CHAPTER 62Q

REQUIREMENTS FOR HEALTH PLAN COMPANIES

62Q.001 APPLICATION OF LAWS 2005, CHAPTER 56, TERMINOLOGY CHANGES.

State agencies shall use the terminology changes specified in Laws 2005, chapter 56, section 1, when printed material and signage are replaced and new printed material and signage are obtained. State agencies do not have to replace existing printed material and signage

to comply with Laws 2005, chapter 56, sections 1 and 2. Language changes made according to Laws 2005, chapter 56, sections 1 and 2, shall not expand or exclude eligibility to services.

History: *2005 c 56 s 3*

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 for purposes of regulating health maintenance organizations, and community integrated service networks, or the commissioner of commerce for purposes of regulating all other health plan companies. For all other purposes, "commissioner" means the commissioner of health.

Subd. 2a. **Enrollee.** "Enrollee" means a natural person covered by a health plan and includes an insured, policyholder, subscriber, contract holder, member, covered person, or certificate holder.

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.

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

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

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

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

Subd. 5. **Managed care organization.** "Managed care organization" means: (1) a health maintenance organization operating under chapter 62D; (2) a community integrated service network as defined under section 62N.02, subdivision 4a; or (3) an insurance company licensed under chapter 60A, nonprofit health service plan corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

Subd. 6. **Medicare–related coverage.** "Medicare–related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.3099 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by sections 1833 (known as "cost" or "HCPP" contracts), 1851 to 1859 (Medicare Advantage), 1860D (Medicare Part D), or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law 105–33), Sections 1851 to 1859 of the Social Security Act establishing Part C of the Medicare program, known as the "Medicare Advantage program."

History: *1994 c 625 art 2 s 14; 1995 c 234 art 2 s 2–6; art 3 s 5; 1997 c 225 art 2 s 37–39,62; 1998 c 254 art 1 s 15; 2001 c 215 s 26; 2004 c 268 s 7; 2005 c 17 art 1 s 14; art 3 s 2*

62Q.02 APPLICABILITY OF CHAPTER.

(a) This chapter applies only to health plans, as defined in section 62Q.01, and not to other types of insurance issued or renewed by health plan companies, unless otherwise specified.

(b) This chapter applies to a health plan company only with respect to health plans, as defined in section 62Q.01, issued or renewed by the health plan company, unless otherwise specified.

(c) If a health plan company issues or renews health plans in other states, this chapter applies only to health plans issued or renewed in this state for Minnesota residents, or to cover a resident of the state, unless otherwise specified.

History: *1995 c 234 art 2 s 7*

62Q.021 FEDERAL ACT; COMPLIANCE REQUIRED.

Each health plan company shall comply with the federal Health Insurance Portability and Accountability Act of 1996, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this section.

History: *1997 c 175 art 4 s 2*

62Q.025 PRODUCT APPROVALS.

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

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

History: *2004 c 268 s 8*

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

Subdivision 1. **Purpose.** The purpose of risk adjustment is to reduce the effects of risk selection on health insurance premiums by making monetary transfers from health plan companies that insure lower risk populations to health plan companies that insure higher risk populations. Risk adjustment is needed to: achieve a more equitable, efficient system of health care financing; remove current disincentives in the health care system to insure and provide adequate access for 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 risk status of those in a given insurance pool; and help maintain the viability of health plan companies, by protecting them from the financial effects of enrolling a disproportionate number of high risk individuals. It is the commitment of the state to develop and implement a risk adjustment system. The risk adjustment system shall:

(1) possess a reasonable level of accuracy and administrative feasibility, be adaptable to changes as methods improve, incorporate safeguards against fraud and manipulation, and shall neither reward inefficiency nor penalize for verifiable improvements in health status;

(2) require participation by all health plan companies providing coverage in the individual, small group, and Medicare supplement markets;

(3) address unequal distribution of risk between health plan companies, but shall not address the financing of public programs or subsidies for low–income people; and

(4) be developed and implemented by the Risk Adjustment Association with joint oversight by the commissioners of health and commerce.

Subd. 2. [Repealed, 1995 c 234 art 2 s 36]

Subd. 3. [Repealed, 1995 c 234 art 2 s 36]

Subd. 4. [Repealed, 1995 c 234 art 2 s 36]

Subd. 5. [Repealed, 1995 c 234 art 2 s 36]

Subd. 5a. **Public programs.** (a) A separate risk adjustment system must be developed for state–run public programs, including medical assistance, general assistance medical

care, and MinnesotaCare. The system must be developed in accordance with the general risk adjustment methodologies described in this section, must include factors in addition to age and sex adjustment, and may include additional demographic factors, different targeted conditions, and/or different payment amounts for conditions. The risk adjustment system for public programs must attempt to reflect the special needs related to poverty, cultural, or language barriers and other needs of the public program population.

(b) The commissioner of human services shall phase in risk adjustment according to the following schedule:

(1) for the first contract year, no more than ten percent of reimbursements shall be risk adjusted; and

(2) for the second contract year, no more than 30 percent of reimbursements shall be risk adjusted.

Subd. 5b. **Medicare supplement market.** A risk adjustment system may be developed for the Medicare supplement market. The Medicare supplement risk adjustment system may include a demographic component and may, but is not required to, include a condition–specific risk adjustment component.

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, but is authorized to incorporate under chapter 317A.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association may operate under the approved plan of operation and shall be governed in accordance with this chapter and may operate in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation meets the requirements of filing articles of incorporation.

The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 14, 60A, and 62A. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. The board of directors and health carriers who are members of the association are exempt from sections 325D.49 to 325D.66 in the performance of their duties as directors and members of the association. The Risk Adjustment Association is subject to the Open Meeting Law.

Subd. 7. **Purpose of association.** The association is established to develop and implement a private sector risk adjustment system.

Subject to state oversight set forth in subdivision 10, the association shall:

(1) develop and implement comprehensive risk adjustment systems for individual, small group, and Medicare supplement markets consistent with the provisions of this chapter;

(2) submit a plan for the development of the risk adjustment system which identifies appropriate implementation dates consistent with the rating and underwriting restrictions of each market, recommends whether transfers attributable to risk adjustment should be required between the individual and small group markets, and makes other appropriate recommendations to the commissioners of health and commerce by November 5, 1995;

(3) develop a combination of a demographic risk adjustment system and payments for targeted conditions;

(4) test an ambulatory care groups (ACGs) and diagnostic cost groups (DCGs) system, and recommend whether such a methodology should be adopted;

(5) fund the development and testing of the risk adjustment system;

(6) recommend market conduct guidelines; and

(7) develop a plan for assessing members for the costs of administering the risk adjustment system.

Subd. 8. **Governance.** The association shall be governed according to the plan of operation as established in subdivision 8a.

Subd. 8a. **Plan of operation.** The board shall submit a proposed plan of operation by August 15, 1995, to the commissioners of health and commerce for review. The commissioners of health and commerce shall have the authority to approve or reject the plan of operation.

Amendments to the plan of operation may be made by the commissioners or by the directors of the association, subject to the approval of the commissioners.

Subd. 9. **Data collection and data privacy.** The association members shall not have access to unaggregated data on individuals or health plan companies. The association shall develop, as a part of the plan of operation, procedures for ensuring that data is collected by an appropriate entity. The commissioners of health and commerce shall have the authority to audit and examine data collected by the association for the purposes of the development and implementation of the risk adjustment system. Data on individuals obtained for the purposes of risk adjustment development, testing, and operation are designated as private data. Data not on individuals which is obtained for the purposes of development, testing, and operation of risk adjustment are designated as nonpublic data, except that the proposed and approved plan of operation, the risk adjustment methodologies examined, the plan for testing, the plan of the risk adjustment system, minutes of meetings, and other general operating information are classified as public data. Nothing in this section is intended to prohibit the preparation of summary data under section 13.05, subdivision 7. The association, state agencies, and any contractors having access to this data shall maintain it in accordance with this classification. The commissioners of health and human services have the authority to collect data from health plan companies as needed for the purpose of developing a risk adjustment mechanism for public programs.

Subd. 10. **State oversight of risk adjustment activities.** The association's activities shall be supervised by the commissioners of health and commerce. The commissioners shall provide specific oversight functions during the development and implementation phases of the risk adjustment system as follows:

(1) the commissioners shall approve or reject the association's plan for testing risk adjustment methods, the methods to be used, and any changes to those methods;

(2) the commissioners must have the right to attend and participate in all meetings of the association and its work groups or committees, except for meetings involving privileged communication between the association and its counsel as permitted under section 13D.05, subdivision 3, paragraph (b);

(3) the commissioners shall approve any consultants or administrators used by the association;

(4) the commissioners shall approve or reject the association's plan of operation; and

(5) the commissioners shall approve or reject the plan for the risk adjustment system described in subdivision 7, clause (2).

If the commissioners reject any of the plans identified in clauses (1), (4), and (5), the directors shall submit for review an appropriate revised plan within 30 days.

Subd. 11. [Repealed, 1995 c 234 art 2 s 36]

Subd. 12. **Participation by all health plan companies.** Upon its implementation, all health plan companies, as a condition of licensure, must participate in the risk adjustment system to be implemented under this section.

History: *1994 c 625 art 2 s 15; 1995 c 234 art 2 s 8–17; 1996 c 440 art 1 s 33; 1996 c 451 art 4 s 2; 1997 c 192 s 18; 1997 c 225 art 2 s 40; 1998 c 254 art 1 s 16; 1999 c 245 art 2 s 12; 2001 c 161 s 15*

62Q.07 [Repealed, 2001 c 170 s 11]

62Q.075 LOCAL PUBLIC ACCOUNTABILITY AND COLLABORATION PLAN.

Subdivision 1. [Repealed by amendment, 2001 c 171 s 1]

Subd. 2. **Requirement.** Beginning October 31, 2004, all health maintenance organizations shall file a plan every four years with the commissioner of health describing the actions the health maintenance organization intends to take to contribute to achieving one or more high priority public health goals. This plan must be jointly developed in collaboration with the local public health units, and other community organizations providing health services within the same service area as the health maintenance organization. Local government units with responsibilities and authority defined under chapter 145A may designate individuals to participate in the collaborative planning with the health maintenance organization to provide expertise and represent community needs and goals as identified under chapter 145A. Every other year, beginning October 31, 2002, all health maintenance organizations shall file reports updating progress on the four–year collaboration plan.

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

(1) specific measurement strategies and a description of any activities which contribute to one or more high priority public health goals;

(2) description of the process by which the health maintenance organization will coordinate its activities with the community health boards, and other relevant community organizations servicing the same area;

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

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

Subd. 4. **Review.** Upon receipt of the plan, the commissioner of health shall provide a copy to the local community health boards, and other relevant community organizations within the health maintenance organization's service area. After reviewing the plan, these community groups may submit written comments on the plan to the commissioner of health and may advise the commissioner of the health maintenance organization's effectiveness in assisting to achieve high priority 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 health maintenance organization's service area to determine whether the plan is consistent with the goals and objectives of the plans required under chapter 145A 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 health maintenance organization. The county board, or applicable city council, may submit written comments to the commissioner of health, and may advise the commissioner of the health maintenance organization's effectiveness in assisting to meet the needs and goals as defined under the responsibilities of chapter 145A. Copies of these written comments must be provided to the health maintenance 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; 1995 c 234 art 8 s 17; 1996 c 451 art 4 s 3; 1997 c 225 art 2 s 62; 1999 c 245 art 2 s 13; 2001 c 171 s 1; 2005 c 98 art 3 s 24*

62Q.09 [Expired]

62Q.095 [Repealed, 2005 c 77 s 8]

62Q.096 CREDENTIALING OF PROVIDERS.

