~~(6)~~ (5) to hire, discharge, and compensate any attorney, accountant, expert witness, or other assistants, when the attorney-in-fact deems that action to be desirable for the proper execution by the attorney-in-fact of any of the powers described in this subdivision, and for the keeping of needed records; and

~~(7)~~ (6) in general, and in addition to all the specific acts listed in this subdivision, to do any other acts with respect to a fund of which the principal is a fiduciary.

Nothing in this subdivision authorizes delegation of any power of a fiduciary unless the power is one the fiduciary is authorized to delegate under the terms of the instrument governing the exercise of the power or under local law.

For the purposes of clauses (1) to ~~(7)~~ (6), "fund" means any trust, probate estate, guardianship, conservatorship, escrow, custodianship, or any other fund in which the principal has, or claims to have, an interest as a fiduciary.

All powers described in this subdivision are exercisable equally with respect to any fund of which the principal is a fiduciary to the giving of the power of attorney or becomes a fiduciary after that time, and whether located in the state of Minnesota or elsewhere.

Sec. 30. **REPEALER.**

Minnesota Statutes 1990, section 523.25, is repealed.

Presented to the governor April 17, 1992

Signed by the governor April 27, 1992, 2:02 p.m.

CHAPTER 549—H.F.No. 2800

An act relating to health care; providing health coverage for low-income uninsured persons; establishing statewide and regional cost containment programs; reforming requirements for health insurance companies; establishing rural health system initiatives; creating quality of care and data collection programs; revising malpractice laws; creating a health care access fund; imposing taxes; providing penalties; appropriating money; amending Minnesota Statutes 1990, sections 16A.124, by adding a subdivision; 43A.17, subdivision 9; 60A.15, subdivision 1; 62A.02, subdivisions 1, 2, 3, and by adding subdivisions; 62C.01, subdivision 3; 62E.02, subdivision 23; 62E.10, subdivision 1; 62E.11, subdivision 9, and by adding a subdivision; 62H.01; 136A.1355, subdivisions 2 and 3; 144.147, subdivisions 1, 3, and 4; 144.581, subdivision 1; 144.8093; 145.682, subdivision 4; 256.936, subdivisions 1, 2, 3, 4, and by adding subdivisions; 256B.057, by adding a subdivision; 290.01, subdivision 19b; and 447.31, subdivisions 1 and 3; Minnesota Statutes 1991 Supplement, sections 62A.31, subdivision 1; 145.61, subdivision 5; 145.64, subdivision 2; 256.936, subdivision 5; 297.02, subdivision 1; and 297.03, subdivision 5; proposing coding for new law in Minnesota Statutes, chapter 16A;

43A; 62A; 62E; 62J; 136A; 137; 144; 214; 256; 256B; 295; and 604; proposing coding for new law as Minnesota Statutes, chapter 62L; repealing Minnesota Statutes 1990, section 62A.02, subdivisions 4 and 5.

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

ARTICLE 1

COST CONTAINMENT

Section 1. **[62J.015] PURPOSE.**

The legislature finds that the staggering growth in health care costs is having a devastating effect on the health and cost of living of Minnesota residents. The legislature further finds that the number of uninsured and underinsured residents is growing each year and that the cost of health care coverage for our insured residents is increasing annually at a rate that far exceeds the state's overall rate of inflation.

The legislature further finds that it must enact immediate and intensive cost containment measures to limit the growth of health care expenditures, reform insurance practices, and finance a plan that offers access to affordable health care for our permanent residents by capturing dollars now lost to inefficiencies in Minnesota's health care system.

The legislature further finds that controlling costs is essential to the maintenance of the many factors contributing to the quality of life in Minnesota: our environment, education system, safe communities, affordable housing, provision of food, economic vitality, purchasing power, and stable population.

It is, therefore, the intent of the legislature to lay a new foundation for the delivery and financing of health care in Minnesota and to call this new foundation The Minnesota Health Right Act.

Sec. 2. **[62J.03] DEFINITIONS.**

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

Subd. 2. **CLINICALLY EFFECTIVE.** "Clinically effective" means that the use of a particular medical technology improves patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology demonstrates a clinical advantage over alternative technologies.

Subd. 3. **COMMISSION.** "Commission" or "state commission" means the Minnesota health care commission established in section 62J.05.

Subd. 4. **COMMISSIONER.** "Commissioner" means the commissioner of health.

Subd. 5. **COST EFFECTIVE.** "Cost effective" means that the economic costs of using a particular technology to achieve improvement in a patient's health outcome are justified given a comparison to both the economic costs and the improvement in patient health outcome resulting from the use of alternative technologies.

Subd. 6. **GROUP PURCHASER.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, health insurance companies, health maintenance organizations and other health plan companies; employee health plans offered by self-insured employers; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Subd. 7. **IMPROVEMENT IN HEALTH OUTCOME.** "Improvement in health outcome" means an improvement in patient clinical status, and an improvement in patient quality-of-life status, as measured by ability to function, ability to return to work, and other variables.

Subd. 8. **PROVIDER.** "Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee, as further defined in rules adopted by the commissioner.

Sec. 3. **[62J.04] CONTROLLING THE RATE OF GROWTH OF HEALTH CARE SPENDING.**

Subdivision 1. **COMPREHENSIVE BUDGET.** The commissioner of health shall set an annual limit on the rate of growth of public and private spending on health care services for Minnesota residents. The limit on growth must be set at a level that will slow the current rate of growth by at least ten percent per year using the spending growth rate for 1991 as a base year. This limit must be achievable through good faith, cooperative efforts of health care consumers, purchasers, and providers.

Subd. 2. **DATA COLLECTION.** For purposes of setting limits under this section, the commissioner shall collect from all Minnesota health care providers data on patient revenues received during a time period specified by the commissioner. The commissioner shall also collect data on health care spending from all group purchasers of health care. All health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. Professional licens-

ing boards and state agencies responsible for licensing, registering, or regulating providers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements. Intentional failure to provide reports requested under this section is grounds for revocation of a license or other disciplinary or regulatory action against a regulated provider. The commissioner may assess a fine against a provider who refuses to provide information required by the commissioner under this section. If a provider refuses to provide a report or information required under this section, the commissioner may obtain a court order requiring the provider to produce documents and allowing the commissioner to inspect the records of the provider for purposes of obtaining the information required under this section. All data received is nonpublic, trade secret information under section 13.37. The commissioner shall establish procedures and safeguards to ensure that data provided to the Minnesota health care commission is in a form that does not identify individual patients, providers, employers, purchasers, or other individuals and organizations, except with the permission of the affected individual or organization.

Subd. 3. **COST CONTAINMENT DUTIES.** After obtaining the advice and recommendations of the Minnesota health care commission, the commissioner shall:

(1) establish statewide and regional limits on growth in total health care spending under this section, monitor regional and statewide compliance with the spending limits, and take action to achieve compliance to the extent authorized by the legislature;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve spending limits;

(3) provide technical assistance to regional coordinating boards;

(4) monitor the quality of health care throughout the state, conduct consumer satisfaction surveys, and take action as necessary to ensure an appropriate level of quality;

(5) develop uniform billing forms, uniform electronic billing procedures, and other uniform claims procedures for health care providers by January 1, 1993;

(6) undertake health planning responsibilities as provided in section 62J.15;

(7) monitor and promote the development and implementation of practice parameters;

(8) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(9) designate centers of excellence for specialized and high-cost procedures and treatment and establish minimum standards and requirements for particular procedures or treatment;

(10) administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services;

(11) administer the health care analysis unit under article 7; and

(12) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans.

Subd. 4. **CONSULTATION WITH THE COMMISSION.** Before undertaking any of the duties required under this chapter, the commissioner of health shall consult with the Minnesota health care commission and obtain the commission's advice and recommendations. If the commissioner intends to depart from the commission's recommendations, the commissioner shall inform the commission of the intended departure, provide a written explanation of the reasons for the departure, and give the commission an opportunity to comment on the intended departure. If, after receiving the commission's comment, the commissioner still intends to depart from the commission's recommendations, the commissioner shall notify each member of the legislative oversight commission of the commissioner's intent to depart from the recommendations of the Minnesota health care commission. The notice to the legislative oversight commission must be provided at least ten days before the commissioner takes final action. If emergency action is necessary that does not allow the commissioner to obtain the advice and recommendations of the Minnesota health care commission or to provide advance notice and an opportunity for comment as required in this subdivision, the commissioner shall provide a written notice and explanation to the Minnesota health care commission and the legislative oversight commission at the earliest possible time.

Subd. 5. **APPEALS.** A person or organization may appeal a decision of the commissioner through a contested case proceeding under chapter 14.

Subd. 6. **RULEMAKING.** The commissioner shall adopt rules under chapter 14 to implement this chapter, including appeals of decisions by the Minnesota health care commission and the regional coordinating boards.

Subd. 7. **PLAN FOR CONTROLLING GROWTH IN SPENDING.** (a) By January 15, 1993, the Minnesota health care commission shall submit to the legislature and the governor for approval a plan, with as much detail as possible, for slowing the growth in health care spending to the growth rate identified by the commission, beginning July 1, 1993. The goal of the plan shall be to reduce the growth rate of health care spending, adjusted for population changes, so that it declines by at least ten percent per year for each of the next five years. The commission shall use the rate of spending growth in 1991 as the base year for developing its plan. The plan may include tentative targets for reducing the growth in spending for consideration by the legislature.

(b) In developing the plan, the commission shall consider the advisability and feasibility of the following options, but is not obligated to incorporate them into the plan:

(1) data and methods that could be used to calculate regional and statewide spending limits and the various options for expressing spending limits, such as maximum percentage growth rates or actuarially adjusted average per capita rates that reflect the demographics of the state or a region of the state;

(2) methods of adjusting spending limits to account for patients who are not Minnesota residents, to reflect care provided to a person outside the person's region, and to adjust for demographic changes over time;

(3) methods that could be used to monitor compliance with the limits;

(4) criteria for exempting spending on research and experimentation on new technologies and medical practices when setting or enforcing spending limits;

(5) methods that could be used to help providers, purchasers, consumers, and communities control spending growth;

(6) methods of identifying activities of consumers, providers, or purchasers that contribute to excessive growth in spending;

(7) methods of encouraging voluntary activities that will help keep spending within the limits;

(8) methods of consulting providers and obtaining their assistance and cooperation and safeguards that are necessary to protect providers from abrupt changes in revenues or practice requirements;

(9) methods of avoiding, preventing, or recovering spending in excess of the rate of growth identified by the commission;

(10) methods of depriving those who benefit financially from overspending of the benefit of overspending, including the option of recovering the amount of the excess spending from the greater provider community or from individual providers or groups of providers through targeted assessments;

(11) methods of reallocating health care resources among provider groups to correct existing inequities, reward desirable provider activities, discourage undesirable activities, or improve the quality, affordability, and accessibility of health care services;

(12) methods of imposing mandatory requirements relating to the delivery of health care, such as practice parameters, hospital admission protocols, 24-hour emergency care screening systems, or designated specialty providers;

(13) methods of preventing unfair health care practices that give a provider or group purchaser an unfair advantage or financial benefit or that significantly circumvent, subvert, or obstruct the goals of this chapter;

(14) methods of providing incentives through special spending allowances or other means to encourage and reward special projects to improve outcomes or quality of care; and

(15) the advisability or feasibility of a system of permanent, regional coordinating boards to ensure community involvement in activities to improve affordability, accessibility, and quality of health care in each region.

Sec. 4. **[62J.05] MINNESOTA HEALTH CARE COMMISSION.**

Subdivision 1. **PURPOSE OF THE COMMISSION.** The Minnesota health care commission consists of health care providers, purchasers, consumers, employers, and employees. The two major functions of the commission are:

(1) to make recommendations to the commissioner of health and the legislature regarding statewide and regional limits on the rate of growth of health care spending and activities to prevent or address spending in excess of the limits; and

(2) to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

Subd. 2. **MEMBERSHIP.** (a) **NUMBER.** The Minnesota health care commission consists of 25 members, as specified in this subdivision. A member may designate a representative to act as a member of the commission in the member's absence. The governor and legislature shall coordinate appointments under this subdivision to ensure gender balance and ensure that geographic areas of the state are represented in proportion to their population.

(b) **HEALTH PLAN COMPANIES.** The commission includes four members representing health plan companies, including one member appointed by the Minnesota Council of Health Maintenance Organizations, one member appointed by the Insurance Federation of Minnesota, one member appointed by Blue Cross and Blue Shield of Minnesota, and one member appointed by the governor.

(c) **HEALTH CARE PROVIDERS.** The commission includes six members representing health care providers, including one member appointed by the Minnesota Hospital Association, one member appointed by the Minnesota Medical Association, one member appointed by the Minnesota Nurses' Association, one rural physician appointed by the governor, and two members appointed by the governor to represent providers other than hospitals, physicians, and nurses.

(d) **EMPLOYERS.** The commission includes four members representing employers, including (1) two members appointed by the Minnesota Chamber of Commerce, including one self-insured employer and one small employer; and (2) two members appointed by the governor.

(e) **CONSUMERS.** The commission includes five consumer members,

including three members appointed by the governor, one of whom must represent persons over age 65; one appointed under the rules of the senate; and one appointed under the rules of the house of representatives.

(f) **EMPLOYEE UNIONS.** The commission includes three representatives of labor unions, including two appointed by the AFL-CIO Minnesota and one appointed by the governor to represent other unions.

(g) **STATE AGENCIES.** The commission includes the commissioners of commerce, employee relations, and human services.

(h) **CHAIR.** The governor shall designate the chair of the commission from among the governor's appointees.

Subd. 3. **FINANCIAL INTERESTS OF MEMBERS.** A member representing employers, consumers, or employee unions must not have any personal financial interest in the health care system except as an individual consumer of health care services. An employee who participates in the management of a health benefit plan may serve as a member representing employers or unions.

Subd. 4. **CONFLICTS OF INTEREST.** No member may participate or vote in commission proceedings involving an individual provider, purchaser, or patient, or a specific activity or transaction, if the member has a direct financial interest in the outcome of the commission's proceedings other than as an individual consumer of health care services.

Subd. 5. **IMMUNITY FROM LIABILITY.** No member of the commission shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

Subd. 6. **TERMS; COMPENSATION; REMOVAL; AND VACANCIES.** The commission is governed by section 15.0575.

Subd. 7. **ADMINISTRATION.** The commissioner of health shall provide office space, equipment and supplies, and technical support to the commission.

