enrollee access to the essential community provider for the population that the essential community provider is certified to serve. A health plan company may also make other providers available to this same population. A health plan company may require an essential community provider to meet all data requirements, utilization review, and quality assurance requirements on the same basis as other health plan providers.

Subd. 4. **Essential community provider responsibilities.** Essential community providers must agree to serve enrollees of all health plan companies operating in the area that the essential community provider is certified to serve.

Subd. 5. **Contract payment rates.** An essential community provider and a health plan company may negotiate the payment rate for covered services provided by the essential community provider. This rate must be competitive with rates paid to other health plan providers for the same or similar services.

Subd. 6. **Termination.** The designation as an essential community provider is terminated five years after it is granted, and the former essential community provider has no rights or privileges beyond those of any other health care provider.

Subd. 7. **Recommendations and rulemaking on essential community providers.** (a) As part of the implementation plan due January 1, 1995, the commissioner shall present proposed rules and any necessary recommendations for legislation for defining essential community providers, using the criteria established under subdivision 1, and defining the relationship between essential community providers and health plan companies.

(b) By January 1, 1996, the commissioner shall adopt rules for establishing essential community providers and for governing their relationship with health plan companies. The commissioner shall also identify and address any conflict of interest issues regarding essential community provider designation for local governments.

**History:** *1994 c 625 art 4 s 6*

## 62Q.21 UNIVERSAL STANDARD BENEFITS SET.

Subdivision 1. **Mandatory offering.** Effective January 1, 1996, each health plan company shall offer the universal standard benefits set to its enrollees.

Subd. 2. **Standard benefit set.** Effective July 1, 1997, health plan companies shall offer, sell, issue, or renew only the universal standard benefits set and the cost-sharing and supplemental coverage options established in accordance with sections 62Q.25 and 62Q.27.

Subd. 3. **General description.** The universal standard benefits set must contain all appropriate and necessary health care services. Benefits necessary to meet public health goals, adequately serve high risk and special needs populations, facilitate the utilization of cost-effective alternatives to traditional inpatient acute and extended health care delivery, or meet other objectives of health care reform shall be considered by the commissioner for inclusion in the universal standard benefits set. Appropriate and necessary dental services must be included.

Subd. 4. **Benefit set recommendations.** The commissioner of health, in consultation with the Minnesota health care commission and the commissioners of human services and commerce, shall develop the universal standard benefits set and report these recommendations to the legislature by January 1, 1995. The commissioners shall include in this report a definition for appropriate and necessary care, in terms of type, frequency, level, setting, and duration of services which address the enrollee's mental and physical condition. In developing this definition, the commissioners shall consider that a benefit set that excludes genuinely appropriate and necessary services will not reduce or contain costs, but will only transfer those costs onto individuals and the public sector. Therefore, the definition of appropriate and necessary care must be sufficiently broad to address the needs of those with chronic conditions or disabilities, including those who need health services to improve their functioning, and those for whom maintenance of health may not be possible and those for whom preventing deterioration in their health conditions might not be achievable, and meet other health care reform objectives. In developing the universal standard benefits set, the commissioners shall take into account factors including, but not limited to:

(1) information regarding the benefits, risks, and cost-effectiveness of health care interventions;

(2) development of practice parameters;

(3) technology assessments;

(4) medical innovations;

(5) health status assessments;

(6) identification of unmet needs or particular barriers to access;

(7) public health goals;

(8) expenditure limits and available funding;

(9) cost savings resulting from the inclusion of a health care service that will decrease the utilization of other health care services in the benefit set;

(10) cost efficient and effective alternatives to inpatient health care services for acute or extended health care needs, such as home health care services; and

(11) the desirability of including coverage for all court-ordered mental health services for juveniles.

Subd. 5. **Advisory committee on the universal benefits set.** The commissioner shall appoint an advisory committee to develop recommendations regarding the services other than dental services to be included in the universal benefits set. The committee must include representatives of health care providers, purchasers, consumers, health plan companies, and counties. The health care provider representatives must include both physicians and allied independent health care providers representing both physical and mental health conditions. The committee shall report these recommendations to the commissioner by October 1, 1994.