If a health plan company has initially credentialed, as providers in its provider network, individual providers employed by or under contract with an entity that:

(1) is authorized to bill under section 256B.0625, subdivision 5;

(2) meets the requirements of Minnesota Rules, parts 9520.0750 to 9520.0870;

(3) is designated an essential community provider under section 62Q.19; and

(4) is under contract with the health plan company to provide mental health services, the health plan company must continue to credential at least the same number of providers from that entity, as long as those providers meet the health plan company's credentialing standards.

A health plan company shall not refuse to credential these providers on the grounds that their provider network has a sufficient number of providers of that type.

History: *1998 c 407 art 8 s 4*

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.105 [Repealed, 1999 c 239 s 43]

62Q.1055 CHEMICAL DEPENDENCY.

All health plan companies shall use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660, when assessing and placing enrollees for chemical dependency treatment.

History: *1995 c 234 art 2 s 22*

62Q.106 DISPUTE RESOLUTION BY COMMISSIONER.

A complainant may at any time submit a complaint to the appropriate commissioner to investigate. After investigating a complaint, or reviewing a company's decision, the appropriate commissioner may order a remedy as authorized under chapter 45, 60A, or 62D.

History: *1995 c 234 art 2 s 23; 1997 c 225 art 2 s 41; 1999 c 239 s 32*

62Q.107 PROHIBITED PROVISION; JUDICIAL REVIEW.

Beginning January 1, 1999, no health plan, including the coverages described in section 62A.011, subdivision 3, clauses (7) and (10), may specify a standard of review upon which a court may review denial of a claim or of any other decision made by a health plan company with respect to an enrollee. This section prohibits limiting court review to a determination of whether the health plan company's decision is arbitrary and capricious, an abuse of discretion, or any other standard less favorable to the enrollee than a preponderance of the evidence.

History: *1998 c 407 art 2 s 21*

62Q.11 [Repealed, 1999 c 239 s 43]

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.121 LICENSURE OF MEDICAL DIRECTORS.

(a) No health plan company may employ a person as a medical director unless the person is licensed as a physician in this state. This section does not apply to a health plan compa-

ny that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.

(b) For purposes of this section, "medical director" means a physician employed by a health plan company who has direct decision–making authority, based upon medical training and knowledge, regarding the health plan company's medical protocols, medical policies, or coverage of treatment of a particular enrollee, regardless of the physician's title.

(c) This section applies only to medical directors who make recommendations or decisions that involve or affect enrollees who live in this state.

(d) Each health plan company that is subject to this section shall provide the commissioner with the names and licensure information of its medical directors and shall provide updates no later than 30 days after any changes.

History: *1Sp2001 c 9 art 16 s 6; 2002 c 379 art 1 s 113*

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.137 CHEMICAL DEPENDENCY TREATMENT; COVERAGE.

(a) Any health plan that provides coverage for chemical dependency treatment must cover chemical dependency treatment provided to an enrollee by the Department of Corrections while the enrollee is committed to the custody of the commissioner of corrections following a conviction for a first–degree driving while impaired offense under section 169A.24 if: (1) a court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and (2) the Department of Corrections makes a determination based on a chemical assessment conducted while the individual is in the custody of the department that treatment is appropriate. Treatment provided by the Department of Corrections that meets the requirements of this section shall not be subject to a separate medical necessity determination under the health plan company's utilization review procedures.

(b) The health plan company must be given a copy of the court's preliminary determination and supporting documents and the assessment conducted by the Department of Corrections.

(c) Payment rates for treatment provided by the Department of Corrections shall not exceed the lowest rate for outpatient chemical dependency treatment paid by the health plan company to a participating provider of the health plan company.

(d) For purposes of this section, chemical dependency treatment means all covered services that are intended to treat chemical dependency and that are covered by the enrollee's health plan or by law.

History: *1Sp2001 c 9 art 19 s 1; 2002 c 379 art 1 s 113*

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.145 ABORTION AND SCOPE OF PRACTICE.

Health plan company policies related to scope of practice for allied independent health providers as defined in section 62Q.095, subdivision 5, midlevel practitioners as defined in section 144.1501, subdivision 1, and other nonphysician health care professionals must comply with the requirements governing the performance of abortions in section 145.412, subdivision 1.

History: *1995 c 234 art 2 s 25; 1997 c 183 art 2 s 20; 1Sp2003 c 14 art 7 s 88*

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.

Subdivision 1. **Definition.** It is the commitment of the state to achieve universal health coverage for all Minnesotans. Universal coverage is achieved when:

(1) every Minnesotan has access to a full range of quality health care services;

(2) every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care; and

(3) every Minnesotan pays into the health care system according to that person's ability.

Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward reducing the number of Minnesotans who do not have health coverage so that by January 1, 2000, fewer than four percent of the state's population will be without health coverage. The goal will be achieved by improving access to private health coverage through insurance reforms and market reforms, by making health coverage more affordable for low-income Minnesotans through purchasing pools and state subsidies, and by reducing the cost of health coverage through cost containment programs and methods of ensuring that all Minnesotans are paying into the system according to their ability.

Subd. 3. [Repealed, 1997 c 225 art 2 s 63]

History: *1994 c 625 art 6 s 1; 1995 c 234 art 4 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 other common factor as approved by the commissioner of commerce. The membership criteria must not be designed to include disproportionately employers, groups, or individuals likely to have low costs of health coverage, or to exclude disproportionately employers, groups, or individuals likely to have high costs of health coverage.

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 on July 1 thereafter, each pool shall file a report with the information clearinghouse and the commissioner of commerce. 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 co–payments 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.

Subd. 9. **Enforcement.** Purchasing pools must register prior to offering coverage, and annually on July 1 thereafter, with the commissioner of commerce on a form prescribed by the commissioner. The commissioner of commerce shall enforce this section and all other state laws with respect to purchasing pools, and has for that purpose all general rulemaking and enforcement powers otherwise available to the commissioner of commerce. The commissioner may charge an annual registration fee sufficient to meet the costs of the commissioner's duties under this section.

History: *1994 c 625 art 6 s 2; 1995 c 234 art 7 s 24–26*

62Q.18 PORTABILITY OF COVERAGE.

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

(1) "continuous coverage" has the meaning given in section 62L.02, subdivision 9;

(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, in-

cluding 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) "large employer" means an entity that would be a small employer, as defined in section 62L.02, subdivision 26, except that the entity has more than 50 current employees, based upon the method provided in that subdivision for determining the number of current employees;

(4) "preexisting condition" has the meaning given in section 62L.02, subdivision 23; and

(5) "qualifying coverage" has the meaning given in section 62L.02, subdivision 24.

Subd. 2. [Repealed, 1995 c 234 art 4 s 4]

Subd. 3. [Repealed, 1995 c 234 art 4 s 4]

Subd. 4. [Repealed, 1995 c 234 art 4 s 4]

Subd. 5. [Repealed, 1995 c 234 art 4 s 4]

Subd. 6. [Repealed, 1995 c 234 art 4 s 4]

Subd. 7. **Portability of coverage.** 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 and who qualify under the group's eligibility requirements:

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

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

(3) with respect to a group health plan offered, sold, issued, or renewed to a large employer, impose preexisting condition limitations or preexisting condition exclusions except to the extent that would be permitted under chapter 62L if the group sponsor were a small employer as defined in section 62L.02, subdivision 26.

To the extent that this subdivision conflicts with chapter 62L, chapter 62L governs, regardless of whether the group sponsor is a small employer as defined in section 62L.02, except that for group health plans issued to groups that are not small employers, this subdivision's requirement that the individual have maintained continuous coverage applies. An individual who has maintained continuous coverage, but would be considered a late entrant under chapter 62L, may be treated as a late entrant in the same manner under this subdivision as permitted under chapter 62L.

Subd. 8. [Repealed, 1995 c 234 art 4 s 4]

Subd. 9. [Repealed, 1995 c 234 art 4 s 4]

History: *1994 c 625 art 6 s 3; art 8 s 72; 1995 c 96 s 2; 1995 c 234 art 4 s 2; 1997 c 175 art 3 s 1,2; 1997 c 225 art 2 s 63*

62Q.181 WRITTEN CERTIFICATION OF COVERAGE.

A health plan company shall provide the written certifications of coverage required under United States Code, title 42, sections 300gg(e) and 300gg–43. This section applies only to coverage that is subject to regulation under state law and only to the extent that the certification of coverage is required under federal law. The commissioner shall enforce this section.

History: *1997 c 175 art 4 s 3*

62Q.185 GUARANTEED RENEWABILITY; LARGE EMPLOYER GROUP.

(a) No health plan company, as defined in section 62Q.01, subdivision 4, shall refuse to renew a health benefit plan, as defined in section 62L.02, subdivision 15, but issued to a large employer, as defined in section 62Q.18, subdivision 1.

(b) This section does not require renewal if:

(1) the large employer has failed to pay premiums or contributions as required under the terms of the health benefit plan, or the health plan company has not received timely premium payments unless the late payments were received within a grace period provided under state law;

(2) the large employer has performed an act or practice that constitutes fraud or misrepresentation of material fact under the terms of the health benefit plan;

(3) the large employer has failed to comply with a material plan provision relating to employer contribution or group participation rules not prohibited by state law;

(4) the health plan company is ceasing to offer coverage in the large employer market in this state in compliance with United States Code, title 42, section 300gg–12(c), and applicable state law;

(5) in the case of a health maintenance organization, there is no longer any enrollee in the large employer's health benefit plan who lives, resides, or works in the approved service area; or

(6) in the case of a health benefit plan made available to large employers only through one or more bona fide associations, the membership of the large employer in the association ceases, but only if such coverage is terminated uniformly without regard to any health–related factor relating to any covered individual.

(c) This section does not prohibit a health plan company from modifying the premium rate or from modifying the coverage for purposes of renewal.

(d) This section does not require renewal of the coverage of individual enrollees under the health benefit plan if the individual enrollee has performed an act or practice that constitutes fraud or misrepresentation of material fact under the terms of the health benefit plan.

History: *1997 c 175 art 3 s 3; 1999 c 177 s 57*

62Q.19 ESSENTIAL COMMUNITY PROVIDERS.

Subdivision 1. **Designation.** (a) 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, 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;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal government, an Indian health service unit, or a community health board as defined in chapter 145A;

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions; or

(5) a sole community hospital. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services. For purposes of this section, "sole community hospital" means a rural hospital that:

(i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less

than 5,000 and located more than 25 miles from a like hospital currently providing acute short–term services;

(ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and

(iii) consists of 40 or fewer licensed beds.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30–day period has expired.

(c) 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.

(d) 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.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner. Except as provided in paragraph (d), applications must be accepted within two years after the effective date of the rules adopted by the commissioner to implement this section.

(b) Each application submitted must be accompanied by an application fee in an amount determined by the commissioner. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

(d) The commissioner shall accept an application for designation as an essential community provider until June 30, 2004, from one applicant that is a nonprofit community services agency certified as a medical assistance provider that provides mental health, behavioral health, chemical dependency, employment, and health wellness services to the underserved Spanish–speaking Latino families and individuals with locations in Minneapolis and St. Paul.

Subd. 2a. **Definition of health plan company.** For purposes of this section, "health plan company" does not include a health plan company as defined in section 62Q.01 with fewer than 50,000 enrollees, all of whose enrollees are covered under medical assistance, general assistance medical care, or MinnesotaCare.

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 services designated to be provided by 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 for these services. 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 in which the essential community provider is located.