Subd. 8. **STAFF.** The commission may hire an executive director who serves in the unclassified service. The executive director may hire employees and consultants as authorized by the commission and may prescribe their duties. The attorney general shall provide legal services to the commission.

Sec. 5. **[62J.07] LEGISLATIVE OVERSIGHT COMMISSION.**

Subdivision 1. **LEGISLATIVE OVERSIGHT.** The legislative commission on health care access reviews the activities of the commissioner of health, the state health care commission, and all other state agencies involved in the implementation and administration of this chapter, including efforts to obtain federal approval through waivers and other means.

Subd. 2. **MEMBERSHIP.** The legislative commission on health care access consists of five members of the senate appointed under the rules of the senate and five members of the house of representatives appointed under the rules of the house of representatives. The legislative commission on health care access must include three members of the majority party and two members of the minority party in each house.

Subd. 3. **REPORTS TO THE COMMISSION.** The commissioner of health and the Minnesota health care commission shall report on their activities and the activities of the regional boards annually and at other times at the request of the legislative commission on health care access. The commissioners of health, commerce, and human services shall provide periodic reports to the legislative commission on the progress of rulemaking that is authorized or required under this act and shall notify members of the commission when a draft of a proposed rule has been completed and scheduled for publication in the State Register. At the request of a member of the commission, a commissioner shall provide a description and a copy of a proposed rule.

Subd. 4. **REPORT ON REVENUE SOURCES.** The legislative commission on health care access shall study the long-term integrity and stability of the revenue sources created in this act as the funding mechanism for the health right program and related health care initiatives. The study must include:

(1) an analysis of the impact of the provider taxes on the health care system and the relationship between the taxes and other initiatives related to health care access, affordability, and quality;

(2) the adequacy of the revenues generated in relation to the costs of a fully implemented and appropriately designed health right program;

(3) the extent to which provider taxes are passed on to individual and group purchasers and the ability of individual providers and groups of provider to absorb all or part of the tax burden;

(4) alternative funding sources and financing methods; and

(5) other appropriate issues relating to the financing of the health right program and related initiatives.

The commission shall provide a preliminary report and recommendations to the legislature by January 15, 1993, and a final report and recommendations by January 15, 1994. The commissioners of revenue, human services, and health shall provide assistance to the commission.

Sec. 6. **[62J.09] REGIONAL COORDINATING BOARDS.**

Subdivision 1. **GENERAL DUTIES.** The regional coordinating boards are locally controlled boards consisting of providers, health plan companies, employers, consumers, and elected officials. Regional boards may:

(1) recommend that the commissioner sanction voluntary agreements between providers in the region that will improve quality, access, or affordability of health care but might constitute a violation of antitrust laws if undertaken without government direction;

(2) make recommendations to the commissioner regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by providers;

(3) undertake voluntary activities to educate consumers, providers, and purchasers or to promote voluntary, cooperative community cost containment, access, or quality of care projects;

(4) make recommendations to the commissioner regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

Subd. 2. **MEMBERSHIP.** (a) Each regional health care management board consists of 16 members as provided in this subdivision. A member may designate a representative to act as a member of the commission in the member's absence.

(b) **PROVIDER REPRESENTATIVES.** Each regional board must include four members representing health care providers who practice in the region. One member is appointed by the Minnesota Medical Association. One member is appointed by the Minnesota Hospital Association. One member is appointed by the Minnesota Nurses' Association. The remaining member is appointed by the governor to represent providers other than physicians, hospitals, and nurses.

(c) **HEALTH PLAN COMPANY REPRESENTATIVES.** Each regional board includes three members representing health plan companies who provide coverage for residents of the region, including one member representing health insurers who is elected by a vote of all health insurers providing coverage in the region, one member elected by a vote of all health maintenance organizations providing coverage in the region, and one member appointed by Blue Cross and Blue Shield of Minnesota. The fourth member is appointed by the governor.

(d) **EMPLOYER REPRESENTATIVES.** Regional boards include three members representing employers in the region. Employer representatives are elected by a vote of the employers who are members of chambers of commerce in the region. At least one member must represent self-insured employers.

(e) **EMPLOYEE UNIONS.** Regional boards include one member appointed by the AFL-CIO Minnesota who is a union member residing or working in the region or who is a representative of a union that is active in the region.

(f) **PUBLIC MEMBERS.** Regional boards include three consumer members. One consumer member is elected by the community health boards in the region, with each community health board having one vote. One consumer

member is elected by the state legislators with districts in the region. One consumer member is appointed by the governor.

(g) **COUNTY COMMISSIONER.** Regional boards include one member who is a county board member. The county board member is elected by a vote of all of the county board members in the region, with each county board having one vote.

(h) **STATE AGENCY.** Regional boards include one state agency commissioner appointed by the governor to represent state health coverage programs.

Subd. 3. **ESTABLISHMENT OF REGIONAL COORDINATING ORGANIZATIONS AND STRUCTURE.** The providers of health services in each region should begin formulating the appropriate structure for organizing the delivery networks or systems to accomplish the objectives in subdivision 1. Once a draft plan is outlined, or during the drafting process, other entities should be included as appropriate so as to ensure the comprehensiveness of the plan and the regional planning process. The ultimate structure of the regional coordinating organization may vary by region and in composition. Each region may consult with the commissioner of health and the Minnesota health care commission during the planning process.

Subd. 4. **FINANCIAL INTERESTS OF MEMBERS.** A member representing employers, consumers, or employee unions must not have any personal financial interest in the health care system except as an individual consumer of health care services. An employee who participates in the management of a health benefit plan may serve as a member representing employers or unions.

Subd. 5. **CONFLICTS OF INTEREST.** No member may participate or vote in commission proceedings involving an individual provider, purchaser, or patient, or a specific activity or transaction, if the member has a direct financial interest in the outcome of the commission's proceedings other than as an individual consumer of health care services.

Subd. 6. **TECHNICAL ASSISTANCE.** The state health care commission shall provide technical assistance to regional boards.

Subd. 7. **TERMS; COMPENSATION; REMOVAL; AND VACANCIES.** Regional coordinating boards are governed by section 15.0575, except that members do not receive per diem payments.

Subd. 8. **REPEALER.** This section is repealed effective July 1, 1993.

Sec. 7. **[62J.15] HEALTH PLANNING.**

Subdivision 1. **HEALTH PLANNING ADVISORY COMMITTEE.** The Minnesota health care commission shall convene an advisory committee to make recommendations regarding the use and distribution of new and existing health care technologies and procedures and major capital expenditures by providers. The advisory committee may include members of the state commission

and other persons appointed by the commission. The advisory committee must include at least one person representing physicians, at least one person representing hospitals, and at least one person representing the health care technology industry. Health care technologies and procedures include high-cost pharmaceuticals, organ and other high-cost transplants, high-cost health care procedures and devices excluding United States Food and Drug Administration approved implantable or wearable medical devices, and expensive, large-scale technologies such as scanners and imagers.

Subd. 2. **HEALTH PLANNING.** In consultation with the health planning advisory committee, the Minnesota health care commission shall:

(1) make recommendations on the types of high-cost technologies, procedures, and capital expenditures for which a plan on statewide use and distribution should be made;

(2) develop criteria for evaluating new high-cost health care technology and procedures and major capital expenditures that take into consideration the clinical effectiveness, cost effectiveness, and health outcome;

(3) recommend to the commissioner of health and the regional coordinating organizations statewide and regional goals and targets for the distribution and use of new and existing high-cost health care technologies and procedures and major capital expenditures;

(4) make recommendations to the commissioner regarding the designation of centers of excellence for transplants and other specialized medical procedures; and

(5) make recommendations to the commissioner regarding minimum volume requirements for the performance of certain procedures by hospitals and other health care facilities or providers.

Sec. 8. **[62J.17] EXPENDITURE REPORTING.**

Subdivision 1. **PURPOSE.** To ensure access to affordable health care services for all Minnesotans it is necessary to restrain the rate of growth in health care costs. An important factor believed to contribute to escalating costs may be the purchase of costly new medical equipment, major capital expenditures, and the addition of new specialized services. After spending limits are established under section 62J.04, providers, patients, and communities will have the opportunity to decide for themselves whether they can afford capital expenditures or new equipment or specialized services within the constraints of a spending limit. In this environment, the state's role in reviewing these spending commitments can be more limited. However, during the interim period until spending targets are established, it is important to prevent unrestrained major spending commitments that will contribute further to the escalation of health care costs and make future cost containment efforts more difficult. In addition, it is essential to protect against the possibility that the legislature's expression of its attempt to con-

trol health care costs may lead a provider to make major spending commitments before targets or other cost containment constraints are fully implemented because the provider recognizes that the spending commitment may not be considered appropriate, needed, or affordable within the context of a fixed budget for health care spending. Therefore, the legislature finds that a requirement for reporting health care expenditures is necessary.

Subd. 2. **DEFINITIONS.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) **CAPITAL EXPENDITURE.** "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

(b) **HEALTH CARE SERVICE.** "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

(c) **MAJOR SPENDING COMMITMENT.** "Major spending commitment" means:

(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

(d) **MEDICAL EQUIPMENT.** "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

(e) **NEW SPECIALIZED SERVICE.** "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

(f) **PROVIDER.** "Provider" means an individual, corporation, association, firm, partnership, or other entity that is regularly engaged in providing health care services in Minnesota.

Subd. 3. **HOSPITAL AND NURSING HOME MORATORIA PRESERVED; NURSING HOMES EXEMPT.** Nothing in this section supersedes or limits the applicability of section 144.551 or 144A.071. This section does not apply to major spending commitments made by nursing homes or intermediate care facilities that are related to the provision of long-term care services to residents.

Subd. 4. **EXPENDITURE REPORTING.** Any provider making a capital expenditure establishing a health care service or new specialized service, or making a major spending commitment after April 1, 1992, that is in excess of $500,000, shall submit notification of this expenditure to the commissioner and provide the commissioner with any relevant background or other information. The commissioner shall not have any approval or denial authority, but should use such information in the ongoing evaluation of statewide and regional progress toward cost containment and other objectives.

Subd. 5. **RETROSPECTIVE REVIEW.** The commissioner of health, in consultation with the Minnesota health care commission, shall retrospectively review capital expenditures and major spending commitments that are required to be reported by providers under subdivision 4. In the event that health care providers refuse to cooperate with attempts by the Minnesota health care commission and regional coordinating organizations to coordinate the use of health care technologies and procedures, and reduce the growth rate in health care expenditures; or in the event that health care providers use, purchase, or perform health care technologies and procedures that are not clinically effective and cost effective and do not improve health outcomes based on the results of medical research; or in the event providers have failed to pursue collaborative arrangements; the commissioner shall require those health care providers to follow the procedures for prospective review and approval established in subdivision 6.

Subd. 6. **PROSPECTIVE REVIEW AND APPROVAL.** (a) **REQUIREMENT.** The commissioner shall prohibit those health care providers subject to retrospective review under subdivision 5 from making future major spending commitments or capital expenditures that are required to be reported under subdivision 4 for a period of up to five years, unless: (1) the provider has filed an application to proceed with the major spending commitment or capital expenditure with the commissioner and provided supporting documentation and evidence requested by the commissioner; and (2) the commissioner determines, based upon this documentation and evidence, that the spending commitment or capital expenditure is appropriate. The commissioner shall make a decision on a completed application within 60 days after an application is submitted. The Minnesota health care commission shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, and health care expenditures to review applications and make recommendations to the commissioner and the commission.

(b) **EXCEPTIONS.** This subdivision does not apply to:

(1) a major spending commitment to replace existing equipment with comparable equipment, if the old equipment will no longer be used in the state;

(2) a major spending commitment made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school, or by a federal or foundation grant, or clinical trials;

(3) a major spending commitment to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided; and

(4) mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

(c) **APPEALS.** A provider may appeal a decision of the commissioner under this section through a contested case proceeding under chapter 14.

(d) **PENALTIES AND REMEDIES.** The commissioner of health shall have the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

Sec. 9. **[62J.19] SUBMISSION OF REGIONAL PLAN TO COMMISSIONER.**

Each regional coordinating organization shall submit its plan to the commissioner on or before June 30, 1993. In the event that any major provider, provider group or other entity within the region chooses to not participate in the regional planning process, the commissioner may require the participation of that entity in the planning process or adopt other rules or criteria for that entity. In the event that a region fails to submit a plan to the commissioner that satisfactorily promotes the objectives in section 62J.09, subdivisions 1 and 2, or where competing plans and regional coordination organizations exist, the commissioner has the authority to establish a public regional coordinating organization for purposes of establishing a regional plan which will achieve the objectives. The public regional coordinating organization shall be appointed by the commissioner and under the commissioner's direction.

Sec. 10. **[62J.21] REPORTING TO THE LEGISLATURE.**

The commissioner shall report to the legislature by January 1, 1993 regarding the process being made within each region with respect to the establishment of a regional coordinating organization and the development of a regional plan. In the event that the commissioner determines that any region is not making reasonable progress or a good-faith commitment towards establishing a regional coordinating organization and regional plan, the commissioner may establish a public regional board for this purpose. The commissioner's report should also include the issues, if any, raised during the planning process to date and request any appropriate legislate action that would facilitate the planning process.

Sec. 11. **[62J.22] PARTICIPATION OF FEDERAL PROGRAMS.**

The commissioner of health shall seek the full participation of federal health care programs under this chapter, including Medicare, medical assistance, veterans administration programs, and other federal programs. The commissioner of human services shall under the direction of the health care commission submit waiver requests and take other action necessary to obtain federal approval to allow participation of the medical assistance program. Other state agencies shall provide assistance at the request of the commission. If federal approval is not given for one or more federal programs, data on the amount of health care spending that is collected under section 62J.04 shall be adjusted so that state and regional spending limits take into account the failure of the federal program to participate.

Sec. 12. **[62J.23] PROVIDER CONFLICTS OF INTEREST.**

Subdivision 1. **RULES PROHIBITING CONFLICTS OF INTEREST.** The commissioner of health shall adopt rules restricting financial relationships or payment arrangements involving health care providers under which a provider benefits financially by referring a patient to another provider, recommending another provider, or furnishing or recommending an item or service. The rules must be compatible with, and no less restrictive than, the federal Medicare antikickback statute, in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and regulations adopted under it. However, the commissioner's rules may be more restrictive than the federal law and regulations and may apply to additional provider groups and business and professional arrangements. When the state rules restrict an arrangement or relationship that is permissible under federal laws and regulations, including an arrangement or relationship expressly permitted under the federal safe harbor regulations, the fact that the state requirement is more restrictive than federal requirements must be clearly stated in the rule.