Subd. 6. **Advisory committee on dental services.** The commissioner shall appoint an advisory committee to develop recommendations regarding the level of appropriate and necessary dental services to be included in the universal standard benefits set. The committee shall also develop recommendations on an appropriate system to deliver dental services. In its analysis the committee shall study the quality and cost-effectiveness of dental services delivered through capitated dental networks, discounted dental preferred provider organizations, and independent practice dentistry. The committee shall report these recommendations to the commissioner by October 1, 1994.

Subd. 7. **Chemical dependency services.** If chemical dependency services are included in the universal standard benefits set, the commissioner shall consider the cost-effectiveness of requiring health plan companies and chemical dependency facilities to use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660.

**History:** *1994 c 625 art 4 s 7*

## 62Q.23 GENERAL SERVICES.

(a) Health plan companies shall comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(b) Health plan companies shall comply with sections 62A.047, 62A.27, and any other coverage required under chapter 62A of newborn infants, dependent children who do not reside with a covered person, handicapped children and dependents, and adopted children. A health plan company providing dependent coverage shall comply with section 62A.302.

(c) Health plan companies shall comply with the equal access requirements of section 62A.15.

**History:** *1994 c 625 art 4 s 8*

NOTE: This section, as added by Laws 1994, chapter 625, article 4, section 8, is effective July 1, 1997. See Laws 1994, chapter 625, article 4, section 14.

## 62Q.25 SUPPLEMENTAL COVERAGE.

Health plan companies may choose to offer separate supplemental coverage for services not covered under the universal benefits set. Health plan companies may offer any Medicare supplement, Medicare select, or other Medicare-related product otherwise permitted for any type of health plan company 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.

**History:** *1994 c 625 art 4 s 9*

NOTE: This section, as added by Laws 1994, chapter 625, article 4, section 9, is effective July 1, 1997. See Laws 1994, chapter 625, article 4, section 14.

## 62Q.27 ENROLLEE COST-SHARING.

(a) The commissioner, as part of the implementation plan due January 1, 1995, shall present to the legislature recommendations and draft legislation to establish up to five standardized benefit plans which may be offered by each health plan company. 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. Each plan offered may include out-of-network coverage options.

(b) For purposes of this section, "enrollee 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 following principles must apply to cost-sharing:

(1) enrollees must have a choice of cost-sharing arrangements;

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

(3) cost-sharing for recipients of medical assistance, general assistance medical care, or the MinnesotaCare program must be determined by applicable law and rules governing these programs;

(4) cost-sharing must be capped at an annual limit determined by the commissioner to protect individuals and families from severe financial hardship and to protect individuals with substantial health care needs;

(5) cost-sharing must not be applied to preventive health services as defined in Minnesota Rules, part 4685.0801, subpart 8;

(6) the impact of enrollee cost-sharing requirements on appropriate utilization must be considered when cost-sharing requirements are developed;

(7) additional requirements may 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;

(8) a copayment may be no greater than 25 percent of the paid charges for the service or product;

(9) 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

(10) 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.

(d) The commissioner shall consider whether a health plan company may return to the enrollee all or part of an enrollee's premium as an incentive for completing preventive care, and may return all or part of an enrollee's cost-sharing for participating in health education, improving health, or reducing health risks.

**History:** *1994 c 625 art 4 s 10*

## 62Q.29 STATE-ADMINISTERED PUBLIC PROGRAMS.

Public agencies, in conjunction with the department of health and the department of human services, on behalf of eligible recipients enrolled in public programs such as medical assistance, general assistance medical care, and MinnesotaCare, may contract with health plan companies to provide services included in these programs, but not included in the universal standard benefits set.

**History:** *1994 c 625 art 4 s 11*

NOTE: This section, as added by Laws 1994, chapter 625, article 4, section 11, is effective July 1, 1997. See Laws 1994, chapter 625, article 4, section 14.

## 62Q.30 EXPEDITED FACT FINDING AND DISPUTE RESOLUTION PROCESS.

The commissioner shall establish an expedited fact finding and dispute resolution process to assist enrollees of integrated service networks and all-payer insurers with contested treatment, coverage, and service issues to be in effect July 1, 1997. The commissioner may order an integrated service network or an all-payer insurer to provide or pay for a service that is within the universal standard benefits set. If the disputed issue relates to whether a service is appropriate and necessary, the commissioner shall issue an order only after consulting with appropriate experts knowledgeable, trained, and practicing in the area in dispute, reviewing pertinent literature, and considering the availability of satisfactory alternatives. The commissioner shall take steps including but not limited to fining, suspending, or revoking the license of an integrated service network or an all-payer insurer that is the subject of repeated orders by the commissioner that suggests a pattern of inappropriate underutilization.