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 com-

munity provider. This rate must be at least the same rate per unit of service as is paid to other health plan providers for the same or similar services.

Subd. 5a. **Cooperation.** Each health plan company and essential community provider shall cooperate to facilitate the use of the essential community provider by the high risk and special needs populations. This includes cooperation on the submission and processing of claims, sharing of all pertinent records and data, including performance indicators and specific outcomes data, and the use of all dispute resolution methods.

Subd. 5b. **Enforcement.** For any violation of this section or any rule applicable to an essential community provider, the commissioner may suspend, modify, or revoke an essential community provider designation. The commissioner may also use the enforcement authority specified in section 62D.17.

Subd. 6. **Termination or renewal of designation; commissioner review.** The designation as an essential community provider shall be valid for a five–year period from the date of designation. Five years after the designation of essential community provider is granted to a provider, the commissioner shall review the need for and appropriateness of continuing the designation for that provider. The commissioner may require a provider whose designation is to be reviewed to submit an application to the commissioner for renewal of the designation and may require an application fee to be submitted with the application to cover the administrative costs of processing the application. Based on that review, the commissioner may renew a provider's essential community provider designation for an additional five–year period or terminate the designation. Once the designation terminates, the former essential community provider has no rights or privileges beyond those of any other health care provider.

Subd. 7. **Rulemaking.** 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. The rules shall require health plan companies to comply with all provisions of section 62Q.14 with respect to enrollee use of essential community providers.

History: *1994 c 625 art 4 s 6; 1995 c 234 art 2 s 26; 1996 c 451 art 2 s 1,2; 1997 c 225 art 2 s 42; 1999 c 239 s 33; 2000 c 340 s 1,2; 2001 c 170 s 3; 2003 c 100 s 1; 1Sp2003 c 14 art 7 s 22,23; 2004 c 279 art 9 s 1; 2006 c 212 art 3 s 4*

62Q.21 [Repealed, 1995 c 234 art 2 s 36]

62Q.22 HEALTH CARE SERVICES PREPAID OPTION.

Subdivision 1. **Scope.** A community health clinic that is designated as an essential community provider under section 62Q.19 and is associated with a hospital, a governmental unit, or the University of Minnesota may offer to individuals and families the option of purchasing basic health care services on a fixed prepaid basis without satisfying the requirements of chapter 60A, 62A, 62C, or 62D, or any other law or rule that applies to entities licensed under those chapters.

Subd. 2. **Registration.** A community health clinic that offers a prepaid option under this section must register on an annual basis with the commissioner of health.

Subd. 3. **Premiums.** The premiums for a prepaid option offered under this section must be based on a sliding fee schedule based on current poverty income guidelines.

Subd. 4. **Health care services.** (a) A prepaid option offered under this section must provide basic health care services including:

(1) services for the diagnosis and treatment of injuries, illnesses, or conditions;

(2) child health supervision services up to age 18, as defined under section 62A.047; and

(3) preventive health services, including:

(i) health education;

(ii) health supervision, evaluation, and follow–up;

(iii) immunization; and

(iv) early disease detection.

(b) Inpatient hospital services shall not be offered as a part of a community health clinic's prepaid option. A clinic may associate with a hospital to provide hospital services to an individual or family who is enrolled in the prepaid option so long as these services are not offered as part of the prepaid option.

(c) All health care services included by the community health clinic in a prepaid option must be services that are offered within the scope of practice of the clinic by the clinic's professional staff.

Subd. 5. **Guaranteed renewability.** A community health clinic shall not refuse to renew a prepaid option, except for nonpayment of premiums, fraud, or misrepresentation, or as permitted under subdivisions 8 and 9, paragraph (b).

Subd. 6. **Information to be provided.** (a) A community health clinic must provide an individual or family who purchases a prepaid option a clear and concise written statement that includes the following information:

(1) the health care services that the prepaid option covers;

(2) any exclusions or limitations on the health care services offered, including any preexisting condition limitations, cost–sharing arrangements, or prior authorization requirements;

(3) where the health care services may be obtained;

(4) a description of the clinic's method for resolving patient complaints, including a description of how a patient can file a complaint with the Department of Health; and

(5) a description of the conditions under which the prepaid option may be canceled or terminated.

(b) The commissioner of health must approve a copy of the written statement before the community health clinic may offer the prepaid option described in this section.

Subd. 7. **Complaint process.** (a) A community health clinic that offers a prepaid option under this section must establish a complaint resolution process. As an alternative to establishing its own process, a community health clinic may use the complaint process of another organization.

(b) A community health clinic must make reasonable efforts to resolve complaints and to inform complainants in writing of the clinic's decision within 60 days of receiving the complaint.

(c) A community health clinic that offers a prepaid option under this section must report all complaints that are not resolved within 60 days to the commissioner of health.

Subd. 8. **Public assistance program eligibility.** A community health clinic may require an individual or family enrolled in the clinic's prepaid option to apply for medical assistance, general assistance medical care, or the MinnesotaCare program. The clinic must assist the individual or family in filing the application for the appropriate public program. If, upon the request of the clinic, an individual or family refuses to apply for these programs, the clinic may disenroll the individual or family from the prepaid option at any time.

Subd. 9. **Limitations on enrollment.** (a) A community health clinic may limit enrollment in its prepaid option. If enrollment is limited, a waiting list must be established.

(b) A community health clinic may deny enrollment in its prepaid option to an individual or family whose gross family income is greater than 275 percent of the federal poverty guidelines.

(c) No community health clinic may restrict or deny enrollment in its prepaid option because of an individual's or a family's financial limitations, except as permitted under this subdivision.

History: *1997 c 194 s 1*

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, disabled 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; 2005 c 56 s 1*

62Q.25 [Repealed, 1997 c 225 art 2 s 63]

62Q.251 [Repealed, 2006 c 255 s 77]

62Q.27 [Repealed, 1995 c 234 art 2 s 36]

62Q.29 [Repealed, 1997 c 225 art 2 s 63]

62Q.30 [Repealed, 1999 c 239 s 43]

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. The commissioner of health shall make recommendations for funding these functions including the amount of funding needed and a plan for distribution. The commissioner shall submit these recommendations to the Legislative Commission on Health Care Access by January 15, 1996.

History: *1994 c 625 art 7 s 2; 1995 c 234 art 8 s 18*

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, area Indian health services, health care providers, and citizens concerned about public health, shall coordinate the process for defining implementation 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 through the health plan companies 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. Funding recommendations must be broad–based and must consider all financial resources.

Subd. 5. **Timeline.** (a) MS 2000 [Obsolete]

(b) By January 15, 1997, and by January 15 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; 1995 c 234 art 8 s 19,20; 1997 c 225 art 2 s 43*

62Q.37 AUDITS CONDUCTED BY INDEPENDENT ORGANIZATION.

Subdivision 1. **Applicability.** This section applies only to (i) a nonprofit health service plan corporation operating under chapter 62C; (ii) a health maintenance organization operating under chapter 62D; (iii) a community integrated service network operating under chapter 62N; and (iv) managed care organizations operating under chapter 256B, 256D, or 256L.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of health for purposes of regulating health maintenance organizations and community integrated service networks, the commissioner of commerce for purposes of regulating nonprofit health service plan corporations, or the commissioner of human services for the purpose of contracting with managed care organizations serving persons enrolled in programs under chapter 256B, 256D, or 256L.

(b) "Health plan company" means (i) a nonprofit health service plan corporation operating under chapter 62C; (ii) a health maintenance organization operating under chapter 62D; (iii) a community integrated service network operating under chapter 62N; or (iv) a managed care organization operating under chapter 256B, 256D, or 256L.

(c) "Nationally recognized independent organization" means (i) an organization that sets specific national standards governing health care quality assurance processes, utilization review, provider credentialing, marketing, and other topics covered by this chapter and other chapters and audits and provides accreditation to those health plan companies that meet those standards. The American Accreditation Health Care Commission (URAC), the National Committee for Quality Assurance (NCQA), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are, at a minimum, defined as nationally recognized independent organizations; and (ii) the Centers for Medicare and Medicaid Services for purposes of reviews or audits conducted of health plan companies under Part C of Title XVIII of the Social Security Act or under section 1876 of the Social Security Act.

(d) "Performance standard" means those standards relating to quality management and improvement, access and availability of service, utilization review, provider selection, provider credentialing, marketing, member rights and responsibilities, complaints, appeals, grievance systems, enrollee information and materials, enrollment and disenrollment, subcontractual relationships and delegation, confidentiality, continuity and coordination of care, assurance of adequate capacity and services, coverage and authorization of services, practice guidelines, health information systems, and financial solvency.

Subd. 3. **Audits.** (a) The commissioner may conduct routine audits and investigations as prescribed under the commissioner's respective state authorizing statutes. If a nationally recognized independent organization has conducted an audit of the health plan company using audit procedures that are comparable to or more stringent than the commissioner's audit procedures:

(1) the commissioner may accept the independent audit and require no further audit if the results of the independent audit show that the performance standard being audited meets or exceeds state standards;

(2) the commissioner may accept the independent audit and limit further auditing if the results of the independent audit show that the performance standard being audited partially meets state standards;

(3) the health plan company must demonstrate to the commissioner that the nationally recognized independent organization that conducted the audit is qualified and that the results of the audit demonstrate that the particular performance standard partially or fully meets state standards; and

(4) if the commissioner has partially or fully accepted an independent audit of the performance standard, the commissioner may use the finding of a deficiency with regard to statutes or rules by an independent audit as the basis for a targeted audit or enforcement action.

(b) If a health plan company has formally delegated activities that are required under either state law or contract to another organization that has undergone an audit by a nationally recognized independent organization, that health plan company may use the nationally recognized accrediting body's determination on its own behalf under this section.

Subd. 4. **Disclosure of national standards and reports.** The health plan company shall:

(1) request that the nationally recognized independent organization provide to the commissioner a copy of the current nationally recognized independent organization's standards upon which the acceptable accreditation status has been granted; and

(2) provide the commissioner a copy of the most current final audit report issued by the nationally recognized independent organization.

Subd. 5. **Accreditation not required.** Nothing in this section requires a health plan company to seek an acceptable accreditation status from a nationally recognized independent organization.

Subd. 6. **Continued authority.** Nothing in this section precludes the commissioner from conducting audits and investigations or requesting data as granted under the commissioner's respective state authorizing statutes.

Subd. 7. **Human services.** (a) The commissioner of human services shall implement this section in a manner that is consistent with applicable federal laws and regulations and that avoids the duplication of review activities performed by a nationally recognized independent organization.

(b) By December 31 of each year, the commissioner shall submit to the legislature a written report identifying the number of audits performed by a nationally recognized independent organization that were accepted, partially accepted, or rejected by the commissioner under this section. The commissioner shall provide the rationale for partial acceptance or rejection. If the rationale for the partial acceptance or rejection was based on the commissioner's determination that the standards used in the audit were not equivalent to state law, regulation, or contract requirement, the report must document the variances between the audit standards and the applicable state requirements.

Subd. 8. **Confidentiality.** Any documents provided to the commissioner related to the audit report that may be accepted under this section are private data on individuals pursuant to chapter 13 and may only be released as permitted under section 60A.03, subdivision 9.

History: *2004 c 288 art 6 s 8; 1Sp2005 c 4 art 8 s 4*

62Q.41 [Repealed, 1997 c 225 art 2 s 63]

62Q.43 GEOGRAPHIC ACCESS.

Subdivision 1. **Closed–panel health plan.** For purposes of this section, "closed–panel health plan" means a health plan as defined in section 62Q.01 that requires an enrollee to receive all or a majority of primary care services from a specific clinic or physician designated by the enrollee that is within the health plan company's clinic or physician network.