Subd. 2. **INTERIM RESTRICTIONS.** From July 1, 1992, until rules are adopted by the commissioner under this section, the restrictions in the federal Medicare antikickback statutes in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and rules adopted under the federal statutes, apply to all health care providers in the state, regardless of whether the provider participates in any state health care program. The commissioner shall approve a transition plan submitted to the commissioner by January 1, 1993, by a provider who is in violation of this section that provides a reasonable time for the provider to modify prohibited practices or divest financial interests in other providers in order to come into compliance with this section.

Subd. 3. **PENALTY.** The commissioner may assess a fine against a provider who violates this section. The amount of the fine is $1,000 or 110 percent of the estimated financial benefit that the provider realized as a result of the prohibited financial arrangement or payment relationship, whichever is greater. A provider who is in compliance with a transition plan approved by the commissioner under subdivision 2, or who is making a good faith effort to obtain the commissioner's approval of a transition plan, is not in violation of this section.

Sec. 13. **[62J.25] MANDATORY MEDICARE ASSIGNMENT.**

(a) Effective January 1, 1993, a health care provider authorized to participate in the Medicare program shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 115 percent of the Medicare-approved amount for any Medicare-covered service provided.

(b) Effective January 1, 1994, a health care provider authorized to participate in the Medicare program shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 110 percent of the Medicare-approved amount for any Medicare-covered service provided.

(c) Effective January 1, 1995, a health care provider authorized to participate in the Medicare program shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 105 percent of the Medicare-approved amount for any Medicare-covered service provided.

(d) Effective January 1, 1996, a health care provider authorized to participate in the Medicare program shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of the Medicare-approved amount for any Medicare-covered service provided.

(e) This section does not apply to ambulance services as defined in section 144.801, subdivision 4.

Sec. 14. **[62J.29] ANTITRUST EXCEPTIONS.**

Subdivision 1. **PURPOSE.** The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care services will be significantly enhanced by some cooperative arrangements involving providers or purchasers that would be prohibited by state and federal antitrust laws if undertaken without governmental involvement. The purpose of this section is to create an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result in lower costs, or greater access or quality, than would otherwise occur in the competitive marketplace. The legislature intends that approval of relationships be accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power.

Subd. 2. **REVIEW AND APPROVAL.** The commissioner shall establish criteria and procedures to review and authorize contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that might be construed to be violations of state or federal antitrust laws but which are in the best interests of the state and further the policies and goals of this chapter. The commissioner shall not approve any application unless the commissioner finds that the proposed arrangement is likely to result in lower health care costs, or greater access to or quality of health care, than would occur in the competitive marketplace. The commissioner may condition approval of a proposed arrangement on a modification of all or part of the arrangement to eliminate any restriction on competition that is not reasonably related to the goals of controlling costs or improving access or quality. The commissioner may also establish conditions for approval that are reasonably necessary to protect against any abuses of private economic power and to ensure that the arrangement is appropriately supervised and regulated by the state. The commissioner shall actively monitor and regulate arrangements approved under this section to ensure that the arrangements remain in compliance with the conditions of approval. The commissioner may revoke an approval upon a finding that the arrangement is not in substantial compliance with the terms of the application or the conditions of approval.

Subd. 3. **APPLICATIONS.** Applications for approval under this section

must be filed with the commissioner. An application for approval must describe the proposed arrangement in detail. The application must include at least: the identities of all parties, the intent of the arrangement, the expected effects of the arrangement, an explanation of how the arrangement will control costs or improve access or quality, and financial statements showing how the efficiencies of operation will be passed along to patients and purchasers of health care. The commissioner may ask the attorney general to comment on an application, but the application and any information obtained by the commissioner under this section is not admissible in any proceeding brought by the attorney general based on antitrust.

Subd. 4. **STATE ANTITRUST LAW.** Notwithstanding the Minnesota antitrust law of 1971, as amended, in Minnesota Statutes, sections 325D.49 to 325D.66, contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that are approved by the commissioner under this section do not constitute an unlawful contract, combination, or conspiracy in unreasonable restraint of trade or commerce under Minnesota Statutes, sections 325D.49 to 325D.66. Approval by the state commission is an absolute defense against any action under state antitrust laws.

Subd. 5. **RULEMAKING.** The commissioner shall by January 1, 1994, adopt permanent rules to implement this section. The commissioner is exempt from rulemaking until January 1, 1994.

Sec. 15. **HOSPITAL PLANNING TASK FORCE.**

The legislative commission on health care access shall convene a hospital health planning task force to undertake preliminary planning relating to cost containment, accessibility of health care services, and quality of care, and to develop options and recommendations to be presented to the legislative commission and to the Minnesota health care commission. The task force consists of interested representatives of Minnesota hospitals, the commissioner of health or the commissioner's representatives, and the members of the legislative commission or their representatives. The task force shall submit reports to the Minnesota health care commission by August 1, 1992, and July 1, 1993. The task force expires on August 1, 1993. The expenses and compensation of members is the responsibility of the institutions, organizations, or agencies they represent.

Sec. 16. **STUDY ON RECOVERY OF UNCOMPENSATED CARE COSTS.**

The commissioner of health shall study cost-shifting and uncompensated care costs in the health care industry. The commissioner shall recommend to the legislature by January 15, 1993, methods to recover from health care providers an amount equal to the share of uncompensated care costs shifted to other payers that are no longer incurred by the provider as uncompensated care costs, due to the availability of the health right plan.

Sec. 17. **STUDY OF HEALTH CARE MANAGEMENT COMPANIES.**

The commissioner of commerce and the commissioner of health shall study and make recommendations to the legislature regarding the regulation of health care management companies. The recommendations shall include, but are not limited to:

(1) the definition of a for-profit, and nonprofit health care management company;

(2) the scope and appropriateness of regulation of for-profit health care management companies, and of nonprofit health care management companies;

(3) the extent to which cost containment and expenditure targets can be attained or realized through regulation of health care management companies; and

(4) the relationship between health care management companies and health care providers, health care plans, health care technology entities, and other components of the health care system.

The commissioners of commerce and health shall present a joint report to the legislature on or before January 15, 1993.

Sec. 18. **STUDY OF HEALTH MAINTENANCE ORGANIZATION REGULATION.**

The commissioners of health and commerce shall jointly study the regulation of health maintenance organizations. The commissioners shall examine the level and type of regulation that is appropriate for the department of health and for the department of commerce and shall report to the legislature by January 15, 1993. The report must contain a consensus plan to transfer authority over the financial aspects of health maintenance organizations to the commissioner of commerce, while allowing the commissioner of health to retain authority over the health care quality aspects of health maintenance organizations.

Sec. 19. **STUDY OF MEDICARE ASSIGNMENT FOR HOME MEDICAL EQUIPMENT.**

The commissioner of health, in consultation with representatives of the home medical equipment industry, shall study the financial impact of the phase-in of mandatory Medicare assignment on the home medical equipment suppliers. The study must include an examination of charges for medical equipment, physician documentation of medical need for medical equipment, the appropriateness of federal guidelines regarding the treatment of assignment, and other factors related to Medicare assignment that may be unique to the home medical equipment industry. The commissioner shall present recommendations to the legislature by January 15, 1993.

Sec. 20. **EFFECTIVE DATE.**

Sections 1 to 11; 12, subdivisions 1 and 2; and 13 to 19 are effective the day following final enactment. Section 12, subdivision 3, is effective July 1, 1993.

ARTICLE 2

SMALL EMPLOYER INSURANCE REFORM

Section 1. **[62L.01] CITATION.**

Subdivision 1. **POPULAR NAME.** Sections 62L.01 to 62L.23 may be cited as the Minnesota small employer health benefit act.

Subd. 2. **JURISDICTION.** Sections 62L.01 to 62L.23 apply to any health carrier that offers, issues, delivers, or renews a health benefit plan to a small employer.

Subd. 3. **LEGISLATIVE FINDINGS AND PURPOSE.** The legislature finds that underwriting and rating practices in the individual and small employer markets for health coverage create substantial hardship and unfairness, create unnecessary administrative costs, and adversely affect the health of residents of this state. The legislature finds that the premium restrictions provided by this chapter reduce but do not eliminate these harmful effects. Accordingly, the legislature declares its desire to phase out the remaining rating bands as quickly as possible, with the end result of eliminating all rating practices based on risk by July 1, 1997.

Sec. 2. **[62L.02] DEFINITIONS.**

Subdivision 1. **APPLICATION.** The definitions in this section apply to sections 62L.01 to 62L.23.

Subd. 2. **ACTUARIAL OPINION.** "Actuarial opinion" means a written statement by a member of the American Academy of Actuaries that a health carrier is in compliance with this chapter, based on the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the health carrier in establishing premium rates for health benefit plans.

Subd. 3. **ASSOCIATION.** "Association" means the health coverage reinsurance association.

Subd. 4. **BASE PREMIUM RATE.** "Base premium rate" means as to a rating period, the lowest premium rate charged or which could have been charged under the rating system by the health carrier to small employers for health benefit plans with the same or similar coverage.

Subd. 5. **BOARD OF DIRECTORS.** "Board of directors" means the board of directors of the health coverage reinsurance association.

Subd. 6. **CASE CHARACTERISTICS.** "Case characteristics" means the relevant characteristics of a small employer, as determined by a health carrier in accordance with this chapter, which are considered by the carrier in the determination of premium rates for the small employer.

Subd. 7. **COINSURANCE.** "Coinsurance" means an established dollar amount or percentage of health care expenses that an eligible employee or dependent is required to pay directly to a provider of medical services or supplies under the terms of a health benefit plan.

Subd. 8. **COMMISSIONER.** "Commissioner" means the commissioner of commerce for health carriers subject to the jurisdiction of the department of commerce or the commissioner of health for health carriers subject to the jurisdiction of the department of health, or the relevant commissioner's designated representative.

Subd. 9. **CONTINUOUS COVERAGE.** "Continuous coverage" means the maintenance of continuous and uninterrupted qualifying prior coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous coverage if the individual requests enrollment in a health benefit plan within 30 days of termination of the qualifying prior coverage.

Subd. 10. **DEDUCTIBLE.** "Deductible" means the amount of health care expenses an eligible employee or dependent is required to incur before benefits are payable under a health benefit plan.

Subd. 11. **DEPENDENT.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 19 years, unmarried child who is a full-time student under the age of 25 years as defined in section 62A.301 and financially dependent upon the eligible employee, or dependent child of any age who is handicapped and who meets the eligibility criteria in section 62A.14, subdivision 2. For the purpose of this definition, a child may include a child for whom the employee or the employee's spouse has been appointed legal guardian.

Subd. 12. **ELIGIBLE CHARGES.** "Eligible charges" means the actual charges submitted to a health carrier by or on behalf of a provider, eligible employee, or dependent for health services covered by the health carrier's health benefit plan. Eligible charges do not include charges for health services excluded by the health benefit plan or charges for which an alternate health carrier is liable under the coordination of benefit provisions of the health benefit plan.

Subd. 13. **ELIGIBLE EMPLOYEE.** "Eligible employee" means an individual employed by a small employer for at least 20 hours per week and who has satisfied all employer participation and eligibility requirements, including, but not limited to, the satisfactory completion of a probationary period of not less than 30 days but no more than 90 days. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include employees who work on a temporary, seasonal, or substitute basis.

Subd. 14. **FINANCIALLY IMPAIRED CONDITION.** "Financially impaired condition" means a situation in which a health carrier is not insolvent, but (1) is considered by the commissioner to be potentially unable to fulfill its

contractual obligations, or (2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

Subd. 15. **HEALTH BENEFIT PLAN.** "Health benefit plan" means a policy, contract, or certificate issued by a health carrier to a small employer for the coverage of medical and hospital benefits. Health benefit plan includes a small employer plan. Health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense-incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) long-term care insurance as defined in section 62A.46;

(10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the Federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended through December 31, 1991; or

(11) workers' compensation insurance.

For the purpose of this chapter, a health benefit plan issued to employees of a small employer who meets the participation requirements of section 62L.03, subdivision 3, is considered to have been issued to a small employer. A health benefit plan issued on behalf of a health carrier is considered to be issued by the health carrier.

Subd. 16. **HEALTH CARRIER.** "Health carrier" means 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; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; and a multiple employer welfare arrangement, as defined in United States Code, title 29, section 1002(40), as amended through December 31, 1991. For the purpose of this chapter, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that any insurance

company or health service plan corporation that is an affiliate of a health maintenance organization located in Minnesota, or any health maintenance organization located in Minnesota that is an affiliate of an insurance company or health service plan corporation, or any health maintenance organization that is an affiliate of another health maintenance organization in Minnesota, may treat the health maintenance organization as a separate carrier.

Subd. 17. **HEALTH PLAN.** "Health plan" means a health benefit plan issued by a health carrier, except that it may be issued:

(1) to a small employer;

(2) to an employer who does not satisfy the definition of a small employer as defined under subdivision 26; or

(3) to an individual purchasing an individual or conversion policy of health care coverage issued by a health carrier.

Subd. 18. **INDEX RATE.** "Index rate" means as to a rating period for small employers the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

Subd. 19. **LATE ENTRANT.** "Late entrant" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period applicable to the employee or dependent under the terms of the health benefit plan, provided that the initial enrollment period must be a period of at least 30 days. However, an eligible employee or dependent must not be considered a late entrant if:

(1) the individual was covered under qualifying existing coverage at the time the individual was eligible to enroll in the health benefit plan, declined enrollment on that basis, and presents to the carrier a certificate of termination of the qualifying prior coverage, provided that the individual maintains continuous coverage;

(2) the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law Number 99-272, as amended, and any state continuation laws applicable to the employer or carrier, provided that the individual maintains continuous coverage;

(3) the individual is a new spouse of an eligible employee, provided that enrollment is requested within 30 days of becoming legally married;

(4) the individual is a new dependent child of an eligible employee, provided that enrollment is requested within 30 days of becoming a dependent;

(5) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(6) a court has ordered that coverage be provided for a dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

Subd. 20. **MCHA.** "MCHA" means the Minnesota comprehensive health association established under section 62E.10.

Subd. 21. **MEDICAL NECESSITY.** "Medical necessity" means the appropriate and necessary medical and hospital services eligible for payment under a health benefit plan as determined by a health carrier.

Subd. 22. **MEMBERS.** "Members" means the health carriers operating in the small employer market who may participate in the association.

Subd. 23. **PREEXISTING CONDITION.** "Preexisting condition" means a condition manifesting in a manner that causes an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage, or a pregnancy existing as of the effective date of coverage of a health benefit plan.