**History:** *1994 c 625 art 4 s 12*

## 62Q.32 LOCAL OMBUDSPERSON.

County board or community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services through a health plan company. The ombudsperson's functions may include, but are not limited to:

(a) mediation or advocacy on behalf of a person accessing the complaint and appeal procedures to ensure that necessary medical services are provided by the health plan company; and

(b) investigation of the quality of services provided to a person and determine the extent to which quality assurance mechanisms are needed or any other system change may be needed.

**History:** *1994 c 625 art 7 s 2*

## 62Q.33 LOCAL GOVERNMENT PUBLIC HEALTH FUNCTIONS.

Subdivision 1. **Findings.** The legislature finds that the local government public health functions of community assessment, policy development, and assurance of service delivery are essential elements in consumer protection and in achieving the objectives of health care reform in Minnesota. The legislature further finds that the site-based and population-based services provided by state and local health departments are a critical strategy for the long-term containment of health care costs. The legislature further finds that without adequate resources, the local government public health system will lack the capacity to fulfill these functions in a manner consistent with the needs of a reformed health care delivery system.

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 implementa-

tion 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.

Subd. 3. **Core public health functions.** (a) The report required by subdivision 2 must describe the local government core public health functions of: assessment of community health needs; goal-determination, public policy, and program development for addressing these needs; and assurance of service availability and accessibility to meet community health goals and needs. The report must further describe activities for implementation of these functions that are the continuing responsibility of the local government public health system, taking into account the ongoing reform of the health care delivery system.

(b) The activities to be defined in terms of the local government core public health functions include, but are not limited to:

(1) consumer protection and advocacy;

(2) targeted outreach and linkage to personal services;

(3) health status monitoring and disease surveillance;

(4) investigation and control of diseases and injuries;

(5) protection of the environment, work places, housing, food, and water;

(6) laboratory services to support disease control and environmental protection;

(7) health education and information;

(8) community mobilization for health-related issues;

(9) training and education of public health professionals;

(10) public health leadership and administration;

(11) emergency medical services;

(12) violence prevention; and

(13) other activities that have the potential to improve the health of the population or special needs populations and reduce the need for or cost of health care services.

Subd. 4. **Capacity building, accountability and funding.** The recommendations required by subdivision 2 shall include:

(1) a definition of minimum outcomes for implementing core public health functions, including a local ombudsperson under the assurance of services function;

(2) the identification of counties and applicable cities with public health programs that need additional assistance to meet the minimum outcomes;

(3) a budget for supporting all functions needed to achieve the minimum outcomes, including the local ombudsperson assurance of services function;

(4) an analysis of the costs and benefits expected from achieving the minimum outcomes;

(5) strategies for improving local government public health functions throughout the state to meet the minimum outcomes including: (i) funding distribution for local government public health functions necessary to meet the minimum outcomes; and (ii) strategies for the financing of personal health care services within the uniform benefits set and identifying appropriate mechanisms for the delivery of these services; and

(6) a recommended level of dedicated funding for local government public health functions in terms of a percentage of total health service expenditures by the state or in terms of a per capita basis, including methods of allocating the dedicated funds to local government.

Subd. 5. **Timeline.** (a) By October 1, 1994, the commissioner shall submit to the legislative commission on health care access the initial report and recommendations required by subdivisions 2 to 4.

(b) By February 15, 1995, the commissioner, in cooperation with the legislative commission on health care access, shall submit a final report to the legislature, with specific recommendations for capacity building and financing to be implemented over the period from January 1, 1996, through December 31, 1997.

(c) By January 1, 1997, and by January 1 of each odd-numbered year thereafter, the commissioner shall present to the legislature an updated report and recommendations.

**History:** *1994 c 625 art 7 s 3*

**62Q.41 ANNUAL IMPLEMENTATION REPORT.**

The commissioner of health, in consultation with the Minnesota health care commission, shall develop an annual implementation report to be submitted to the legislature each year beginning January 1, 1995, describing the progress and status of rule development and implementation of the integrated service network system and the regulated all-payer option, and providing recommendations for legislative changes that the commissioner determines may be needed.

**History:** *1994 c 625 art 5 s 1*