Subd. 2. **Access requirement.** Every closed–panel health plan must allow enrollees who are full–time students under the age of 25 years to change their designated clinic or physician at least once per month, as long as the clinic or physician is part of the health plan company's statewide clinic or physician network. A health plan company shall not charge enrollees who choose this option higher premiums or cost sharing than would otherwise apply to enrollees who do not choose this option. A health plan company may require enrollees to provide 15 days' written notice of intent to change their designated clinic or physician.

History: *1995 c 234 art 2 s 27*

62Q.45 COVERAGE FOR OUT–OF–AREA PRIMARY CARE.

Subdivision 1. **Study.** The commissioner of health shall develop methods to allow enrollees of managed care organizations to obtain primary care health services outside of the service area of their managed care organization, from health care providers who are employed by or under contract with another managed care organization. The commissioner shall make recommendations on: (1) whether this out–of–area primary care coverage should be available to students and/or other enrollees without additional premium charges or cost

sharing; (2) methods to coordinate the services provided by different managed care organizations; (3) methods to manage the quality of care provided by different managed care organizations and monitor health care outcomes; (4) methods to reimburse managed care organizations for care provided to enrollees of other managed care organizations; and (5) other issues relevant to the design and administration of out–of–area primary care coverage. The commissioner shall present recommendations to the legislature by January 15, 1996.

Subd. 2. **Definition.** For purposes of this section, "managed care organization" means:

(1) a health maintenance organization operating under chapter 62D;

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

(3) an insurance company licensed under chapter 60A, nonprofit health service plan corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

History: *1995 c 234 art 2 s 28; 1997 c 225 art 2 s 44*

62Q.47 MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for mental health or chemical dependency services, must comply with the requirements of this section.

(b) 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.

(c) 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: *1995 c 234 art 2 s 29*

62Q.471 EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED.

(a) No health plan may exclude or reduce coverage for health care for an enrollee who is otherwise covered under the health plan on the basis that the need for the health care arose out of a suicide or suicide attempt by the enrollee.

(b) For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, clauses (4), (6), and (7) through (10).

History: *1Sp2001 c 9 art 9 s 1; 2002 c 379 art 1 s 113; 2005 c 132 s 16*

62Q.49 ENROLLEE COST SHARING; NEGOTIATED PROVIDER PAYMENTS.

Subdivision 1. **Applicability.** This section applies to all health plans, as defined in section 62Q.01, subdivision 3, that provide coverage for health care to be provided entirely or partially:

(1) through contracts in which health care providers agree to accept discounted charges, negotiated charges, or other limits on health care provider charges;

(2) by employees of, or facilities or entities owned by, the issuer of the health plan; or

(3) through contracts with health care providers that provide for payment to the providers on a fully or partially capitated basis or on any other non–fee–for–service basis.

Subd. 2. **Disclosure required.** (a) All health plans included in subdivision 1 must clearly specify how the cost of health care used to calculate any co–payments, coinsurance, or lifetime benefits will be affected by the arrangements described in subdivision 1.

(b) Any summary or other marketing material used in connection with marketing of a health plan that is subject to this section must prominently disclose and clearly explain the provisions required under paragraph (a), if the summary or other marketing material refers to co–payments, coinsurance, or maximum lifetime benefits.

(c) A health plan that is subject to paragraph (a) must not be used in this state if the commissioner of commerce or health, as appropriate, has determined that it does not comply with this section.

History: *1996 c 446 art 1 s 50*

62Q.50 PROSTATE CANCER SCREENING.

A health plan must cover prostate cancer screening for men 40 years of age or over who are symptomatic or in a high–risk category and for all men 50 years of age or older.

The screening must consist at a minimum of a prostate–specific antigen blood test and a digital rectal examination.

This coverage is subject to any deductible, coinsurance, co–payment, or other limitation on coverage applicable to other coverages under the plan.

For purposes of this section, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clauses (7) and (10).

History: *1996 c 446 art 1 s 51,72,73; 1998 c 339 s 12*

62Q.51 POINT–OF–SERVICE OPTION.

Subdivision 1. **Definition.** For purposes for this section, "point–of–service option" means a health plan under which the health plan company will reimburse an appropriately licensed or registered provider for providing covered services to an enrollee, without regard to whether the provider belongs to a particular network and without regard to whether the enrollee was referred to the provider by another provider.

Subd. 2. **Required point–of–service option.** Each health plan company operating in the small group or large group market shall offer at least one point–of–service option in each such market in which it operates.

Subd. 3. **Rate approval.** The premium rates and cost sharing requirements for each option must be submitted to the commissioner of health or the commissioner of commerce as required by law. A health plan that includes lower enrollee cost sharing for services provided by network providers than for services provided by out–of–network providers, or lower enrollee cost sharing for services provided with prior authorization or second opinion than for services provided without prior authorization or second opinion, qualifies as a point–of–service option.

Subd. 4. **Exemption.** This section does not apply to a health plan company with fewer than 50,000 enrollees in its commercial health plan products.

History: *1996 c 446 art 1 s 52; 1999 c 181 s 6*

62Q.52 DIRECT ACCESS TO OBSTETRIC AND GYNECOLOGIC SERVICES.

(a) Health plan companies shall allow female enrollees direct access to obstetricians and gynecologists for the following services:

(1) annual preventive health examinations, which shall include a gynecologic examination, and any subsequent obstetric or gynecologic visits determined to be medically necessary by the examining obstetrician or gynecologist, based upon the findings of the examination;

(2) maternity care; and

(3) evaluation and necessary treatment for acute gynecologic conditions or emergencies.

(b) For purposes of this section, "direct access" means that a female enrollee may obtain the obstetric and gynecologic services specified in paragraph (a) from obstetricians and gynecologists in the enrollee's network without a referral from, or prior approval through, another physician, the health plan company, or its representatives.

(c) Health plan companies shall not require higher co–payments, coinsurance, deductibles, or other enrollee cost–sharing for direct access.

(d) This section applies only to services described in paragraph (a) that are covered by the enrollee's coverage, but coverage of a preventive health examination for female enrollees must not exclude coverage of a gynecologic examination.

History: *1997 c 26 s 1*

62Q.525 COVERAGE FOR OFF–LABEL DRUG USE.

Subdivision 1. **Scope of coverage.** This section applies to all health plans, including the coverages described in section 62A.011, subdivision 3, clauses (7) and (10), that are issued or renewed to a Minnesota resident.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Medical literature" means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

(c) "Off–label use of drugs" means when drugs are prescribed for treatments other than those stated in the labeling approved by the federal Food and Drug Administration.

(d) "Standard reference compendia" means:

(1) the United States Pharmacopeia Drug Information; or

(2) the American Hospital Formulary Service Drug Information.

Subd. 3. **Required coverage.** (a) Every type of coverage included in subdivision 1 that provides coverage for drugs may not exclude coverage of a drug for the treatment of cancer on the ground that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard reference compendia or in one article in the medical literature, as defined in subdivision 2.

(b) Coverage of a drug required by this subdivision includes coverage of medically necessary services directly related to and required for appropriate administration of the drug.

(c) Coverage required by this subdivision does not include coverage of a drug not listed on the formulary of the coverage included in subdivision 1.

(d) Coverage of a drug required under this subdivision must not be subject to any co–payment, coinsurance, deductible, or other enrollee cost–sharing greater than the coverage included in subdivision 1 applies to other drugs.

(e) The commissioner of commerce or health, as appropriate, may direct a person that issues coverage included in subdivision 1 to make payments required by this section.

Subd. 4. **Construction.** This section must not be construed to:

(1) alter existing law limiting the coverage of drugs that have not been approved by the federal Food and Drug Administration;

(2) require coverage for any drug when the federal Food and Drug Administration has determined its use to be contraindicated;

(3) require coverage for experimental drugs not otherwise approved for any indication by the federal Food and Drug Administration; or

(4) reduce or limit coverage for off–label use of drugs otherwise required by law or contract.

History: *1998 c 301 s 1*

62Q.527 NONFORMULARY ANTIPSYCHOTIC DRUGS; REQUIRED COVERAGE.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

(c) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a).

(d) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (7) and (10).

Subd. 2. **Required coverage for antipsychotic drugs.** (a) A health plan that provides prescription drug coverage must provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the drug is in the health plan's drug formulary, if the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the health care provider has considered all equivalent drugs in the health plan's drug formulary and has determined that the drug prescribed will best treat the patient's condition.

(b) The health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

(c) For drugs covered under this section, no health plan company that has received a certification from the health care provider as described in paragraph (a), may:

(1) impose a special deductible, co–payment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or

(2) require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.

Subd. 3. **Continuing care.** (a) Enrollees receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, co–payment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit:

(1) the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan;

(2) the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(3) the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(b) The continuing care benefit shall be extended annually when the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(c) The health plan company is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

Subd. 4. **Exception to formulary.** A health plan company must promptly grant an exception to the health plan's drug formulary for an enrollee when the health care provider prescribing the drug indicates to the health plan company that:

(1) the formulary drug causes an adverse reaction in the patient;

(2) the formulary drug is contraindicated for the patient; or

(3) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

History: *1Sp2001 c 9 art 9 s 2; 2002 c 379 art 1 s 113*

62Q.53 MENTAL HEALTH COVERAGE; MEDICALLY NECESSARY CARE.

Subdivision 1. **Requirement.** No health plan that covers mental health services may be offered, sold, issued, or renewed in this state that requires mental health services to satisfy a definition of "medically necessary care," "medical necessity," or similar term that is more restrictive with respect to mental health than the definition provided in subdivision 2.

Subd. 2. **Minimum definition.** "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the enrollee's health; or

(2) prevent deterioration of the enrollee's condition.

Subd. 3. **Health plan; definition.** For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages listed in section 62A.011, subdivision 3, clauses (7) and (10).

History: *1997 c 49 s 1*

62Q.535 COVERAGE FOR COURT–ORDERED MENTAL HEALTH SERVICES.

Subdivision 1. **Mental health services.** For purposes of this section, mental health services means all covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are covered by the policy, contract, or certificate of coverage of the enrollee's health plan company or by law.

Subd. 2. **Coverage required.** (a) All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The health plan company must be given a copy of the court order and the behavioral care evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and shall be financially liable for the care included in the court–ordered individual treatment plan if the care is covered by the health plan and ordered to be provided by a participating provider or another provider as required by rule or law. This court–ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.

(b) A party or interested person, including a health plan company or its designee, may make a motion for modification of the court–ordered plan of care pursuant to the applicable rules of procedure for modification of the court's order. The motion may include a request for a new behavioral care evaluation according to this section.

History: *1Sp2001 c 9 art 9 s 3; 2002 c 379 art 1 s 113*

62Q.54 REFERRALS FOR RESIDENTS OF HEALTH CARE FACILITIES.

If an enrollee is a resident of a health care facility licensed under chapter 144A or a housing with services establishment registered under chapter 144D, the enrollee's primary care physician must refer the enrollee to that facility's skilled nursing unit or that facility's appropriate care setting, provided that the health plan company and the provider can best meet the patient's needs in that setting, if the following conditions are met:

(1) the facility agrees to be reimbursed at that health plan company's contract rate negotiated with similar providers for the same services and supplies; and

(2) the facility meets all guidelines established by the health plan company related to quality of care, utilization, referral authorization, risk assumption, use of health plan company network, and other criteria applicable to providers under contract for the same services and supplies.

History: *1997 c 225 art 2 s 45*

62Q.55 EMERGENCY SERVICES.