Subd. 24. **QUALIFYING PRIOR COVERAGE OR QUALIFYING EXISTING COVERAGE.** "Qualifying prior coverage" or "qualifying existing coverage" means health benefits or health coverage provided under:

(1) a health plan, as defined in this section;

(2) Medicare;

(3) medical assistance under chapter 256B;

(4) general assistance medical care under chapter 256D;

(5) MCHA;

(6) a self-insured health plan;

(7) the health right plan established under section 256.936, subdivision 2, when the plan includes inpatient hospital services as provided in section 256.936, subdivision 2a, paragraph (c);

(8) a plan provided under section 43A.316; or

(9) a plan similar to any of the above plans provided in this state or in another state as determined by the commissioner.

Subd. 25. **RATING PERIOD.** "Rating period" means the 12-month period for which premium rates established by a health carrier are assumed to be in effect, as determined by the health carrier. During the rating period, a health carrier may adjust the rate based on the prorated change in the index rate.

Subd. 26. **SMALL EMPLOYER.** "Small employer" means a person, firm, corporation, partnership, association, or other entity actively engaged in business who, on at least 50 percent of its working days during the preceding calendar year, employed no fewer than two nor more than 29 eligible employees, the majority of whom were employed in this state. If a small employer has only two eligible employees, one employee must not be the spouse, child, sibling, parent, or grandparent of the other, except that a small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than two employees or the employees are family members. Entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer for purposes of determining the number of eligible employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan. Where an association, described in section 62A.10, subdivision 1, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association may elect to be considered to be a small employer, even though the association provides coverage to more than 29 employees of its members, so long as each employer that is provided coverage through the association qualifies as a small employer. An association's election to be considered a small employer under this section is not effective unless filed with the commissioner of commerce. The association may revoke its election at any time by filing notice of revocation with the commissioner.

Subd. 27. **SMALL EMPLOYER MARKET.** (a) "Small employer market" means the market for health benefit plans for small employers.

(b) A health carrier is considered to be participating in the small employer market if the carrier offers, sells, issues, or renews a health benefit plan to: (1) any small employer; or (2) the eligible employees of a small employer offering a health benefit plan if, with the knowledge of the health carrier, both of the following conditions are met:

(i) any portion of the premium or benefits is paid for or reimbursed by a small employer; and

(ii) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of the Internal Revenue Code, section 106, 125, or 162.

Subd. 28. **SMALL EMPLOYER PLAN.** "Small employer plan" means a health benefit plan issued by a health carrier to a small employer for coverage of the medical and hospital benefits described in section 62L.05.

Sec. 3. **[62L.03] AVAILABILITY OF COVERAGE.**

Subdivision 1. **GUARANTEED ISSUE AND REISSUE.** Every health carrier shall, as a condition of authority to transact business in this state in the

small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans to any small employer as provided in this chapter. Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers. A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

Subd. 2. **EXCEPTIONS.** (a) No health maintenance organization is required to offer coverage or accept applications under subdivision 1 in the case of the following:

(1) with respect to a small employer, where the worksite of the employees of the small employer is not physically located in the health maintenance organization's approved service areas; or

(2) with respect to an employee, when the employee does not work or reside within the health maintenance organization's approved service areas.

(b) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subdivision 1 where the commissioner finds that the acceptance of an application or applications would place the small employer carrier in a financially impaired condition, provided, however, that a small employer carrier that has not offered coverage or accepted applications pursuant to this paragraph shall not offer coverage or accept applications for any health benefit plan until 180 days following a determination by the commissioner that the small employer carrier has ceased to be financially impaired.

Subd. 3. **MINIMUM PARTICIPATION.** (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan must be guaranteed coverage from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier may not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to coverage under another group health plan.

(b) A health carrier may require that small employers contribute a specified minimum percentage toward the cost of the coverage of eligible employees, so long as the requirement is uniformly applied for all small employers. For the small employer plans, a health carrier must require that small employers contribute at least 50 percent of the cost of the coverage of eligible employees. The health carrier must impose this requirement on a uniform basis for both small employer plans and for all small employers.

(c) Nothing in this section obligates a health carrier to issue coverage to a

small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer.

Subd. 4. **UNDERWRITING RESTRICTIONS.** Health carriers may apply underwriting restrictions to coverage for health benefit plans for small employers, including any preexisting condition limitations, only as expressly permitted under this chapter. Health carriers may collect information relating to the case characteristics and demographic composition of small employers, as well as health status and health history information about employees of small employers. Except as otherwise authorized for late entrants, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the effective date of coverage of an eligible employee or dependent. When calculating a preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying prior coverage, provided that the individual maintains continuous coverage. Late entrants may be subject to a preexisting condition limitation not to exceed 18 months from the effective date of coverage of the late entrant. Late entrants may also be excluded from coverage for a period not to exceed 18 months, provided that if a health carrier imposes an exclusion from coverage and a preexisting condition limitation, the combined time period for both the coverage exclusion and preexisting condition limitation must not exceed 18 months.

Subd. 5. **CANCELLATIONS AND FAILURES TO RENEW.** No health carrier shall cancel, decline to issue, or fail to renew a health benefit plan as a result of the claim experience or health status of the small employer group. A health carrier may cancel or fail to renew a health benefit plan:

(1) for nonpayment of the required premium;

(2) for fraud or misrepresentation by the small employer, or, with respect to coverage of an individual eligible employee or dependent, fraud or misrepresentation by the eligible employee or dependent, with respect to eligibility for coverage or any other material fact;

(3) if eligible employee participation during the preceding calendar year declines to less than 75 percent, subject to the waiver of coverage provision in subdivision 3;

(4) if the employer fails to comply with the minimum contribution percentage legally required by the health carrier;

(5) if the health carrier ceases to do business in the small employer market; or

(6) for any other reasons or grounds expressly permitted by the respective licensing laws and regulations governing a health carrier, including, but not limited to, service area restrictions imposed on health maintenance organizations under section 62D.03, subdivision 4, paragraph (m), to the extent that these grounds are not expressly inconsistent with this chapter.

Subd. 6. **MCHA ENROLLEES.** Health carriers shall offer coverage to any eligible employee or dependent enrolled in MCHA at the time of the health carrier's issuance or renewal of a health benefit plan to a small employer. The health benefit plan must require that the employer permit MCHA enrollees to enroll in the small employer's health benefit plan as of the first date of renewal of a health benefit plan occurring on or after July 1, 1993, or, in the case of a new group, as of the initial effective date of the health benefit plan. Unless otherwise permitted by this chapter, health carriers must not impose any underwriting restrictions, including any preexisting condition limitations or exclusions, on any eligible employee or dependent previously enrolled in MCHA and transferred to a health benefit plan so long as continuous coverage is maintained, provided that the health carrier may impose any unexpired portion of a preexisting condition limitation under the person's MCHA coverage. An MCHA enrollee is not a late entrant, so long as the enrollee has maintained continuous coverage.

Sec. 4. **[62L.04] COMPLIANCE REQUIREMENTS.**

Subdivision 1. **APPLICABILITY OF CHAPTER REQUIREMENTS.** Beginning July 1, 1993, health carriers participating in the small employer market must offer and make available any health benefit plan that they offer, including both of the small employer plans provided in section 62L.05, to all small employers who satisfy the small employer participation requirements specified in this chapter. Compliance with these requirements is required as of the first renewal date of any small employer group occurring after July 1, 1993. For new small employer business, compliance is required as of the first date of offering occurring after July 1, 1993.

Compliance with these requirements is required as of the first renewal date occurring after July 1, 1994, with respect to employees of a small employer who had been issued individual coverage prior to July 1, 1993, administered by the health carrier on a group basis. Notwithstanding any other law to the contrary, the health carrier shall terminate any individual coverage for employees of small employers who satisfy the small employer participation requirements specified in section 62L.03 and offer to replace it with a health benefit plan. If the employer elects not to purchase a health benefit plan, the health carrier must offer all covered employees and dependents the option of maintaining their current coverage, administered on an individual basis, or replacement individual coverage. Small employer and replacement individual coverage provided under this subdivision must be without application of underwriting restrictions, provided continuous coverage is maintained.

Subd. 2. **NEW CARRIERS.** A health carrier entering the small employer market after July 1, 1993, shall begin complying with the requirements of this chapter as of the first date of offering of a health benefit plan to a small employer. A health carrier entering the small employer market after July 1, 1993, is considered to be a member of the health coverage reinsurance association as of the date of the health carrier's initial offer of a health benefit plan to a small employer.

Sec. 5. **[62L.05] SMALL EMPLOYER PLAN BENEFITS.**

Subdivision 1. **TWO SMALL EMPLOYER PLANS.** Each health carrier in the small employer market must make available to any small employer both of the small employer plans described in subdivisions 2 and 3. Under subdivisions 2 and 3, coinsurance and deductibles do not apply to child health supervision services and prenatal services, as defined by section 62A.047. The maximum out-of-pocket costs for covered services must be $3,000 per individual and $6,000 per family per year. The maximum lifetime benefit must be $500,000. The out-of-pocket cost limits and the deductible amounts provided in subdivision 2 must be adjusted on July 1 every two years, based upon changes in the consumer price index, as of the end of the previous calendar year, as determined by the commissioner of commerce. Adjustments must be in increments of $50 and must not be made unless at least that amount of adjustment is required.

Subd. 2. **DEDUCTIBLE-TYPE SMALL EMPLOYER PLAN.** The benefits of the deductible-type small employer plan offered by a health carrier must be equal to 80 percent of the eligible charges for health care services, supplies, or other articles covered under the small employer plan, in excess of an annual deductible which must be $500 per individual and $1,000 per family.

Subd. 3. **COPAYMENT-TYPE SMALL EMPLOYER PLAN.** The benefits of the copayment-type small employer plan offered by a health carrier must be equal to 80 percent of the eligible charges for health care services, supplies, or other articles covered under the small employer plan, in excess of the following copayments:

(1) $15 per outpatient visit, other than to a hospital outpatient department or emergency room, urgent care center, or similar facility;

(2) $15 per day for the services of a home health agency or private duty registered nurse;

(3) $50 per outpatient visit to a hospital outpatient department or emergency room, urgent care center, or similar facility; and

(4) $300 per inpatient admission to a hospital.

Subd. 4. **BENEFITS.** The medical services and supplies listed in this subdivision are the benefits that must be covered by the small employer plans described in subdivisions 2 and 3:

(1) inpatient and outpatient hospital services, excluding services provided for the diagnosis, care, or treatment of chemical dependency or a mental illness or condition, other than those conditions specified in clauses (10), (11), and (12);

(2) physician and nurse practitioner services for the diagnosis or treatment of illnesses, injuries, or conditions;

(3) diagnostic X-rays and laboratory tests;

(4) ground transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, or as otherwise required by the health carrier;

(5) services of a home health agency if the services qualify as reimbursable services under Medicare and are directed by a physician or qualify as reimbursable under the health carrier's most commonly sold health plan for insured group coverage;

(6) services of a private duty registered nurse if medically necessary, as determined by the health carrier;

(7) the rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

(8) child health supervision services up to age 18, as defined in section 62A.047;

(9) maternity and prenatal care services, as defined in sections 62A.041 and 62A.047;

(10) inpatient hospital and outpatient services for the diagnosis and treatment of certain mental illnesses or conditions, as defined by the International Classification of Diseases-Clinical Modification (ICD-9-CM), seventh edition (1990) and as classified as ICD-9 codes 295 to 299;

(11) ten hours per year of outpatient mental health diagnosis or treatment for illnesses or conditions not described in clause (10);

(12) 60 hours per year of outpatient treatment of chemical dependency; and

(13) 50 percent of eligible charges for prescription drugs, up to a separate annual maximum out-of-pocket expense of $1,000 per individual for prescription drugs, and 100 percent of eligible charges thereafter.

Subd. 5. **PLAN VARIATIONS.** (a) No health carrier shall offer to a small employer a health benefit plan that differs from the two small employer plans described in subdivisions 1 to 4, unless the health benefit plan complies with all provisions of chapters 62A, 62C, 62D, 62E, 62H, and 64B that otherwise apply to the health carrier, except as expressly permitted by paragraph (b).

(b) As an exception to paragraph (a), a health benefit plan is deemed to be a small employer plan and to be in compliance with paragraph (a) if it differs from one of the two small employer plans described in subdivisions 1 to 4 only by providing benefits in addition to those described in subdivision 4, provided that the health care benefit plan has an actuarial value that exceeds the actuarial value of the benefits described in subdivision 4 by no more than two percent. "Benefits in addition" means additional units of a benefit listed in subdivision 4 or one or more benefits not listed in subdivision 4.

Subd. 6. **CHOICE PRODUCTS EXCEPTION.** Nothing in subdivision 1 prohibits a health carrier from offering a small employer plan which provides for different benefit coverages based on whether the benefit is provided through a primary network of providers or through a secondary network of providers so long as the benefits provided in the primary network equal the benefit requirements of the small employer plan as described in this section. For purposes of products issued under this subdivision, out-of-pocket costs in the secondary network may exceed the out-of-pocket limits described in subdivision 1.

Subd. 7. **BENEFIT EXCLUSIONS.** No medical, hospital, or other health care benefits, services, supplies, or articles not expressly specified in subdivision 4 are required to be included in a small employer plan. Nothing in subdivision 4 restricts the right of a health carrier to restrict coverage to those services, supplies, or articles which are medically necessary. Health carriers may exclude a benefit, service, supply, or article not expressly specified in subdivision 4 from a small employer plan.

Subd. 8. **CONTINUATION COVERAGE.** Small employer plans must include the continuation of coverage provisions required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law Number 99-272, as amended through December 31, 1991, and by state law.

Subd. 9. **DEPENDENT COVERAGE.** Other state law and rules applicable to health plan coverage of newborn infants, dependent children who do not reside with the eligible employee, handicapped children and dependents, and adopted children apply to a small employer plan. Health benefit plans that provide dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

Subd. 10. **MEDICAL EXPENSE REIMBURSEMENT.** Health carriers may reimburse or pay for medical services, supplies, or articles provided under a small employer plan in accordance with the health carrier's provider contract requirements including, but not limited to, salaried arrangements, capitation, the payment of usual and customary charges, fee schedules, discounts from fee-for-service, per diems, diagnostic-related groups (DRGs), and other payment arrangements. Nothing in this chapter requires a health carrier to develop, implement, or change its provider contract requirements for a small employer plan. Coinsurance, deductibles, out-of-pocket maximums, and maximum lifetime benefits must be calculated and determined in accordance with each health carrier's standard business practices.