(a) Enrollees have the right to available and accessible emergency services, 24 hours a day and seven days a week. The health plan company shall inform its enrollees how to obtain emergency care and, if prior authorization for emergency services is required, shall make available a toll-free number, which is answered 24 hours a day, to answer questions about emergency services and to receive reports and provide authorizations, where appropriate, for treatment of emergency medical conditions. Emergency services shall be covered whether provided by participating or nonparticipating providers and whether provided within or outside the health plan company's service area. In reviewing a denial for coverage of emergency services, the health plan company shall take the following factors into consideration:

(1) a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment;

(2) the time of day and day of the week the care was provided;

(3) the presenting symptoms, including, but not limited to, severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis;

(4) the enrollee's efforts to follow the health plan company's established procedures for obtaining emergency care; and

(5) any circumstances that precluded use of the health plan company's established procedures for obtaining emergency care.

(b) The health plan company may require enrollees to notify the health plan company of nonreferred emergency care as soon as possible, but not later than 48 hours, after the emergency care is initially provided. However, emergency care which would have been covered under the contract had notice been provided within the set time frame must be covered.

(c) Notwithstanding paragraphs (a) and (b), a health plan company, health insurer, or health coverage plan that is in compliance with the rules regarding accessibility of services adopted under section 62D.20 is in compliance with this section.

History: *1997 c 237 s 11*

62Q.56 CONTINUITY OF CARE.

Subdivision 1. **Change in health care provider; general notification.** (a) If enrollees are required to access services through selected primary care providers for coverage, the health plan company shall prepare a written plan that provides for continuity of care in the event of contract termination between the health plan company and any of the contracted primary care providers, specialists, or general hospital providers. The written plan must explain:

(1) how the health plan company will inform affected enrollees about termination at least 30 days before the termination is effective, if the health plan company or health care network cooperative has received at least 120 days' prior notice;

(2) how the health plan company will inform the affected enrollees about what other participating providers are available to assume care and how it will facilitate an orderly transfer of its enrollees from the terminating provider to the new provider to maintain continuity of care;

(3) the procedures by which enrollees will be transferred to other participating providers, when special medical needs, special risks, or other special circumstances, such as cultural or language barriers, require them to have a longer transition period or be transferred to nonparticipating providers;

(4) who will identify enrollees with special medical needs or at special risk and what criteria will be used for this determination; and

(5) how continuity of care will be provided for enrollees identified as having special needs or at special risk, and whether the health plan company has assigned this responsibility to its contracted primary care providers.

(b) For purposes of this section, contract termination includes nonrenewal.

Subd. 1a. **Change in health care provider; termination not for cause.** (a) If the contract termination was not for cause and the contract was terminated by the health plan company, the health plan company must provide the terminated provider and all enrollees being treated by that provider with notification of the enrollees' rights to continuity of care with the terminated provider.

(b) The health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life–threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization to receive services under this paragraph, the health plan company must grant the request unless the enrollee does not meet the criteria provided in this paragraph.

(c) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for enrollees who request continuity of care with their former provider, if the enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

Subd. 1b. **Change in health care provider; termination for cause.** If the contract termination was for cause, enrollees must be notified of the change and transferred to participating providers in a timely manner so that health care services remain available and accessible

to the affected enrollees. The health plan company is not required to refer an enrollee back to the terminating provider if the termination was for cause.

Subd. 2. **Change in health plans.** (a) If an enrollee is subject to a change in health plans, the enrollee's new health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the new health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization under this paragraph, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria provided in this paragraph.

(b) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for new enrollees who request continuity of care with their former provider, if the new enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

(c) This subdivision applies only to group coverage and continuation and conversion coverage, and applies only to changes in health plans made by the employer.

Subd. 2a. **Limitations.** (a) Subdivisions 1, 1a, 1b, and 2 apply only if the enrollee's health care provider agrees to:

(1) accept as payment in full the lesser of the health plan company's reimbursement rate for in-network providers for the same or similar service or the enrollee's health care provider's regular fee for that service;

(2) adhere to the health plan company's preauthorization requirements; and

(3) provide the health plan company with all necessary medical information related to the care provided to the enrollee.

(b) Nothing in this section requires a health plan company to provide coverage for a health care service or treatment that is not covered under the enrollee's health plan.

Subd. 2b. **Request for authorization.** The health plan company may require medical records and other supporting documentation to be submitted with the requests for authorization made under subdivision 1, 1a, 1b, or 2. If the authorization is denied, the health plan company must explain the criteria it used to make its decision on the request for authorization. If the authorization is granted, the health plan company must explain how continuity of care will be provided.

Subd. 3. **Disclosure.** Information regarding an enrollee's rights under this section must be included in member contracts or certificates of coverage and must be provided by a health plan company upon request of an enrollee or prospective enrollee.

History: *1997 c 237 s 12; 1Sp2001 c 9 art 16 s 7; 2002 c 379 art 1 s 113*

62Q.58 ACCESS TO SPECIALTY CARE.

Subdivision 1. **Standing referral.** A health plan company shall establish a procedure by which an enrollee may apply for and, if appropriate, receive a standing referral to a health care provider who is a specialist if a referral to a specialist is required for coverage. This procedure for a standing referral must specify the necessary managed care review and approval an enrollee must obtain before such a standing referral is permitted.

Subd. 1a. **Mandatory standing referral.** (a) An enrollee who requests a standing referral to a specialist qualified to treat the specific condition described in clauses (1) to (5) must be given a standing referral for visits to such a specialist if benefits for such treatment are provided under the health plan and the enrollee has any of the following conditions:

(1) a chronic health condition;

(2) a life-threatening mental or physical illness;

(3) pregnancy beyond the first trimester of pregnancy;

(4) a degenerative disease or disability; or

(5) any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist.

(b) Nothing in this section limits the application of section 62Q.52 specifying direct access to obstetricians and gynecologists.

(c) Paragraph (a) does not apply to health plans issued under sections 43A.23 to 43A.31.

Subd. 2. **Coordination of services.** An enrollee with a standing referral to a specialist may request primary care services from that specialist. The specialist, in agreement with the enrollee and primary care provider or primary care group, may elect to provide primary care services to the enrollee, authorize tests and services, and make secondary referrals according to procedures established by the health plan company. The health plan company may limit the primary care services, tests and services, and secondary referrals authorized under this subdivision to those that are related to the specific condition or conditions for which the standing referral was made.

Subd. 3. **Disclosure.** Information regarding referral procedures must be included in member contracts or certificates of coverage and must be provided to an enrollee or prospective enrollee by a health plan company upon request.

Subd. 4. **Referral.** (a) If a standing referral is authorized under subdivision 1 or is mandatory under subdivision 1a, the health plan company must provide a referral to an appropriate participating specialist who is reasonably available and accessible to provide the treatment or to a nonparticipating specialist if the health plan company does not have an appropriate participating specialist who is reasonably available and accessible to treat the enrollee's condition or disease.

(b) If an enrollee receives services from a nonparticipating specialist because a participating specialist is not available, services must be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received from a participating specialist.

History: *1997 c 237 s 13; 1Sp2001 c 9 art 16 s 8; 2002 c 379 art 1 s 113*

62Q.64 DISCLOSURE OF EXECUTIVE COMPENSATION.

(a) Each health plan company doing business in this state shall annually file with the Consumer Advisory Board created in section 62J.75:

(1) a copy of the health plan company's form 990 filed with the federal Internal Revenue Service; or

(2) if the health plan company did not file a form 990 with the federal Internal Revenue Service, a list of the amount and recipients of the health plan company's five highest salaries, including all types of compensation, in excess of $50,000.

(b) A filing under this section is public data under section 13.03.

History: *1997 c 237 s 14*

62Q.645 EFFICIENCY REPORTS AND DISTRIBUTION OF INFORMATION.

(a) The commissioner may use reports submitted by health plan companies, service cooperatives, and the public employee insurance program created in section 43A.316 to compile entity specific administrative efficiency reports; may make these reports available on state agency Web sites, including minnesotahealthinfo.com; and may include information on:

(1) number of covered lives;

(2) covered services;

(3) geographic availability;

(4) whom to contact to obtain current premium rates;

(5) administrative costs, using the definition of administrative costs developed under section 62J.38;

(6) Internet links to information on the health plan, if available; and

(7) any other information about the health plan identified by the commissioner as being useful for employers, consumers, providers, and others in evaluating health plan options.

(b) This section does not apply to a health plan company unless its annual Minnesota premiums exceed $50,000,000 based on the most recent assessment base of the Minnesota Comprehensive Health Association. For purposes of this determination, the premiums of a health plan company include those of its affiliates.

History: *2006 c 255 s 34*

62Q.65 ACCESS TO PROVIDER DISCOUNTS.

Subdivision 1. **Requirement.** A high deductible health plan must, when used in connection with a medical savings account or health savings account, provide the enrollee access to any discounted provider fees for services covered by the high deductible health plan, regardless of whether the enrollee has satisfied the deductible for the high deductible health plan.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given:

(1) "high deductible health plan" has the meaning given under the Internal Revenue Code of 1986, section 220(c)(2), with respect to a medical savings account; and the meaning given under Internal Revenue Code of 1986, section 223(c)(2), with respect to a health savings account;

(2) "medical savings account" has the meaning given under the Internal Revenue Code of 1986, section 220(d)(1);

(3) "discounted provider fees" means fees contained in a provider agreement entered into by the issuer of the high deductible health plan, or an affiliate of the issuer, for use in connection with the high deductible health plan; and

(4) "health savings account" has the meaning given under the Internal Revenue Code of 1986, section 223(d).

History: *1997 c 225 art 2 s 46; 2005 c 132 s 17*

62Q.66 DURABLE MEDICAL EQUIPMENT COVERAGE.

No health plan company that covers durable medical equipment may utilize medical coverage criteria for durable medical equipment that limits coverage solely to equipment used in the home.

History: *1998 c 334 s 1*

62Q.67 DISCLOSURE OF COVERED DURABLE MEDICAL EQUIPMENT.

Subdivision 1. **Disclosure.** A health plan company that covers durable medical equipment shall provide enrollees, and upon request prospective enrollees, written disclosure that includes the information set forth in subdivision 2. The health plan company may include the information in the member contract, certificate of coverage, schedule of payments, member handbook, or other written enrollee communication.

Subd. 2. **Information to be disclosed.** A health plan company that covers durable medical equipment shall disclose the following information:

(a) general descriptions of the coverage for durable medical equipment, level of coverage available, and criteria and procedures for any required prior authorizations; and

(b) the address and telephone number of a health plan representative whom an enrollee may contact to obtain specific information verbally, or upon request in writing, about prior authorization including criteria used in making coverage decisions and information on limitations or exclusions for durable medical equipment.

History: *1998 c 334 s 2*

62Q.675 HEARING AIDS; PERSONS 18 OR YOUNGER.

A health plan must cover hearing aids for individuals 18 years of age or younger for hearing loss due to functional congenital malformation of the ears that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co–payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed.

History: *1Sp2003 c 14 art 7 s 24*

COMPLAINT RESOLUTION

62Q.68 DEFINITIONS.

Subdivision 1. **Application.** For purposes of sections 62Q.68 to 62Q.72, the terms defined in this section have the meanings given them. For purposes of sections 62Q.69 and 62Q.70, the term "health plan company" does not include an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01 or a nonprofit health service plan corporation regulated under chapter 62C that only provides dental coverage or vision coverage. For purposes of sections 62Q.69 through 62Q.73, the term "health plan company" does not include the Comprehensive Health Association created under chapter 62E.

Subd. 2. **Complaint.** "Complaint" means any grievance against a health plan company that is not the subject of litigation and that has been submitted by a complainant to a health plan company regarding the provision of health services including, but not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the period of time the individual was an enrollee. Any grievance requiring a medical determination in its resolution must have the medical determination aspect of the complaint processed under the appeal procedure described in section 62M.06.

Subd. 3. **Complainant.** "Complainant" means an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant, or former enrollee, who submits a complaint.

History: *1999 c 239 s 34; 2002 c 330 s 28*

62Q.69 COMPLAINT RESOLUTION.

Subdivision 1. **Establishment.** Each health plan company must establish and maintain an internal complaint resolution process that meets the requirements of this section to provide for the resolution of a complaint initiated by a complainant.

Subd. 2. **Procedures for filing a complaint.** (a) A complainant may submit a complaint to a health plan company either by telephone or in writing. If a complaint is submitted orally and the resolution of the complaint, as determined by the complainant, is partially or wholly adverse to the complainant, or the oral complaint is not resolved to the satisfaction of the complainant, by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing. The health plan company must also offer to provide the complainant with any assistance needed to submit a written complaint, including an offer to complete the complaint form for a complaint that was previously submitted orally and promptly mail the completed form to the complainant for the complainant's signature. At the complainant's request, the health plan company must provide the assistance requested by the complainant. The complaint form must include the following information:

(1) the telephone number of the Office of Health Care Consumer Assistance, Advocacy, and Information, and the health plan company member services or other departments or persons equipped to advise complainants on complaint resolution;

(2) the address to which the form must be sent;

(3) a description of the health plan company's internal complaint procedure and the applicable time limits; and

(4) the toll–free telephone number of either the commissioner of health or commerce and notification that the complainant has the right to submit the complaint at any time to the appropriate commissioner for investigation.

(b) Upon receipt of a written complaint, the health plan company must notify the complainant within ten business days that the complaint was received, unless the complaint is resolved to the satisfaction of the complainant within the ten business days.

(c) Each health plan company must provide, in the member handbook, subscriber contract, or certification of coverage, a clear and concise description of how to submit a complaint and a statement that, upon request, assistance in submitting a written complaint is available from the health plan company.

Subd. 3. **Notification of complaint decisions.** (a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint. If the health plan company cannot make a decision within 30 days due to circumstances outside the control of the health plan company, the health plan company may take up to 14 additional days to notify the complainant of its decision. If the health plan company takes any additional days beyond the initial 30–day period to make its decision, it must inform the complainant, in advance, of the extension and the reasons for the extension.

(b) If the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.

(c) The notification must also inform the complainant of the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll–free telephone number of the appropriate commissioner.

History: *1999 c 239 s 35*

62Q.70 APPEAL OF THE COMPLAINT DECISION.

Subdivision 1. **Establishment.** (a) Each health plan company shall establish an internal appeal process for reviewing a health plan company's decision regarding a complaint filed in

accordance with section 62Q.69. The appeal process must meet the requirements of this section.

(b) The person or persons with authority to resolve or recommend the resolution of the internal appeal must not be solely the same person or persons who made the complaint decision under section 62Q.69.

(c) The internal appeal process must permit the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigating or presiding over the appeal.

Subd. 2. **Procedures for filing an appeal.** If a complainant notifies the health plan company of the complainant's desire to appeal the health plan company's decision regarding the complaint through the internal appeal process, the health plan company must provide the complainant the option for the appeal to occur either in writing or by hearing.

Subd. 3. **Notification of appeal decisions.** (a) If a complainant appeals in writing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 30 days of the health plan company's receipt of the complainant's written notice of appeal. If a complainant appeals by hearing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 45 days of the health plan company's receipt of the complainant's written notice of appeal.

(b) If the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the appeal decision to the external review process described in section 62Q.73 and the procedure for initiating the external process.

(c) Upon the request of the complainant, the health plan company must provide the complainant with a complete summary of the appeal decision.

History: *1999 c 239 s 36*

62Q.71 NOTICE TO ENROLLEES.

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services;

(3) how to request an appeal either through the procedures described in sections 62Q.69 and 62Q.70 or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) of the toll–free telephone number of the appropriate commissioner; and

(6) of the right to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised.

History: *1999 c 239 s 37; 2003 c 2 art 1 s 8*

62Q.72 RECORD KEEPING; REPORTING.

Subdivision 1. **Record keeping.** Each health plan company shall maintain records of all enrollee complaints and their resolutions. These records shall be retained for five years and shall be made available to the appropriate commissioner upon request. An insurance company licensed under chapter 60A may instead comply with section 72A.20, subdivision 30.

Subd. 2. **Reporting.** Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that

are not resolved within 30 days, or 30 business days as provided under section 72A.201, subdivision 4, clause (3), for insurance companies licensed under chapter 60A. The commissioner shall also make this information available to the public upon request.

History: *1999 c 239 s 38*

62Q.73 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.

Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

(1) a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant;

(2) any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination not to certify; or

(3) a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary.

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Subd. 2. **Exception.** (a) This section does not apply to governmental programs except as permitted under paragraph (b). For purposes of this subdivision, "governmental programs" means the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance medical care program, the demonstration project for people with disabilities, and the federal Medicare program.

(b) In the course of a recipient's appeal of a medical determination to the commissioner of human services under section 256.045, the recipient may request an expert medical opinion be arranged by the external review entity under contract to provide independent external reviews under this section. If such a request is made, the cost of the review shall be paid by the commissioner of human services. Any medical opinion obtained under this paragraph shall only be used by a state human services referee as evidence in the recipient's appeal to the commissioner of human services under section 256.045.

(c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights provided in section 256.045 for governmental program recipients.

Subd. 3. **Right to external review.** (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination, if applicable under section 62Q.68, subdivision 1, or 62M.06, to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. Notification of the enrollee's right to external review must accompany the denial issued by the insurer. The written request must be accompanied by a filing fee of $25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship.

(b) Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review.

(c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company.

Subd. 4. **Contract.** Pursuant to a request for proposal, the commissioner of administration, in consultation with the commissioners of health and commerce, shall contract with an organization or business entity to provide independent external reviews of all adverse determinations submitted for external review. The contract shall ensure that the fees for services rendered in connection with the reviews be reasonable.

Subd. 5. **Criteria.** (a) The request for proposal must require that the entity demonstrate:

(1) no conflicts of interest in that it is not owned, a subsidiary of, or affiliated with a health plan company or utilization review organization;

(2) an expertise in dispute resolution;

(3) an expertise in health–related law;

(4) an ability to conduct reviews using a variety of alternative dispute resolution procedures depending upon the nature of the dispute;

(5) an ability to provide data to the commissioners of health and commerce on reviews conducted; and

(6) an ability to ensure confidentiality of medical records and other enrollee information.

(b) The commissioner of administration shall take into consideration, in awarding the contract according to subdivision 4, any national accreditation standards that pertain to an external review entity.

Subd. 6. **Process.** (a) Upon receiving a request for an external review, the external review entity must provide immediate notice of the review to the enrollee and to the health plan company. Within ten business days of receiving notice of the review, the health plan company and the enrollee must provide the external review entity with any information that they wish to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. An enrollee may be assisted or represented by a person of the enrollee's choice.

(b) As part of the external review process, any aspect of an external review involving a medical determination must be performed by a health care professional with expertise in the medical issue being reviewed.

(c) An external review shall be made as soon as practical but in no case later than 40 days after receiving the request for an external review and must promptly send written notice of the decision and the reasons for it to the enrollee, the health plan company, and the commissioner who is responsible for regulating the health plan company.

Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan.

(b) For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

(c) For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.

Subd. 8. **Effects of external review.** A decision rendered under this section shall be nonbinding on the enrollee and binding on the health plan company. The health plan company may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 9. **Immunity from civil liability.** A person who participates in an external review by investigating, reviewing materials, providing technical expertise, or rendering a decision shall not be civilly liable for any action that is taken in good faith, that is within the scope of the person's duties, and that does not constitute willful or reckless misconduct.

Subd. 10. **Data reporting.** The commissioners shall make available to the public, upon request, summary data on the decisions rendered under this section, including the number of

reviews heard and decided and the final outcomes. Any data released to the public must not individually identify the enrollee initiating the request for external review.

History: *1999 c 239 s 39; 2000 c 474 s 2; 2001 c 215 s 27*

62Q.731 EXTERNAL REVIEW OF ADVERSE DETERMINATION.

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Enrollee" means an eligible person as defined in section 62E.02, subdivision 13, and who meets the eligibility criteria established in section 62E.14.

(c) "Board" means the board of directors of the Comprehensive Health Association, as described in section 62E.10, subdivision 2.

Subd. 2. **Appeal to external review entity.** If an enrollee receives an adverse determination as a result of the Comprehensive Health Association's internal appeal process, by which an established enrollee appeal committee renders an adverse determination, the enrollee then has the option of:

(1) appealing the adverse determination to the external review entity under section 62Q.73, which shall constitute a final determination subject to the conditions specified in section 62Q.73; or

(2) appealing to the commissioner of commerce from an adverse determination as provided by the operating rules of the Comprehensive Health Association, in which case the commissioner has the option of making a determination regarding the appeal, or submitting the appeal to the external review entity retained under section 62Q.73.

History: *2002 c 330 s 29*

MINNESOTA HEALTH PLAN CONTRACTING ACT

62Q.732 CITATION.

Sections 62Q.732 to 62Q.75 may be cited as the "Minnesota Health Plan Contracting Act."

History: *2004 c 246 s 2*

62Q.733 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62Q.732 to 62Q.739, the following definitions apply.

Subd. 2. **Contract.** "Contract" means a written agreement between a health care provider and a health plan company to provide health care services.

Subd. 3. **Health care provider or provider.** "Health care provider" or "provider" means a physician, chiropractor, dentist, podiatrist, or other provider as defined under section 62J.03, other than hospitals, ambulatory surgical centers, or freestanding emergency rooms.

Subd. 4. **Health plan company.** (a) "Health plan company" means:

(1) a health maintenance organization operating under chapter 62D;

(2) a community integrated service network operating under chapter 62N;

(3) a preferred provider organization as defined in section 145.61, subdivision 4c; or

(4) an insurance company licensed under chapter 60A, nonprofit health service corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other entity that establishes, operates, or maintains a health benefit plan or network of health care providers where the providers have entered into a contract with the entity to provide health care services.

(b) This subdivision does not apply to a health plan company with respect to coverage described in section 62A.011, subdivision 3, clauses (1) to (5) and (7) to (12).

Subd. 5. **Fee schedule.** "Fee schedule" means the total expected financial compensation paid to a health care provider for providing a health care service as determined by the contract between the health plan company and the provider, inclusive of withhold amounts and any amount for which the patient or other third party may be obligated to pay under the contract.

History: *2004 c 246 s 3*

62Q.734 EXEMPTION.

Sections 62Q.735 to 62Q.739, and 62Q.74 do not apply to health plan companies whose annual Minnesota health premium revenues are less than three percent of the total annual Minnesota health premium revenues, as measured by the assessment base of the Minnesota Comprehensive Health Association. For purposes of this percentage calculation, a health plan company's premiums include the Minnesota health premium revenues of its affiliates.

History: *2004 c 246 s 4*

62Q.735 PROVIDER CONTRACTING PROCEDURES.

Subdivision 1. **Contract disclosure.** (a) Before requiring a health care provider to sign a contract, a health plan company shall give to the provider a complete copy of the proposed contract, including:

(1) all attachments and exhibits;

(2) operating manuals;

(3) a general description of the health plan company's health service coding guidelines and requirement for procedures and diagnoses with modifiers, and multiple procedures; and

(4) all guidelines and treatment parameters incorporated or referenced in the contract.