Subd. 11. **PLAN DESIGN.** Notwithstanding any other law, regulation, or administrative interpretation to the contrary, health carriers may offer small employer plans through any provider arrangement, including, but not limited to, the use of open, closed, or limited provider networks. A health carrier may only use product and network designs currently allowed under existing statutory requirements. The provider networks offered by any health carrier may be specifically designed for the small employer market and may be modified at the carrier's election so long as all otherwise applicable regulatory requirements are met. Health carriers may use professionally recognized provider standards of

practice when they are available, and may use utilization management practices otherwise permitted by law, including, but not limited to, second surgical opinions, prior authorization, concurrent and retrospective review, referral authorizations, case management, and discharge planning. A health carrier may contract with groups of providers with respect to health care services or benefits, and may negotiate with providers regarding the level or method of reimbursement provided for services rendered under a small employer plan.

Subd. 12. **DEMONSTRATION PROJECTS.** Nothing in this chapter prohibits a health maintenance organization from offering a demonstration project authorized under section 62D.30. The commissioner of health may approve a demonstration project which offers benefits that do not meet the requirements of a small employer plan if the commissioner finds that the requirements of section 62D.30 are otherwise met.

Sec. 6. **[62L.06] DISCLOSURE OF UNDERWRITING RATING PRACTICES.**

When offering or renewing a health benefit plan, health carriers shall disclose in all solicitation and sales materials:

(1) the case characteristics and other rating factors used to determine initial and renewal rates;

(2) the extent to which premium rates for a small employer are established or adjusted based upon actual or expected variation in claim experience;

(3) provisions concerning the health carrier's right to change premium rates and the factors other than claim experience that affect changes in premium rates;

(4) provisions relating to renewability of coverage;

(5) the use and effect of any preexisting condition provisions, if permitted; and

(6) the application of any provider network limitations and their effect on eligibility for benefits.

Sec. 7. **[62L.07] SMALL EMPLOYER REQUIREMENTS.**

Subdivision 1. **VERIFICATION OF ELIGIBILITY.** Health benefit plans must require that small employers offering a health benefit plan maintain information verifying the continuing eligibility of the employer, its employees, and their dependents, and provide the information to health carriers on a quarterly basis or as reasonably requested by the health carrier.

Subd. 2. **WAIVERS.** Health benefit plans must require that small employers offering a health benefit plan maintain written documentation of a waiver of coverage by an eligible employee or dependent and provide the documentation to the health carrier upon reasonable request.

Sec. 8. **[62L.08] RESTRICTIONS RELATING TO PREMIUM RATES.**

Subdivision 1. **RATE RESTRICTIONS.** Premium rates for all health benefit plans sold or issued to small employers are subject to the restrictions specified in this section.

Subd. 2. **GENERAL PREMIUM VARIATIONS.** Beginning July 1, 1993, each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, industry of the employer, and duration of coverage from the date of issue. For purposes of this subdivision, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined to be actuarially valid and approved by the commissioner.

Subd. 3. **AGE-BASED PREMIUM VARIATIONS.** Beginning July 1, 1993, each health carrier may offer premium rates to small employers that vary based upon the ages of the eligible employees and dependents of the small employer only as provided in this subdivision. In addition to the variation permitted by subdivision 2, each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

Subd. 4. **GEOGRAPHIC PREMIUM VARIATIONS.** A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than twenty percent. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) if one geographic region is rural, the index rate for the rural region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area;

(4) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

Subd. 5. **GENDER-BASED RATES PROHIBITED.** Beginning July 1, 1993, no health carrier may determine premium rates through a method that is in any way based upon the gender of eligible employees or dependents.

Subd. 6. **RATE CELLS PERMITTED.** Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based on the number of adults and children covered under the policy and may reflect the availability of Medicare coverage.

Subd. 7. **INDEX AND PREMIUM RATE DEVELOPMENT.** In developing its index rates and premiums, a health carrier may take into account only the following factors:

(1) actuarially valid differences in benefit designs of health benefit plans;

(2) actuarially valid differences in the rating factors permitted in subdivisions 2 and 3;

(3) actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4.

Subd. 8. **FILING REQUIREMENT.** No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates.

Subd. 9. **EFFECT OF ASSESSMENTS.** Premium rates must comply with the rating requirements of this section, notwithstanding the imposition of any assessments or premiums paid by health carriers as provided under sections 62L.13 to 62L.22.

Subd. 10. **RATING REPORT.** Beginning January 1, 1995, and annually thereafter, the commissioners of health and commerce shall provide a joint report to the legislature on the effect of the rating restrictions required by this section and the appropriateness of proceeding with additional rate reform. Each report must include an analysis of the availability of health care coverage due to the rating reform, the equitable and appropriate distribution of risk and associated costs, the effect on the self-insurance market, and any resulting or anticipated change in health plan design and market share and availability of health carriers.

Sec. 9. **[62L.09] CESSATION OF SMALL EMPLOYER BUSINESS.**

Subdivision 1. **NOTICE TO COMMISSIONER.** A health carrier electing to cease doing business in the small employer market shall notify the commissioner 180 days prior to the effective date of the cessation. The cessation of business does not include the failure of a health carrier to offer or issue new business in the small employer market or continue an existing product line, provided that a health carrier does not terminate, cancel, or fail to renew its current small employer business or other product lines.

Subd. 2. **NOTICE TO EMPLOYERS.** A health carrier electing to cease doing business in the small employer market shall provide 120 days' written notice to each small employer covered by a health benefit plan issued by the health carrier. A health carrier that ceases to write new business in the small employer market shall continue to be governed by this chapter with respect to continuing small employer business conducted by the carrier.

Subd. 3. **REENTRY PROHIBITION.** A health carrier that ceases to do business in the small employer market after July 1, 1993, is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the small employer market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the small employer market in that same service area.

Subd. 4. **CONTINUING ASSESSMENT LIABILITY.** A health carrier that ceases to do business in the small employer market remains liable for assessments levied by the association as provided in section 62L.22.

Sec. 10. **[62L.10] SUPERVISION BY COMMISSIONER.**

Subdivision 1. **REPORTS.** A health carrier doing business in the small employer market shall file by April 1 of each year an annual actuarial opinion with the commissioner certifying that the health carrier complied with the underwriting and rating requirements of this chapter during the preceding year and that the rating methods used by the health carrier were actuarially sound. A health carrier shall retain a copy of the opinion at its principal place of business.

Subd. 2. **RECORDS.** A health carrier doing business in the small employer market shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

Subd. 3. **SUBMISSIONS TO COMMISSIONER.** Subsequent to the annual filing, the commissioner may request information and documentation from a health carrier describing its rating practices and renewal underwriting practices, including information and documentation that demonstrates that a health carrier's rating methods and practices are in accordance with sound actuarial principles and the requirements of this chapter. Except in cases of violations of this chapter or of another chapter, information received by the commissioner as provided under this subdivision is nonpublic.

Subd. 4. **REVIEW OF PREMIUM RATES.** The commissioner shall regulate premium rates charged or proposed to be charged by all health carriers in the small employer market under section 62A.02. The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.

Subd. 5. **TRANSITIONAL PRACTICES.** The commissioner shall disapprove index rates, premium variations, or other practices of a health carrier if they violate the spirit of this chapter and are the result of practices engaged in by the health carrier between the date of final enactment of this act and July 1,

1993, where the practices engaged in were carried out for the purpose of evading the spirit of this chapter. Each health carrier shall report to the commissioner, within 30 days and on a form prescribed by the commissioner, each cancellation, nonrenewal, or other termination of coverage of a small employer between the date of final enactment of this act and June 30, 1993. The health carrier shall provide any related information requested by the commissioner within the time specified in the request. Any health carrier that engages in a practice of terminating or inducing termination of coverage of small employers in order to evade the effects of this act, is guilty of an unfair method of competition and an unfair or deceptive act or practice in the business of insurance and is subject to the remedies provided in sections 72A.17 to 72A.32.

Sec. 11. **[62L.11] PENALTIES AND ENFORCEMENT.**

Subdivision 1. **DISCIPLINARY PROCEEDINGS.** The commissioner may, by order, suspend or revoke a health carrier's license or certificate of authority and impose a monetary penalty not to exceed $25,000 for each violation of this chapter, including the failure to pay an assessment required by section 62L.22. The notice, hearing, and appeal procedures specified in section 60A.051 or 62D.16, as appropriate, apply to the order. The order is subject to judicial review as provided under chapter 14.

Subd. 2. **ENFORCEMENT POWERS.** The commissioners of health and commerce each has for purposes of this chapter all of each commissioner's respective powers under other chapters that are applicable to their respective duties under this chapter.

Sec. 12. **[62L.12] PROHIBITED PRACTICES.**

Subdivision 1. **PROHIBITION ON ISSUANCE OF INDIVIDUAL POLICIES.** A health carrier operating in the small employer market shall not knowingly offer, issue, or renew an individual policy, subscriber contract, or certificate to an eligible employee or dependent of a small employer that meets the minimum participation requirements defined in section 62L.03, subdivision 3, except as authorized under subdivision 2.

Subd. 2. **EXCEPTIONS.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees and dependents.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees and dependents as required.

(e) A health carrier may sell, issue, or renew individual coverage if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group coverage or due to the person's need for health care services not covered under the employer's group policy.

(f) A health carrier may sell, issue, or renew an individual policy, with the prior consent of the commissioner, if the individual has elected to buy the individual coverage not as part of a general plan to substitute individual coverage for group coverage nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

Subd. 3. **AGENT'S LICENSURE.** An agent licensed under chapter 60A or section 62C.17 who knowingly and willfully breaks apart a small group for the purpose of selling individual policies to eligible employees and dependents of a small employer that meets the participation requirements of section 62L.03, subdivision 3, is guilty of an unfair trade practice and subject to the revocation or suspension of license under section 60A.17, subdivision 6c, or 62C.17. The action must be by order and subject to the notice, hearing, and appeal procedures specified in section 60A.17, subdivision 6d. The action of the commissioner is subject to judicial review as provided under chapter 14.

Subd. 4. **EMPLOYER PROHIBITION.** A small employer shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.

Subd. 5. **SALE OF OTHER PRODUCTS.** A health carrier shall not condition the offer, sale, issuance, or renewal of a health benefit plan on the purchase by a small employer of other insurance products offered by the health carrier or a subsidiary or affiliate of the health carrier, including, but not limited to, life, disability, property, and general liability insurance. This prohibition does not apply to insurance products offered as a supplement to a health maintenance organization plan, including, but not limited to, supplemental benefit plans under section 62D.05, subdivision 6.

Sec. 13. **[62L.13] REINSURANCE ASSOCIATION.**

Subdivision 1. **CREATION.** The health coverage reinsurance association is established as a nonprofit corporation. All health carriers in the small employer market shall be and remain members of the association as a condition of their authority to transact business.

Subd. 2. **PURPOSE.** The association is established to provide for the fair and equitable transfer of risk associated with participation by a health carrier in the small employer market to a private reinsurance pool established and maintained by the association.

Subd. 3. **EXEMPTIONS.** 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 13, 14, 60A, 62A to 62H, and section 471.705. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. Health carriers who are members of the association are exempt from the provisions of sections 325D.49 to 325D.66 in the performance of their duties as members of the association.

Subd. 4. **POWERS OF ASSOCIATION.** The association may exercise all of the powers of a corporation formed under chapter 317A, including, but not limited to, the authority to:

(1) establish operating rules, conditions, and procedures relating to the reinsurance of members' risks;

(2) assess members in accordance with the provisions of this section and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses;

(3) sue and be sued, including taking any legal action necessary to recover any assessments;

(4) enter into contracts necessary to carry out the provisions of this chapter;

(5) establish operating, administrative, and accounting procedures for the operation of the association; and

(6) borrow money against the future receipt of premiums and assessments up to the amount of the previous year's assessment, with the prior approval of the commissioner.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association shall adopt bylaws and shall be governed in accordance with this chapter and chapter 317A.

Subd. 5. **SUPERVISION BY COMMISSIONER.** The commissioner of commerce shall supervise the association in accordance with this chapter. The commissioner of commerce may examine the association. The association's reinsurance policy forms, its contracts, its premium rates, and its assessments are subject to the approval of the commissioner of commerce. The association's policy forms, contracts, and premium rates are deemed approved if not disapproved by the commissioner of commerce within 60 days after the date of filing them with the commissioner of commerce. The association's assessments are deemed approved if not disapproved by the commissioner of commerce within 15 business days after filing them with the commissioner of commerce. The association shall notify the commissioner of all association or board meetings, and the commissioner or the commissioner's designee may attend all association or board meetings. The association shall file an annual report with the commissioner on or before July 1 of each year, beginning July 1, 1994, describing its activities during the preceding calendar year. The report must include a financial report and a summary of claims paid by the association. The annual report must be available for public inspection.

Sec. 14. **[62L.14] BOARD OF DIRECTORS.**

Subdivision 1. **COMPOSITION OF BOARD.** The association shall exercise its powers through a board of 13 directors. Four members must be public members appointed by the commissioner. The public members must not be employees of or otherwise affiliated with any member of the association. The nonpublic members of the board must be representative of the membership of the association and must be officers, employees, or directors of the members during their term of office. No member of the association may have more than three members of the board. Directors are automatically removed if they fail to satisfy this qualification.

Subd. 2. **ELECTION OF BOARD.** On or before July 1, 1992, the commissioner shall appoint an interim board of directors of the association who shall serve through the first annual meeting of the members and for the next two years. Except for the public members, the commissioner's initial appointments must be equally apportioned among the following three categories: accident and health insurance companies, nonprofit health service plan corporations, and health maintenance organizations. Thereafter, members of the association shall elect the board of directors in accordance with this chapter and the bylaws of the association, subject to approval by the commissioner. Members of the association may vote in person or by proxy. The public members shall continue to be appointed by the commissioner.

Subd 3. **TERM OF OFFICE.** The first annual meeting must be held by December 1, 1992. After the initial two-year period, each director shall serve a three-year term, except that the board shall make appropriate arrangements to stagger the terms of the board members so that approximately one-third of the terms expire each year. Each director shall hold office until expiration of the director's term or until the director's successor is duly elected or appointed and qualified, or until the director's death, resignation, or removal.

Subd. 4. **RESIGNATION AND REMOVAL.** A director may resign at any time by giving written notice to the commissioner. The resignation takes effect at the time the resignation is received unless the resignation specifies a later date. A nonpublic director may be removed at any time, with cause, by the members.