(b) The health plan company shall make available to the provider the fee schedule or a method or process that allows the provider to determine the fee schedule for each health care service to be provided under the contract.

(c) Notwithstanding paragraph (b), a health plan company that is a dental plan organization, as defined in section 62Q.76, shall disclose information related to the individual contracted provider's expected reimbursement from the dental plan organization. Nothing in this section requires a dental plan organization to disclose the plan's aggregate maximum allowable fee table used to determine other providers' fees. The contracted provider must not release this information in any way that would violate any state or federal antitrust law.

Subd. 2. **Proposed amendments.** (a) Any amendment or change in the terms of an existing contract between a health plan company and a provider must be disclosed to the provider at least 45 days prior to the effective date of the proposed change, with the exception of amendments required of the health plan company by law or governmental regulatory authority, when notice shall be given to the provider when the requirement is made known to the health plan company.

(b) Any amendment or change in the contract that alters the fee schedule or materially alters the written contractual policies and procedures governing the relationship between the provider and the health plan company must be disclosed to the provider not less than 45 days before the effective date of the proposed change and the provider must have the opportunity to terminate the contract before the amendment or change is deemed to be in effect.

(c) By mutual consent, evidenced in writing in amendments separate from the base contract and not contingent on participation, the parties may waive the disclosure requirements under paragraphs (a) and (b).

(d) Notwithstanding paragraphs (a) and (b), the effective date of contract termination shall comply with the terms of the contract when a provider terminates a contract.

Subd. 3. **Hospital contract amendment disclosure.** (a) Any amendment or change in the terms of an existing contract between a network organization and a hospital, ambulatory surgical center, or freestanding emergency room must be disclosed to that provider.

(b) Any amendment or change in the contract that alters the financial reimbursement or alters the written contractual policies and procedures governing the relationship between the

hospital, ambulatory surgical center, or freestanding emergency room and the network organization must be disclosed to that provider before the amendment or change is deemed to be in effect.

(c) For purposes of this subdivision, "network organization" means a preferred provider organization, as defined in section 145.61, subdivision 4c; a managed care organization, as defined in section 62Q.01, subdivision 5; or other entity that uses or consists of a network of health care providers.

History: *2004 c 246 s 5*

62Q.736 PAYMENT RATES.

A contract between a health plan company and a provider shall comply with section 62A.64.

History: *2004 c 246 s 6*

62Q.737 SERVICE CODE CHANGES.

(a) For purposes of this section, "service code" means current procedural terminology (CPT), current dental terminology (CDT), ICD–CM, diagnosis–related groups (DRGs), or other coding system.

(b) The health plan company shall determine the manner in which it adjudicates claims. The provider may request a description of the general coding guidelines applicable to the health care services the provider is reasonably expected to render pursuant to the contract. The health plan company or its designee shall provide the coding guidelines not later than 30 days after the date the health plan receives the request. The health plan company shall provide notice of material changes to the coding guidelines not later than 45 days prior to the date the changes take effect and shall not make retroactive revision to the coding guidelines, but may issue new guidelines. A provider who receives information under this section may use or disclose the information only for the purpose of practice management, billing activities, or other business operations and may not disclose the information to third parties without the consent of the health plan company.

(c) The health plan company may correct an error in a submitted claim that prevents the claim from being processed, provided that the health plan company:

(1) notifies the provider of the change and reason for the change according to federal Health Insurance Portability and Accountability Act (HIPAA) transaction standards; and

(2) offers the provider the opportunity to appeal any changes.

(d) Nothing in this section shall be interpreted to require a health plan company to violate copyright or other law by disclosing proprietary licensed software. In addition to the above, the health plan company shall, upon request of a contracted provider, disclose the name, edition, and model version of the software that the health plan company uses to determine bundling and unbundling of claims.

(e) This section does not apply to government programs, including state public programs, Medicare, and Medicare–related coverage.

History: *2004 c 246 s 7*

62Q.739 UNILATERAL TERMS PROHIBITED.

(a) A contract between a health plan company and a health care provider shall not contain or require unilateral terms regarding indemnification or arbitration. Notwithstanding any prohibitions in this section, a contract between a health plan company and a health care provider may be unilaterally terminated by either party in accordance with the terms of the contract.

(b) A health plan company may not terminate or fail to renew a health care provider's contract without cause unless the company has given the provider a written notice of the termination or nonrenewal 120 days before the effective date.

History: *2004 c 246 s 8*

62Q.74 NETWORK SHADOW CONTRACTING.

Subdivision 1. **Definitions.** (a) For purposes of this section, "category of coverage" means one of the following types of health–related coverage:

(1) health;

(2) no–fault automobile medical benefits; or

(3) workers' compensation medical benefits.

(b) "Health care provider" or "provider" means a physician, chiropractor, dentist, podiatrist, hospital, ambulatory surgical center, freestanding emergency room, or other provider, as defined in section 62J.03.

Subd. 2. **Provider consent required.** (a) No health plan company shall require a health care provider to participate in a network under a category of coverage that differs from the category or categories of coverage to which the existing contract between the health plan company and the provider applies, without the affirmative consent of the provider obtained under subdivision 3.

(b) No health plan company shall require, as a condition of participation in any health plan, product, or other arrangement, the provider to participate in a new or different health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology without the affirmative consent of the provider obtained under subdivision 3. This paragraph does not apply to participation in health plan products or other arrangements that provide health care services to government programs, including state public programs, Medicare, and Medicare–related coverage.

(c) Compliance with this section may not be waived in a contract or otherwise.

Subd. 3. **Consent procedure.** (a) The health plan company, if it wishes to apply an existing contract with a provider to a different category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology, shall first notify the provider in writing. The written notice must include at least the following:

(1) the health plan company's name, address, and telephone number, and the name of the specific network, if it differs from that of the health plan company;

(2) a description of the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage;

(3) the names of all payers expected by the health plan company to use the network for the new category of coverage or health plan, product, or other arrangement within a category of coverage;

(4) the approximate number of current enrollees of the health plan company in that category of coverage or health plan, product, or other arrangement within a category of coverage within the provider's geographical area;

(5) a disclosure of all contract terms of the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage, including the discount or reduced fees, care guidelines, utilization review criteria, prior notification process, prior authorization process, and dispute resolution process;

(6) a form for the provider's convenience in accepting or declining participation in the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage, provided that the provider need not use that form in responding; and

(7) a statement informing the provider of the provisions of paragraph (b).

(b) Unless the provider has affirmatively agreed to participate within 60 days after the postmark date of the notice, the provider is deemed to have not accepted the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology.

Subd. 4. **Contract termination restricted.** A health plan company must not terminate an existing contract with a provider, or fail to honor the contract in good faith, based solely on the provider's decision not to accept a proposed new category of coverage or health plan,

product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology. The most recent agreed–upon contractual obligations remain in force until the existing contract's renewal or termination date.

Subd. 5. **Remedy.** If a health plan company violates this section by reimbursing a provider as if the provider had agreed under this section to participate in the network under a category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology to which the provider has not agreed, the provider has a cause of action against the health plan company to recover two times the difference between the reasonable charges for claims affected by the violation and the amounts actually paid to the provider. The provider is also entitled to recover costs, disbursements, and reasonable attorney fees.

Subd. 6. **Benefit design changes.** For purposes of this section, "different underlying financial reimbursement methodology" does not include health plan benefit design changes, including, but not limited to, changes in co–payment or deductible amounts or other changes in member cost–sharing requirements.

History: *1999 c 94 s 1; 2000 c 322 s 1; 2001 c 170 s 4,5; 2004 c 246 s 9*

62Q.745 [Repealed, 2004 c 246 s 11]

62Q.746 ACCESS TO CERTAIN INFORMATION REGARDING PROVIDERS.

Upon request of the commissioner, a health plan company licensed under chapters 62C and 62D must provide the following information:

(1) a detailed description 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;

(2) the number of full–time equivalent physicians, by specialty, nonphysician providers, and allied health providers used to provide services; and

(3) summary data that is broken down by type of provider, reflecting actual utilization of network and non–network practitioners and allied professionals by enrollees of the health plan company.

History: *2001 c 170 s 7*

62Q.75 PROMPT PAYMENT REQUIRED.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given to them.

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim under this section. Nothing in this section alters an enrollee's obligation to disclose information as required by law.

(c) "Third–party administrator" means a third–party administrator or other entity subject to section 60A.23, subdivision 8, and Minnesota Rules, chapter 2767.

Subd. 2. **Claims payments.** (a) This section applies to clean claims submitted to a health plan company or third–party administrator for services provided by any:

(1) health care provider, as defined in section 62Q.74, but does not include a provider licensed under chapter 151;

(2) home health care provider, as defined in section 144A.43, subdivision 4; or

(3) health care facility.

All health plan companies and third–party administrators must pay or deny claims that are clean claims within 30 calendar days after the date upon which the health plan company or third–party administrator received the claim.

(b) The health plan company or third–party administrator shall, upon request, make available to the provider information about the status of a claim submitted by the provider consistent with section 62J.581.

(c) If a health plan company or third–party administrator does not pay or deny a clean claim within the period provided in paragraph (a), the health plan company or third–party administrator must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date on which the health plan company or third–party administrator makes the payment or denies the claim. In any payment, the health plan company or third–party administrator must itemize any interest payment being made separately from other payments being made for services provided. The health plan company or third–party administrator shall not require the health care provider to bill the health plan company or third–party administrator for the interest required under this section before any interest payment is made. Interest payments must be made to the health care provider no less frequently than quarterly.

(d) The rate of interest paid by a health plan company or third–party administrator under this subdivision shall be 1.5 percent per month or any part of a month.

(e) A health plan company or third–party administrator is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices.

(f) The commissioner may assess a financial administrative penalty against a health plan company for violation of this subdivision when there is a pattern of abuse that demonstrates a lack of good faith effort and a systematic failure of the health plan company to comply with this subdivision.

Subd. 3. **Claims filing.** Unless otherwise provided by contract, by section 16A.124, subdivision 4a, or by federal law, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third–party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third–party administrator, whichever is later. A health care provider or facility that does not make an initial submission of charges within the six–month period shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. The six–month submission requirement may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. This subdivision also applies to all health care providers and facilities that submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation obligors for treatment of an injury compensable under chapter 65B.

History: *2000 c 349 s 1; 2004 c 246 s 10; 2005 c 77 s 4*

DENTAL PLANS

62Q.76 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62Q.76 to 62Q.79, the terms defined in this section have the meanings given them.

Subd. 2. **Dental care services.** "Dental care services" means services performed by a licensed dentist or any person working under the dentist's supervision as permitted under chapter 150A, which an enrollee might reasonably require to maintain good dental health, including preventive services, diagnostic services, emergency dental care, and restorative services.

Subd. 3. **Dental plan.** "Dental plan" means a policy, contract, or certificate offered by a dental organization for the coverage of dental care services. Dental plan means individual or group coverage.

Subd. 4. **Dentist.** "Dentist" means a person licensed to practice dentistry under chapter 150A.

Subd. 5. **Emergency dental care.** "Emergency dental care" means the provision of dental care services for a sudden, acute dental condition that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment to the dentition or would place the person's oral health in serious jeopardy.

Subd. 6. **Enrollee.** "Enrollee" means an individual covered by a dental organization and includes an insured, policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Subd. 7. **Dental organization.** "Dental organization" means a health insurer licensed under chapter 60A; a health service plan corporation licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; or a third party administrator that:

(i) provides, either directly or through contracts with providers or other persons, dental care services;

(ii) arranges for the provision of these services to enrollees on the basis of a fixed, prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee; or

(iii) administers dental plans.