Subd. 5. **QUORUM.** A majority of the members of the board of directors constitutes a quorum for the transaction of business. If a vacancy exists by reason of death, resignation, or otherwise, a majority of the remaining directors constitutes a quorum.

Subd. 6. **DUTIES OF DIRECTORS.** The board of directors shall adopt or amend the association's bylaws. The bylaws may contain any provision for the purpose of administering the association that is not inconsistent with this chapter. The board shall manage the association in furtherance of its purposes and as provided in its bylaws. On or before January 1, 1993, the board or the interim board shall develop a plan of operation and reasonable operating rules to assure the fair, reasonable, and equitable administration of the association. The plan of operation must include the development of procedures for selecting an administering carrier, establishment of the powers and duties of the administering carrier, and establishment of procedures for collecting assessments from members, including the imposition of interest penalties for late payments of assessments. The plan of operation must be submitted to the commissioner for review and approval and must be submitted to the members for approval at the first meeting of the members. The board of directors may subsequently amend, change, or revise the plan of operation without approval by the members.

Subd. 7. **COMPENSATION.** Members of the board may be reimbursed by the association for reasonable and necessary expenses incurred by them in performing their duties as directors, but shall not otherwise be compensated by the association for their services.

Subd. 8. **OFFICERS.** The board may elect officers and establish committees as provided in the bylaws of the association. Officers have the authority and duties in the management of the association as prescribed by the bylaws and determined by the board of directors.

Subd. 9. **MAJORITY VOTE.** Approval by a majority of the board members present is required for any action of the board. The majority vote must include one vote from a board member representing an accident and health insurance company, one vote from a board member representing a health service plan corporation, one vote from a board member representing a health maintenance organization, and one vote from a public member.

Sec. 15. **[62L.15] MEMBERS.**

Subdivision 1. **ANNUAL MEETING.** The association shall conduct an annual meeting of the members of the association for the purpose of electing directors and transacting any other appropriate business of the membership of the association. The board shall determine the date, time, and place of the annual meeting. The association shall conduct its first annual member meeting on or before December 1, 1992.

Subd. 2. **SPECIAL MEETINGS.** Special meetings of the members must be held whenever called by any three of the directors. At least two categories must be represented among the directors calling a special meeting of the members. The categories are accident and health insurance companies, nonprofit health service plan corporations, and health maintenance organizations. Special meetings of the members must be held at a time and place designated in the notice of the meeting.

Subd. 3. **MEMBER VOTING.** Each member's vote is a weighted vote and is based on each member's total insurance premiums, subscriber contract charges, health maintenance contract payments, or other health benefit plan revenue derived from, or on behalf of, small employers during the preceding calendar year, as determined by the board and approved by the commissioner, based on annual statements and other reports considered necessary by the board of directors.

Subd. 4. **INITIAL MEMBER MEETING.** At least 60 days before the first annual meeting of the members, the commissioner shall give written notice to all members of the time and place of the member meeting. The members shall elect directors representing the members, approve the initial plan of operation of the association, and transact any other appropriate business of the membership of the association.

Subd. 5. **MEMBER COMPLIANCE.** All members shall comply with the provisions of this chapter, the association's bylaws, the plan of operation developed by the board of directors, and any other operating, administrative, or other procedures established by the board of directors for the operation of the association. The board may request the commissioner to secure compliance with this chapter through the use of any enforcement action otherwise available to the commissioner.

Sec. 16. **[62L.16] ADMINISTRATION OF ASSOCIATION.**

Subdivision 1. **ADMINISTRATOR.** The association shall contract with a qualified entity to operate and administer the association. If there is no available qualified entity, or in the event of a termination under subdivision 2, the association may directly operate and administer the reinsurance program. The administrator shall perform all administrative functions required by this chapter. The board of directors shall develop administrative functions required by this chapter and written criteria for the selection of an administrator. The administrator must be selected by the board of directors, subject to approval by the commissioner.

Subd. 2. **TERM.** The administrator shall serve for a period of three years, unless the administrator requests the termination of its contract and the termination is approved by the board of directors. The board of directors shall approve or deny a request to terminate within 90 days of its receipt after consultation with the commissioner. A failure to make a final decision on a request to terminate within 90 days is considered an approval.

Subd. 3. **DUTIES OF ADMINISTRATOR.** The association shall enter into a written contract with the administrator to carry out its duties and responsibilities. The administrator shall perform all administrative functions required by this chapter including the:

(1) preparation and submission of an annual report to the commissioner;

(2) preparation and submission of monthly reports to the board of directors;

(3) calculation of all assessments and the notification thereof of members;

(4) payment of claims to health carriers following the submission by health carriers of acceptable claim documentation; and

(5) provision of claim reports to health carriers as determined by the board of directors.

Subd. 4. **BID PROCESS.** The association shall issue a request for proposal for administration of the reinsurance association and shall solicit responses from health carriers participating in the small employer market and from other qualified entities. Methods of compensation of the administrator must be a part of the bid process. The administrator shall substantiate its cost reports consistent with generally accepted accounting principles.

Subd. 5. **AUDITS.** The board of directors may conduct periodic audits to verify the accuracy of financial data and reports submitted by the administrator.

Subd. 6. **RECORDS OF ASSOCIATION.** The association shall maintain appropriate records and documentation relating to the activities of the association. All individual patient-identifying claims data and information are confidential and not subject to disclosure of any kind, except that a health carrier shall have access upon request to individual claims data relating to eligible employees and dependents covered by a health benefit plan issued by the health carrier. All records, documents, and work product prepared by the association or by the administrator for the association are the property of the association. The commissioner shall have access to the data for the purposes of carrying out the supervisory functions provided for in this chapter.

Sec. 17. **[62L.17] PARTICIPATION IN THE REINSURANCE ASSOCIATION.**

Subdivision 1. **MINIMUM STANDARDS.** The board of directors or the interim board shall establish minimum claim processing and managed care standards which must be met by a health carrier in order to reinsure business.

Subd. 2. **PARTICIPATION.** A health carrier may elect to not participate in the reinsurance association through transferring risk only after filing an application with the commissioner of commerce. The commissioner may approve the application after consultation with the board of directors. In determining whether to approve an application, the commissioner shall consider whether the health carrier meets the following standards:

(1) demonstration by the health carrier of a substantial and established market presence;

(2) demonstrated experience in the small group market and history of rating and underwriting small employer groups;

(3) commitment to comply with the requirements of this chapter for small employers in the state or its service area; and

(4) financial ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance.

Initial application for nonparticipation must be filed with the commissioner no later than February 1993. The commissioner shall make the determination and notify the carrier no later than April 15, 1993.

Subd. 3. **LENGTH OF PARTICIPATION.** A health carrier's initial election is for a period of two years. Subsequent elections of participation are for five-year periods.

Subd. 4. **APPEAL.** A health carrier whose application for nonparticipation has been rejected by the commissioner may appeal the decision. The association may also appeal a decision of the commissioner, if approved by a two-thirds majority of the board. Chapter 14 applies to all appeals.

Subd. 5. **ANNUAL CERTIFICATION.** A health carrier that has received approval to not participate in the reinsurance association shall annually certify to the commissioner on or before December 1 that it continues to meet the standards described in subdivision 2.

Subd. 6. **SUBSEQUENT ELECTION.** Election to participate in the reinsurance association must occur on or before December 31 of each year. If after a period of nonparticipation, the nonparticipating health carrier subsequently elects to participate in the reinsurance association, the health carrier retains the risk it assumed when not participating in the association.

If a participating health carrier subsequently elects to not participate in the reinsurance association, the health carrier shall cease reinsuring through the association all of its small employer business and is liable for any assessment described in section 62L.22 which has been prorated based on the business covered by the reinsurance mechanism during the year of the assessment.

Subd. 7. **ELECTION MODIFICATION.** The commissioner, after consultation with the board, may authorize a health carrier to modify its election to not participate in the association at any time, if the risk from the carrier's existing small employer business jeopardizes the financial condition of the health carrier. If the commissioner authorizes a health carrier to participate in the association, the health carrier shall retain the risk it assumed while not participating in the association. This election option may not be exercised if the health carrier is in rehabilitation.

Sec. 18. **[62L.18] CEDING OF RISK.**

Subdivision 1. **PROSPECTIVE CEDING.** For health benefit plans issued on or after July 1, 1993, all health carriers participating in the association may prospectively reinsure an employee or dependent within a small employer group and entire employer groups of seven or fewer eligible employees. A health carrier must determine whether to reinsure an employee or dependent or entire group within 60 days of the commencement of the coverage of the small employer and must notify the association during that time period.

Subd. 2. **ELIGIBILITY FOR REINSURANCE.** A health carrier may not reinsure existing small employer business through the association. A health carrier may reinsure an employee or dependent who previously had coverage from MCHA who is now eligible for coverage through the small employer group at the time of enrollment as defined in section 62L.03, subdivision 6. A health carrier may not reinsure individuals who have existing individual health care coverage with that health carrier upon replacement of the individual coverage with group coverage as provided in section 62L.04, subdivision 1.

Subd. 3. **REINSURANCE TERMINATION.** A health carrier may terminate reinsurance through the association for an employee or dependent or entire group on the anniversary date of coverage for the small employer. If the health carrier terminates the reinsurance, the health carrier may not subsequently reinsure the individual or entire group.

Subd. 4. **CONTINUING CARRIER RESPONSIBILITY.** A health carrier transferring risk to the association is completely responsible for administering its health benefit plans. A health carrier shall apply its case management and claim processing techniques consistently between reinsured and nonreinsured business. Small employers, eligible employees, and dependents shall not be notified that the health carrier has reinsured their coverage through the association.

Sec. 19. **[62L.19] ALLOWED REINSURANCE BENEFITS.**

A health carrier may reinsure through the association only those benefits described in section 62L.05.

Sec. 20. **[62L.20] TRANSFER OF RISK.**

Subdivision 1. **REINSURANCE THRESHOLD.** A health carrier participating in the association may transfer up to 90 percent of the risk above a reinsurance threshold of $5,000 of eligible charges resulting from issuance of a health benefit plan to an eligible employee or dependent of a small employer group whose risk has been prospectively ceded to the association. If the eligible charges exceed $50,000, a health carrier participating in the association may transfer 100 percent of the risk each policy year not to exceed 12 months.

Satisfaction of the reinsurance threshold must be determined by the board of directors based on eligible charges. The board may establish an audit process

to assure consistency in the submission of charge calculations by health carriers to the association.

Subd. 2. **CONVERSION FACTORS.** The board shall establish a standardized conversion table for determining equivalent charges for health carriers that use alternative provider reimbursement methods. If a health carrier establishes to the board that the carrier's conversion factor is equivalent to the association's standardized conversion table, the association shall accept the health carrier's conversion factor.

Subd. 3. **BOARD AUTHORITY.** The board shall establish criteria for changing the threshold amount or retention percentage. The board shall review the criteria on an annual basis. The board shall provide the members with an opportunity to comment on the criteria at the time of the annual review.

Subd. 4. **NOTIFICATION OF TRANSFER OF RISK.** A participating health carrier must notify the association, within 90 days of receipt of proof of loss, of satisfaction of a reinsurance threshold. After satisfaction of the reinsurance threshold, a health carrier continues to be liable to its providers, eligible employees, and dependents for payment of claims in accordance with the health carrier's health benefit plan. Health carriers shall not pend or delay payment of otherwise valid claims due to the transfer of risk to the association.

Subd. 5. **PERIODIC STUDIES.** The board shall, on a biennial basis, prepare and submit a report to the commissioner of commerce on the effect of the reinsurance association on the small employer market. The first study must be presented to the commissioner no later than January 1, 1995, and must specifically address whether there has been disruption in the small employer market due to unnecessary churning of groups for the purpose of obtaining reinsurance and whether it is appropriate for health carriers to transfer the risk of their existing small group business to the reinsurance association. After two years of operation, the board shall study both the effect of ceding both individuals and entire small groups of seven or fewer eligible employees to the reinsurance association and the composition of the board and determine whether the initial appointments reflect the types of health carriers participating in the reinsurance association and whether the voting power of members of the association should be weighted and recommend any necessary changes.

Sec. 21. **[62L.21] REINSURANCE PREMIUMS.**

Subdivision 1. **MONTHLY PREMIUM.** A health carrier ceding an individual to the reinsurance association shall be assessed a monthly reinsurance coverage premium that is 5.0 times the adjusted average market price. A health carrier ceding an entire group to the reinsurance association shall be assessed a monthly reinsurance coverage premium that is 1.5 times the adjusted average market price. The adjusted average market premium price must be established by the board of directors in accordance with its plan of operation. The board may consider benefit levels in establishing the reinsurance coverage premium.

Subd. 2. **ADJUSTMENT OF PREMIUM RATES.** The board of directors shall establish operating rules to allocate adjustments to the reinsurance premium charge of no more than minus 25 percent of the monthly reinsurance premium for health carriers that can demonstrate administrative efficiencies and cost-effective handling of equivalent risks. The adjustment must be made annually on a retrospective basis. The operating rules must establish objective and measurable criteria which must be met by a health carrier in order to be eligible for an adjustment. These criteria must include consideration of efficiency attributable to case management, but not consideration of such factors as provider discounts.

Subd. 3. **LIABILITY FOR PREMIUM.** A health carrier is liable for the cost of the reinsurance premium and may not directly charge the small employer for the costs. The reinsurance premium may be reflected only in the rating factors permitted in section 62L.08, as provided in section 62L.08, subdivision 10.

Sec. 22. **[62L.22] ASSESSMENTS.**

Subdivision 1. **ASSESSMENT BY BOARD.** For the purpose of providing the funds necessary to carry out the purposes of the association, the board of directors shall assess members as provided in subdivisions 2, 3, and 4 at the times and for the amounts the board of directors finds necessary. Assessments are due and payable on the date specified by the board of directors, but not less than 30 days after written notice to the member. Assessments accrue interest at the rate of six percent per year on or after the due date.

Subd. 2. **INITIAL CAPITALIZATION.** The interim board of directors shall determine the initial capital operating requirements for the association. The board shall assess each licensed health carrier $100 for the initial capital requirements of the association. The assessment is due and payable no later than January 1, 1993.

Subd. 3. **RETROSPECTIVE ASSESSMENT.** On or before July 1 of each year, the administering carrier shall determine the association's net loss, if any, for the previous calendar year, the program expenses of administration, and other appropriate gains and losses. If reinsurance premium charges are not sufficient to satisfy the operating and administrative expenses incurred or estimated to be incurred by the association, the board of directors shall assess each member participating in the association in proportion to each member's respective share of the total insurance premiums, subscriber contract payments, health maintenance organization payments, and other health benefit plan revenue derived from or on behalf of small employers during the preceding calendar year. The assessments must be calculated by the board of directors based on annual statements and other reports considered necessary by the board of directors and filed by members with the association. The amount of the assessment shall not exceed four percent of the member's small group market premium. In establishing this assessment, the board shall consider a formula based on total small employer premiums earned and premiums earned from newly issued small employer plans. A member's assessment may not be reduced or increased by

more than 50 percent as a result of using that formula, which includes a reasonable cap on assessments on any premium category or premium classification. The board of directors may provide for interim assessments as it considers necessary to appropriately carry out the association's responsibilities. The board of directors may establish operating rules to provide for changes in the assessment calculation.

Subd. 4. **ADDITIONAL ASSESSMENTS.** If the board of directors determines that the retrospective assessment formula described in subdivision 3 is insufficient to meet the obligations of the association, the board of directors shall assess each member not participating in the reinsurance association, but which is providing health plan coverage in the small employer market, in proportion to each member's respective share of the total insurance premiums, subscriber contract payments, health maintenance organization payments, and other health benefit plan revenue derived from or on behalf of small employers during the preceding calendar year. The assessment must be calculated by the board of directors based on annual statements and other reports considered necessary by the board of directors and filed by members with the association. The amount of the assessment may not exceed one percent of the member's small group market premium. Members who paid the retrospective assessment described in subdivision 3 are not subject to the additional assessment.

If the additional assessment is insufficient to meet the obligations of the association, the board of directors may assess members participating in the association who paid the retrospective assessment described in subdivision 3 up to an additional one percent of the member's small group market premium.

Subd. 5. **ABATEMENT OR DEFERMENT.** The association may abate or defer, in whole or in part, the retrospective assessment of a member if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations or the member is placed under an order of rehabilitation, liquidation, receivership, or conservation by a court of competent jurisdiction. In the event that a retrospective assessment against a member is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against other members in accordance with the methodology specified in subdivisions 3 and 4.

Subd. 6. **REFUND.** The board of directors may refund to members, in proportion to their contributions, the amount by which the assets of the association exceed the amount the board of directors finds necessary to carry out its responsibilities during the next calendar year. A reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses.

Subd. 7. **APPEALS.** A health carrier may appeal to the commissioner of commerce within 30 days of notice of an assessment by the board of directors. A final action or order of the commissioner is subject to judicial review in the manner provided in chapter 14.

Subd. 8. **LIABILITY FOR ASSESSMENT.** Employer liability for other costs of a health carrier resulting from assessments made by the association under this section are limited by the rate spread restrictions specified in section 62L.08.

Sec. 23. **[62L.23] LOSS RATIO STANDARDS.**

Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, each policy or contract form used with respect to a health benefit plan offered, or issued in the small employer market, is subject, beginning July 1, 1993, to section 62A.021. The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.

Sec. 24. **COMMISSIONER OF COMMERCE STUDY.**

The commissioner of commerce shall study and provide a written report and recommendations to the legislature that analyze the effects of this article and future measures that the legislature could enact to achieve the purpose set forth in section 62L.01, subdivision 3. The commissioner shall study, report, and make recommendations on the following:

(1) the effects of this article on availability of coverage, average premium rates, variations in premium rates, the number of uninsured and underinsured residents of this state, the types of health benefit plans chosen by employers, and other effects on the market for health benefit plans for small employers;

(2) the desirability and feasibility of achieving the goal stated in section 62L.01, subdivision 3, in the small employer market by means of the following timetable:

(i) as of July 1, 1995, a reduction of the age rating bands to 30 percent on each side of the index rate, accompanied by a proportional reduction of the general premium rating bands to 15 percent on each side of the index rate;

(ii) as of July 1, 1996, a reduction in the bands referenced in the preceding clause to 15 percent and 7.5 percent respectively; and

(iii) as of July 1, 1997, a ban on all rating bands; and

(3) Any other aspects of the small employer market considered relevant by the commissioner.

The commissioner shall file the written report and recommendations with the legislature no later than December 1, 1994.

Sec. 25. **EFFECTIVE DATES.**

Sections 1 to 12 and 23 are effective July 1, 1993, except that section 10, subdivision 5, is effective the day following final enactment. Sections 13 to 22 are effective the day following final enactment.

ARTICLE 3

INSURANCE REFORM: INDIVIDUAL MARKET AND MISCELLANEOUS

Section 1. **[43A.317] PRIVATE EMPLOYERS INSURANCE PROGRAM.**

Subdivision 1. **INTENT.** The legislature finds that the creation of a statewide program to provide employers with the advantages of a large pool for insurance purchasing would advance the welfare of the citizens of the state.

Subd. 2. **DEFINITIONS.** (a) **SCOPE.** For the purposes of this section, the terms defined have the meaning given them.

(b) **COMMISSIONER.** "Commissioner" means the commissioner of employee relations.

(c) **ELIGIBLE EMPLOYEE.** "Eligible employee" means an employee eligible to participate in the program under the terms described in subdivision 6.

(d) **ELIGIBLE EMPLOYER.** "Eligible employer" means an employer eligible to participate in the program under the terms described in subdivision 5.

(e) **ELIGIBLE INDIVIDUAL.** "Eligible individual" means a person eligible to participate in the program under the terms described in subdivision 6.

(f) **EMPLOYEE.** "Employee" means a common law employee of an eligible employer.

(g) **EMPLOYER.** "Employer" means a private person, firm, corporation, partnership, association, unit of local government, or other entity actively engaged in business or public services. "Employer" includes both for-profit and nonprofit entities.

(h) **PROGRAM.** "Program" means the private employers insurance program created by this section.

Subd. 3. **ADMINISTRATION.** The commissioner shall, consistent with the provisions of this section, administer the program and determine its coverage options, funding and premium arrangements, contractual arrangements, and all other matters necessary to administer the program. The commissioner's contracting authority for the program, including authority for competitive bidding and negotiations, is governed by section 43A.23.

Subd. 4. **ADVISORY COMMITTEE.** The commissioner shall establish a ten-member advisory committee that includes five members who represent eligible employers and five members who represent eligible individuals. The committee shall advise the commissioner on issues related to administration of the program. The committee is governed by sections 15.014 and 15.059, and continues to exist while the program remains in operation.

Subd. 5. **EMPLOYER ELIGIBILITY.** (a) **PROCEDURES.** All employers are eligible for coverage through the program subject to the terms of this subdivision. The commissioner shall establish procedures for an employer to apply for coverage through the program.

(b) **TERM.** The initial term of an employer's coverage will be two years from the effective date of the employer's application. After that, coverage will be automatically renewed for additional two-year terms unless the employer gives notice of withdrawal from the program according to procedures established by the commissioner or the commissioner gives notice to the employer of the discontinuance of the program. The commissioner may establish conditions under which an employer may withdraw from the program prior to the expiration of a two-year term, including by reason of a midyear increase in health coverage premiums of 50 percent or more. An employer that withdraws from the program may not reapply for coverage for a period of two years from its date of withdrawal.

(c) **MINNESOTA WORK FORCE.** An employer is not eligible for coverage through the program if five percent or more of its eligible employees work primarily outside Minnesota, except that an employer may apply to the program on behalf of only those employees who work primarily in Minnesota.

(d) **EMPLOYEE PARTICIPATION; AGGREGATION OF GROUPS.** An employer is not eligible for coverage through the program unless its application includes all eligible employees who work primarily in Minnesota, except employees who waive coverage as permitted by subdivision 6. Private entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer, except as otherwise approved by the commissioner.

(e) **PRIVATE EMPLOYER.** A private employer is not eligible for coverage unless it has two or more eligible employees in the state of Minnesota. If an employer has only two eligible employees, one employee must not be the spouse, child, sibling, parent, or grandparent of the other.

(f) **MINIMUM PARTICIPATION.** The commissioner must require as a condition of employer eligibility that at least 75 percent of its eligible employees who have not waived coverage participate in the program. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. For purposes of this section, waiver of coverage includes only waivers due to coverage under another group health benefit plan.

(g) **EMPLOYER CONTRIBUTION.** The commissioner must require as a condition of employer eligibility that the employer contribute at least 50 percent toward the cost of the premium of the employee and may require that the contribution toward the cost of coverage is structured in a way that promotes price competition among the coverage options available through the program.

(h) **ENROLLMENT CAP.** The commissioner may limit employer enrollment in the program if necessary to avoid exceeding the program's reserve capacity.

Subd. 6. **INDIVIDUAL ELIGIBILITY.** (a) **PROCEDURES.** The commissioner shall establish procedures for eligible employees and other eligible individuals to apply for coverage through the program.

(b) **EMPLOYEES.** An employer shall determine when it applies to the program the criteria its employees must meet to be eligible for coverage under its plan. An employer may subsequently change the criteria annually or at other times with approval of the commissioner. The criteria must provide that new employees become eligible for coverage after a probationary period of at least 30 days, but no more than 90 days.

(c) **OTHER INDIVIDUALS.** An employer may elect to cover under its plan:

(1) the spouse, dependent children, and dependent grandchildren of a covered employee;

(2) a retiree who is eligible to receive a pension or annuity from the employer and a covered retiree's spouse, dependent children, and dependent grandchildren;

(3) the surviving spouse, dependent children, and dependent grandchildren of a deceased employee or retiree, if the spouse, children, or grandchildren were covered at the time of the death;

(4) a covered employee who becomes disabled, as provided in sections 62A.147 and 62A.148; or

(5) any other categories of individuals for whom group coverage is required by state or federal law.

An employer shall determine when it applies to the program the criteria individuals in these categories must meet to be eligible for coverage. An employer may subsequently change the criteria annually, or at other times with approval of the commissioner. The criteria for dependent children and dependent grandchildren may be no more inclusive than the criteria under section 43A.18, subdivision 2. This paragraph shall not be interpreted as relieving the program from compliance with any federal and state continuation of coverage requirements.

(d) **WAIVER AND LATE ENTRANCE.** An eligible individual may waive coverage at the time the employer joins the program or when coverage first becomes available. The commissioner may establish a preexisting condition exclusion of not more than 18 months for late entrants as defined in section 62L.02, subdivision 19.

(e) **CONTINUATION COVERAGE.** The program shall provide all continuation coverage required by state and federal law.

Subd. 7. **COVERAGE.** Coverage is available through the program begin-

ning on July 1, 1993. At least annually, the commissioner shall solicit bids from carriers regulated under chapters 62A, 62C, and 62D, to provide coverage of eligible individuals. The commissioner shall provide coverage through contracts with carriers, unless the commissioner receives no reasonable bids from carriers.

(a) **HEALTH COVERAGE.** Health coverage is available to all employers in the program. The commissioner shall attempt to establish health coverage options that have strong care management features to control costs and promote quality and shall attempt to make a choice of health coverage options available. Health coverage for a retiree who is eligible for the federal Medicare program must be administered as though the retiree is enrolled in Medicare parts A and B. To the extent feasible as determined by the commissioner and in the best interests of the program, the commissioner shall model coverage after the plan established in section 43A.18, subdivision 2. Health coverage must include at least the benefits required of a carrier regulated under chapter 62A, 62C, or 62D for comparable coverage. Coverage under this paragraph must not be provided as part of the health plans available to state employees.

(b) **OPTIONAL COVERAGES.** In addition to offering health coverage, the commissioner may arrange to offer dental coverage through the program. Employers with health coverage may choose to offer dental coverage according to the terms established by the commissioner.

(c) **OPEN ENROLLMENT.** The program must meet all underwriting requirements of chapter 62L and must provide periodic open enrollments for eligible individuals for those coverages where a choice exists.

(d) **TECHNICAL ASSISTANCE.** The commissioner may arrange for technical assistance and referrals for eligible employers in areas such as health promotion and wellness, employee benefits structure, tax planning, and health care analysis services as described in section 62J.33.

Subd. 8. **PREMIUMS.** (a) **PAYMENTS.** Employers enrolled in the program shall pay premiums according to terms established by the commissioner. If an employer fails to make the required payments, the commissioner may cancel coverage and pursue other civil remedies.

(b) **RATING METHOD.** The commissioner shall determine the premium rates and rating method for the program. The rating method for eligible small employers must meet or exceed the requirements of chapter 62L. The rating methods must recover in premiums all of the ongoing costs for state administration and for maintenance of a premium stability and claim fluctuation reserve. Premiums must be established so as to recover and repay within five years after July 1, 1993, any direct appropriations received to provide start-up administrative costs. Premiums must be established so as to recover and repay within five years after July 1, 1993, any direct appropriations received to establish initial reserves.

(c) **TAXES AND ASSESSMENTS.** To the extent that the program operates

as a self-insured group, the premiums paid to the program are not subject to the premium taxes imposed by sections 60A.15 and 60A.198, but the program is subject to a Minnesota comprehensive health association assessment under section 62E.11.

Subd. 9. **PRIVATE EMPLOYERS INSURANCE TRUST FUND.** (a) **CONTENTS.** The private employer insurance trust fund in the state treasury consists of deposits received from eligible employers and individuals, contractual settlements or rebates relating to the program, investment income or losses, and direct appropriations.

(b) **APPROPRIATION.** All money in the fund is appropriated to the commissioner to pay insurance premiums, approved claims, refunds, administrative costs, and other costs necessary to administer the program.

(c) **RESERVES.** For any coverages for which the program does not contract to transfer full financial responsibility, the commissioner shall establish and maintain reserves:

(1) for claims in process, incomplete and unreported claims, premiums received but not yet earned, and all other accrued liabilities; and

(2) to ensure premium stability and the timely payment of claims in the event of adverse claims experience. The reserve for premium stability and claim fluctuations must be established according to the standards of section 62C.09, subdivision 3, except that the reserve may exceed the upper limit under this standard until July 1, 1997.

(d) **INVESTMENTS.** The state board of investment shall invest the fund's assets according to section 11A.24. Investment income and losses attributable to the fund must be credited to the fund.

Subd. 10. **PROGRAM STATUS.** The private employers insurance program is a state program to provide the advantages of a large pool to small employers for purchasing health coverage, other coverages, and related services from insurance companies, health maintenance organizations, and other organizations. The program is not an insurance company. Coverage under this program shall be considered a certificate of insurance or similar evidence of coverage and is subject to all applicable requirements of chapters 60A, 62A, 62C, 62E, 62H, 62L, and 72A, and is subject to regulation by the commissioner of commerce to the extent applicable. Coverage is subject to section 471.617, subdivisions 2 and 3, and the bidding requirements of section 471.6161.