History: *2000 c 410 s 1*

62Q.77 TERMS OF COVERAGE DISCLOSURE.

A dental organization shall make available to an enrollee, upon request, a clear and concise description of the following terms of coverage:

(1) the dental care services and other benefits to which the enrollee is entitled under the dental plan;

(2) any exclusions or limitation on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or co–payment features and any requirements for referrals to specialists;

(3) a description as to how services, including emergency dental care and out–of–area service, may be obtained;

(4) a general description of payment and co–payment amounts, if any, for dental care services, which the enrollee is obligated to pay; and

(5) a telephone number by which the enrollee may obtain additional information regarding coverage.

History: *2000 c 410 s 2*

62Q.78 DENTAL BENEFIT PLAN REQUIREMENTS.

Subdivision 1. **Utilization profiling.** (a) A dental organization that uses utilization profiling as a method of differentiating provider reimbursement or as a requirement for continued participation in the organization's provider network shall, upon request, make available to participating dentists the following information:

(1) a description of the methodology used in profiling so that dentists can clearly understand why and how they are affected; and

(2)(i) a list of the codes measured; (ii) a dentist's personal frequency data within each code so that the accuracy of the data can be verified; and (iii) an individual dentist's representation of scoring compared to classification points and how the dentist compares with peers in each category including the cutoff point of the score impacting qualification in order to inform the dentist about how the dentist may qualify or retain qualification for differentiated provider reimbursement or continued participation in the dental organization's provider network.

(b) A dental organization that uses utilization profiling as a method of differentiating provider reimbursement or as a requirement for continued participation in the organization's

provider network shall, upon request, provide a clear and concise description of the methodology of the utilization profiling on dental benefits to group purchasers and enrollees.

(c) A dental organization shall not be considered to be engaging in the practice of dentistry pursuant to chapter 150A, to the extent it releases utilization profiling information as required by sections 62Q.76 to 62Q.79.

Subd. 2. **Reimbursement codes.** (a) Unless the federal government requires the use of other procedural codes, for all dental care services in which a procedural code is used by the dental organization to determine coverage or reimbursement, the organization must use the most recent American Dental Association current dental terminology code that is available, within a year of its release. Current dental terminology codes must be used as specifically defined, must be listed separately, and must not be altered or changed by either the dentist or the dental organization.

(b) Enrollee benefits must be determined on the basis of individual codes subject to provider and group contracts.

(c) This subdivision does not prohibit or restrict dental organizations from setting reimbursement and pricing with groups, purchasers, and participating providers or addressing issues of fraud or errors in claims submissions.

Subd. 3. **Treatment options.** No contractual provision between a dental organization and a dentist shall in any way prohibit or limit a dentist from discussing all clinical options for treatment with the patient.

History: *2000 c 410 s 3*

62Q.79 LIMITATIONS.

(a) The provisions contained in section 62Q.77 shall not require a dental organization to disclose information which the dental organization is already obligated to disclose under applicable Minnesota law governing the operation of the dental organization.

(b) Any information a dental organization is required to disclose or communicate under section 62Q.77 to its subscribers, enrollees, participating providers, contracting groups, or dentists may be accomplished by electronic communication including, but not limited to, e–mail, the Internet, Web sites, and employer electronic bulletin boards.

History: *2000 c 410 s 4*

62Q.80 COMMUNITY–BASED HEALTH CARE COVERAGE PROGRAM.

Subdivision 1. **Scope.** (a) A community–based health care initiative may develop and operate a community–based health care coverage program that offers to eligible individuals and their dependents the option of purchasing through their employer health care coverage on a fixed prepaid basis without meeting the requirements of chapter 60A, 62A, 62C, 62D, 62Q, or 62T, or any other law or rule that applies to entities licensed under these chapters.

(b) The initiative shall establish health outcomes to be achieved through the program and performance measurements in order to determine whether these outcomes have been met. The outcomes must include, but are not limited to:

(1) a reduction in uncompensated care provided by providers participating in the community–based health network;

(2) an increase in the delivery of preventive health care services; and

(3) health improvement for enrollees with chronic health conditions through the management of these conditions.

In establishing performance measurements, the initiative shall use measures that are consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures.

(c) Any program established under this section shall not constitute a financial liability for the state, in that any financial risk involved in the operation or termination of the program shall be borne by the community–based initiative and the participating health care providers.

Subd. 2. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Community–based" means located in or primarily relating to the community of geographically contiguous political subdivisions, as determined by the board of a community–based health initiative that is served by the community–based health care coverage program.

(b) "Community–based health care coverage program" or "program" means a program administered by a community–based health initiative that provides health care services through provider members of a community–based health network or combination of networks to eligible individuals and their dependents who are enrolled in the program.

(c) "Community–based health initiative" means a nonprofit corporation that is governed by a board that has at least 80 percent of its members residing in the community and includes representatives of the participating network providers and employers.

(d) "Community–based health network" means a contract–based network of health care providers organized by the community–based health initiative to provide or support the delivery of health care services to enrollees of the community–based health care coverage program on a risk–sharing or nonrisk–sharing basis.

(e) "Dependent" means an eligible employee's spouse or unmarried child who is under the age of 19 years.

Subd. 3. **Approval.** (a) Prior to the operation of a community–based health care coverage program, a community–based health initiative shall submit to the commissioner of health for approval the community–based health care coverage program developed by the initiative. The commissioner shall only approve a program that has been awarded a community access program grant from the United States Department of Health and Human Services. The commissioner shall ensure that the program meets the federal grant requirements and any requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community–based health initiative in establishing premium rates for the community–based health care coverage program.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community–based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Subd. 4. **Establishment.** (a) The initiative shall establish and operate upon approval by the commissioner of health a community–based health care coverage program. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost–sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

(b) The payments collected under paragraph (a), clause (2), may be used to capture available federal funds.

Subd. 5. **Qualifying employees.** To be eligible for the community–based health care coverage program, an individual must:

(1) reside in or work within the designated community–based geographic area served by the program;

(2) be employed by a qualifying employer or be an employee's dependent;

(3) not be enrolled in or have currently available health coverage; and

(4) not be enrolled in medical assistance, general assistance medical care, MinnesotaCare, or Medicare.

Subd. 6. **Qualifying employers.** (a) To qualify for participation in the community–based health care coverage program, an employer must:

(1) employ at least one but no more than 50 employees at the time of initial enrollment in the program;

(2) pay its employees a median wage of $12.50 per hour or less; and

(3) not have offered employer–subsidized health coverage to its employees for at least 12 months prior to the initial enrollment in the program. For purposes of this section, "employer–subsidized health coverage" means health care coverage for which the employer pays at least 50 percent of the cost of coverage for the employee.

(b) To participate in the program, a qualifying employer agrees to:

(1) offer health care coverage through the program to all eligible employees and their dependents regardless of health status;

(2) participate in the program for an initial term of at least one year;

(3) pay a percentage of the premium established by the initiative for the employee; and

(4) provide the initiative with any employee information deemed necessary by the initiative to determine eligibility and premium payments.

Subd. 7. **Participating providers.** Any health care provider participating in the community–based health network must accept as payment in full the payment rate established by the initiative and may not charge to or collect from an enrollee any amount in access of this amount for any service covered under the program.

Subd. 8. **Coverage.** (a) The initiative shall establish the health care benefits offered through the community–based health care coverage program. The benefits established shall include, at a minimum:

(1) child health supervision services up to age 18, as defined under section 62A.047; and

(2) preventive services, including:

(i) health education and wellness services;

(ii) health supervision, evaluation, and follow–up;

(iii) immunizations; and

(iv) early disease detection.

(b) Coverage of health care services offered by the program may be limited to participating health care providers or health networks. All services covered under the program must be services that are offered within the scope of practice of the participating health care providers.

(c) The initiative may establish cost–sharing requirements. Any co–payment or deductible provisions established may not discriminate on the basis of age, sex, race, disability, economic status, or length of enrollment in the program.

(d) If the initiative amends or alters the benefits offered through the program from the initial offering, the initiative must notify the commissioner of health and all enrollees of the benefit change.

Subd. 9. **Enrollee information.** (a) The initiative must provide an individual or family who enrolls in the program a clear and concise written statement that includes the following information:

(1) health care services that are provided under the program;

(2) any exclusions or limitations on the health care services offered, including any cost–sharing arrangements or prior authorization requirements;

(3) a list of where the health care services can be obtained and that all health care services must be provided by or through a participating health care provider or community–based health network;

(4) a description of the program's complaint resolution process, including how to submit a complaint; how to file a complaint with the commissioner of health; and how to obtain an external review of any adverse decisions as provided under subdivision 10;

(5) the conditions under which the program or coverage under the program may be canceled or terminated; and

(6) a precise statement specifying that this program is not an insurance product and, as such, is exempt from state regulation of insurance products.

(b) The commissioner of health must approve a copy of the written statement prior to the operation of the program.

Subd. 10. **Complaint resolution process.** (a) The initiative must establish a complaint resolution process. The process must make reasonable efforts to resolve complaints and to inform complainants in writing of the initiative's decision within 60 days of receiving the complaint. Any decision that is adverse to the enrollee shall include a description of the right to an external review as provided in paragraph (c) and how to exercise this right.

(b) The initiative must report any complaint that is not resolved within 60 days to the commissioner of health.

(c) The initiative must include in the complaint resolution process the ability of an enrollee to pursue the external review process provided under section 62Q.73 with any decision rendered under this external review process binding on the initiative.

Subd. 11. **Data privacy.** The initiative shall establish data privacy policies and procedures for the program that comply with state and federal data privacy laws.

Subd. 12. **Limitations on enrollment.** (a) The initiative may limit enrollment in the program. If enrollment is limited, a waiting list must be established.

(b) The initiative shall not restrict or deny enrollment in the program except for nonpayment of premiums, fraud or misrepresentation, or as otherwise permitted under this section.

(c) The initiative may require a certain percentage of participation from eligible employees of a qualifying employer before coverage can be offered through the program.

Subd. 13. **Report.** (a) The initiative shall submit quarterly status reports to the commissioner of health on January 15, April 15, July 15, and October 15 of each year, with the first report due January 15, 2007. The status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the commissioner of health or commerce or the legislature.

(b) The initiative shall contract with an independent entity to conduct an evaluation of the program to be submitted to the commissioners of health and commerce and the legislature by January 15, 2009. The evaluation shall include:

(1) an analysis of the health outcomes established by the initiative and the performance measurements to determine whether the outcomes are being achieved;

(2) an analysis of the financial status of the program, including the claims to premiums loss ratio and utilization and cost experience;

(3) the demographics of the enrollees, including their age, gender, family income, and the number of dependents;

(4) the number of employers and employees who have been denied access to the program and the basis for the denial;

(5) specific analysis on enrollees who have aggregate medical claims totaling over $5,000 per year, including data on the enrollee's main diagnosis and whether all the medical claims were covered by the program;

(6) number of enrollees referred to state public assistance programs;

(7) a comparison of employer–subsidized health coverage provided in a comparable geographic area to the designated community–based geographic area served by the program, including, to the extent available:

(i) the difference in the number of employers with 50 or fewer employees offering employer–subsidized health coverage;

(ii) the difference in uncompensated care being provided in each area; and

(iii) a comparison of health care outcomes and measurements established by the initiative; and

(8) any other information requested by the commissioner of health or commerce.

Subd. 14. **Sunset.** This section expires December 31, 2011.

History: *2006 c 255 s 35*