Subd. 11. **EVALUATION.** The commissioner shall report to the legislature on December 15, 1995. The report must provide a detailed summary of all direct and indirect administrative costs associated with the program, and must include an analysis of whether the program (1) is providing coverage to persons who would otherwise be unable to purchase coverage in the private sector; (2) will provide coverage at lower premium costs without ongoing state subsidy; (3)

will provide coverage to persons in geographic areas of the state where coverage options would otherwise be limited; and (4) will fulfill the intent of the legislature.

Sec. 2. **[62A.011] DEFINITIONS.**

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

Subd. 2. **HEALTH CARRIER.** "Health carrier" means 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; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H.

Subd. 3. **HEALTH PLAN.** "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified.

Sec. 3. Minnesota Statutes 1990, section 62A.02, subdivision 1, is amended to read:

Subdivision 1. **FILING.** No ~~policy of accident and sickness insurance~~ health plan as defined in section 62A.011 shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection ~~therewith~~ with the health plan, until a copy of ~~the~~ its form ~~thereof~~ and of the classification of risks and the premium rates pertaining ~~thereto~~ to the form have been filed with the commissioner. The filing for nongroup ~~policies~~ health plan forms shall include a statement of actuarial reasons and data to support the ~~need for any premium~~ rate ~~increase~~. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

Sec. 4. Minnesota Statutes 1990, section 62A.02, subdivision 2, is amended to read:

Subd. 2. **APPROVAL.** ~~No such policy~~ The health plan form shall not be issued, nor shall any application, rider, ~~or~~ endorsement, or rate be used in connection ~~therewith~~ with it, until the expiration of 60 days after it has been ~~so~~ filed unless the commissioner ~~shall sooner give written approval thereto~~ approves it before that time.

Sec. 5. Minnesota Statutes 1990, section 62A.02, subdivision 3, is amended to read:

Subd. 3. **STANDARDS FOR DISAPPROVAL.** The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

(1) if the benefits provided ~~therein~~ are ~~unreasonable~~ not reasonable in relation to the premium charged;

(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the ~~policy~~ health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A; ~~or~~

(3) if the proposed premium rate is excessive ~~because the insurer has failed to exercise reasonable cost control~~ or not adequate; or

(4) the actuarial reasons and data submitted do not justify the rate.

The party proposing a rate has the burden of proving by a preponderance of the evidence that it does not violate this subdivision.

In determining the reasonableness of a rate, the commissioner shall also review all administrative contracts, service contracts, and other agreements to determine the reasonableness of the cost of the contracts or agreement and effect of the contracts on the rate. If the commissioner determines that a contract or agreement is not reasonable, the commissioner shall disapprove any rate that reflects any unreasonable cost arising out of the contract or agreement. The commissioner may require any information that the commissioner deems necessary to determine the reasonableness of the cost.

For the purposes of ~~clause (1)~~ this subdivision, the commissioner shall establish by rule a schedule of minimum anticipated loss ratios which shall be based on (i) the type or types of coverage provided, (ii) whether the policy is for group or individual coverage, and (iii) the size of the group for group policies. Except for individual policies of disability or income protection insurance, the minimum anticipated loss ratio shall not be less than 50 percent after the first year that a policy is in force. All applicants for a policy shall be informed in writing at the time of application of the anticipated loss ratio of the policy. ~~For the purposes of this subdivision,~~ "Anticipated loss ratio" means the ratio at the time of ~~form~~ filing, at the time of notice of withdrawal under subdivision 4a, or

at the time of subsequent rate revision of the present value of all expected future benefits, excluding dividends, to the present value of all expected future premiums. ~~Nothing in this paragraph shall prohibit the commissioner from disapproving a form which meets the requirements of this paragraph but which the commissioner determines still provides benefits which are unreasonable in relation to the premium charged.~~

If the commissioner notifies ~~an insurer which~~ a health carrier that has filed any form or rate that ~~the form~~ it does not comply with ~~the provisions of~~ this ~~section or sections 62A.03 to 62A.05 and 72A.20~~ chapter, chapter 62L, or chapter 72A, it shall be unlawful ~~thereafter~~ for the ~~insurer~~ health carrier to issue or use the form or ~~use it in connection with any policy~~ rate. In the notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the ~~insurer~~ health carrier.

The 60-day period within which the commissioner is to approve or disapprove the form or rate does not begin to run until a complete filing of all data and materials required by statute or requested by the commissioner has been submitted.

However, if the supporting data is not filed within 30 days after a request by the commissioner, the rate is not effective and is presumed to be an excessive rate.

Sec. 6. Minnesota Statutes 1990, section 62A.02, is amended by adding a subdivision to read:

Subd. 4a. **WITHDRAWAL OF APPROVAL.** The commissioner may, at any time after a 20-day written notice has been given to the insurer, withdraw approval of any form or rate that has previously been approved on any of the grounds stated in this section. It is unlawful for the health carrier to issue a form or rate or use it in connection with any health plan after the effective date of the withdrawal of approval. The notice of withdrawal of approval must advise the health carrier of the right to a hearing under the contested case procedures of chapter 14, and must specify the matters to be considered at the hearing.

The commissioner may request an health carrier to provide actuarial reasons and data, as well as other information, needed to determine if a previously approved rate continues to satisfy the requirements of this section. If the requested information is not provided within 30 days after request by the commissioner, the rate is presumed to be an excessive rate.

Sec. 7. Minnesota Statutes 1990, section 62A.02, is amended by adding a subdivision to read:

Subd. 5a. **HEARING.** The health carrier must request a hearing before the 20-day notice period has ended, or the commissioner's order is final. A request for hearing stays the commissioner's order until the commissioner notifies the health carrier of the result of the hearing. The commissioner's order may require

the modification of any rate or form and may require continued coverage to persons covered under a health plan to which the disapproved form or rate applies.

Sec. 8. **[62A.021] HEALTH CARE POLICY RATES.**

Subdivision 1. **LOSS RATIO STANDARDS.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, a health care policy form or certificate form shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policy form or certificate form, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of policies issued in the individual market, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. A health carrier shall demonstrate that the third year loss ratio is greater than or equal to the applicable percentage. Assessments by the reinsurance association created in chapter 62L and any types of taxes, surcharges, or assessments created by this act or created on or after the date of final enactment of this act are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policy forms and certificate forms issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, until an 80 percent loss ratio is reached on July 1, 1998. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, until a 70 percent loss ratio is reached on July 1, 1998. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

Notwithstanding section 645.26, any act enacted at this session that amends or repeals section 62A.135 or that otherwise changes the loss ratios provided in that section is void.

All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policy forms or certificate forms in force less than three years. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

For purposes of this section, (1) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (2) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

Subd. 2. **COMPLIANCE AUDIT.** The commissioner has the authority to audit any health carrier to assure compliance with this section. Health carriers shall retain at their principal place of business information necessary for the commissioner to perform compliance audits.

Sec. 9. **[62A.302] COVERAGE OF DEPENDENTS.**

Subdivision 1. **SCOPE OF COVERAGE.** This section applies to all health plans as defined in section 62A.011.

Subd. 2. **REQUIRED COVERAGE.** Every health plan included in subdivision 1 that provides dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

Sec. 10. **[62A.303] PROHIBITION; SEVERING OF GROUPS.**

Section 62L.12, subdivisions 1, 2, 3, and 4, apply to all employer group health plans, as defined in section 62A.011, regardless of the size of the group.

Sec. 11. Minnesota Statutes 1991 Supplement, section 62A.31, subdivision 1, is amended to read:

Subdivision 1. **POLICY REQUIREMENTS.** No individual or group policy, certificate, subscriber contract issued by a health service plan corporation regulated under chapter 62C, or other evidence of accident and health insurance the effect or purpose of which is to supplement Medicare coverage issued or delivered in this state or offered to a resident of this state shall be sold or issued to an individual covered by Medicare unless the following requirements are met:

(a) The policy must provide a minimum of the coverage set out in subdivision 2;

(b) The policy must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage;

(c) The policy must contain a provision that the plan will not be canceled or nonrenewed on the grounds of the deterioration of health of the insured;

(d) Before the policy is sold or issued, an offer of both categories of Medicare supplement insurance has been made to the individual, together with an explanation of both coverages;

(e) An outline of coverage as provided in section 62A.39 must be delivered at the time of application and prior to payment of any premium;

(f)(1) The policy must provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period, not to exceed 24 months, in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder notifies the issuer of the policy within 90 days after the date the individual becomes entitled to this assistance;

(2) If suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder provides notice of loss of the entitlement within 90 days after the date of the loss;

(3) The policy must provide that upon reinstatement (i) there is no additional waiting period with respect to treatment of preexisting conditions, (ii) coverage is provided which is substantially equivalent to coverage in effect before the date of the suspension, and (iii) premiums are classified on terms that are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had coverage not been suspended;

(g) The written statement required by an application for Medicare supplement insurance pursuant to section 62A.43, subdivision 1, shall be made on a form, approved by the commissioner, that states that counseling services may be available in the state to provide advice concerning the purchase of Medicare supplement policies and enrollment under the Medicaid program;

(h) No issuer of Medicare supplement policies, including policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any Medicare supplement insurance policy form available for sale in this state, nor may it discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such insurance is submitted during the six-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B;

(i) If a Medicare supplement policy replaces another Medicare supplement policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits to the extent the time was spent under the original policy;

(j) The policy has been filed with and approved by the department as meeting all the requirements of sections 62A.31 to 62A.44; and

(k) The policy guarantees renewability.

Only the following standards for renewability may be used in Medicare supplement insurance policy forms.

No issuer of Medicare supplement insurance policies may cancel or nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

If a group Medicare supplement insurance policy is terminated by the group policyholder and is not replaced as provided in this clause, the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder, provides for continuation of the benefits contained in the group policy; or provides for such benefits and benefit packages as otherwise meet the requirements of this clause.

If an individual is a certificate holder in a group Medicare supplement insurance policy and the individual terminates membership in the group, the issuer of the policy shall offer the certificate holder the conversion opportunities described in this clause; or offer the certificate holder continuation of coverage under the group policy.

(l) Each health maintenance organization, health service plan corporation, insurer, or fraternal benefit society that sells coverage that supplements Medicare coverage shall establish a separate community rate for that coverage. Beginning January 1, 1993, no coverage that supplements Medicare or that is governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., may be offered, issued, sold, or renewed to a Minnesota resident, except at the community rate required by this paragraph.

For coverage that supplements Medicare and for the Part A rate calculation for plans governed by section 1833 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., the community rate may take into account only the following factors:

(1) actuarially valid differences in benefit designs or provider networks;

(2) geographic variations in rates if preapproved by the commissioner of commerce; and

(3) premium reductions in recognition of healthy lifestyle behaviors, including but not limited to, refraining from the use of tobacco. Premium reductions must be actuarially valid and must relate only to those healthy lifestyle behaviors that have a proven positive impact on health. Factors used by the health carrier making this premium reduction must be filed with and approved by the commissioner.

Sec. 12. **[62A.65] INDIVIDUAL MARKET REGULATION.**

Subdivision 1. **APPLICABILITY.** No health carrier, as defined in chapter 62L, shall offer, sell, issue, or renew any individual policy of accident and sickness coverage, as defined in section 62A.01, subdivision 1, any individual subscriber contract regulated under chapter 62C, any individual health maintenance contract regulated under chapter 62D, any individual health benefit certificate regulated under chapter 64B, or any individual health coverage provided by a multiple employer welfare arrangement, to a Minnesota resident except in compliance with this section. For purposes of this section, "health benefit plan" has the meaning given in chapter 62L, except that the term means individual coverage, including family coverage, rather than employer group coverage. This section does not apply to the comprehensive health association established in section 62E.10 or to coverage described in section 62A.31, subdivision 1, paragraph (h), or to long-term care policies as defined in section 62A.46, subdivision 2.

Subd. 2. **GUARANTEED RENEWAL.** No health benefit plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health benefit plan provides that the plan is guaranteed renewable at a premium rate that does not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the health benefit plan to the person. The premium rate upon renewal must also otherwise comply with this section. A health benefit plan may be subject to refusal to renew only under the conditions provided in chapter 62L.

Subd. 3. **PREMIUM RATE RESTRICTIONS.** No health benefit plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the rating and premium restrictions provided under chapter 62L, except the minimum loss ratio applicable to individual coverage is as provided in section 62A.021. All provisions of chapter 62L apply to rating and premium restrictions in the individual market, unless clearly inapplicable to the individual market.

Subd. 4. **GENDER RATING PROHIBITED.** No health benefit plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, on the gender of any person covered or to be covered under the health benefit plan.

Subd. 5. **PORTABILITY OF COVERAGE.** (a) No health benefit plan may be offered, sold, issued, or renewed to a Minnesota resident that contains a preexisting condition limitation or exclusion, unless the limitation or exclusion would be permitted under chapter 62L. The individual may be treated as a late entrant, as defined in chapter 62L, unless the individual has maintained continuous coverage as defined in chapter 62L. An individual who has maintained continuous coverage may be subjected to a one-time preexisting condition limitation as permitted under chapter 62L for persons who are not late entrants, at the time that the individual first is covered by individual coverage. Thereafter, the person must not be subject to any preexisting condition limitation, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage.

(b) A health carrier must offer individual coverage to any individual previously covered under a group health benefit plan issued by that health carrier, so long as the individual maintained continuous coverage as defined in chapter 62L. Coverage issued under this paragraph must not contain any preexisting condition limitation or exclusion, except for any unexpired limitation or exclusion under the previous coverage. The initial premium rate for the individual coverage must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2.

Subd. 6. **GUARANTEED ISSUE NOT REQUIRED.** Nothing in this section requires a health carrier to initially issue a health benefit plan to a Minnesota resident, except as otherwise expressly provided in subdivision 4 or 5.

Sec. 13. Minnesota Statutes 1990, section 62E.02, subdivision 23, is amended to read:

Subd. 23. "Contributing member" means those companies ~~operating pursuant to~~ regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance ~~or~~; health maintenance organizations ~~and~~ regulated under chapter 62D; nonprofit health service plan corporations ~~incorporated~~ regulated under chapter 62C ~~or~~; fraternal benefit ~~society operating~~ societies regulated under chapter 64B; the private employers insurance program established in section 43A.317, effective July 1, 1993; and joint self-insurance plans regulated under chapter 62H. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization shall be considered to be accident and health insurance premiums.

Sec. 14. Minnesota Statutes 1990, section 62E.10, subdivision 1, is amended to read:

Subdivision 1. **CREATION; TAX EXEMPTION.** There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers~~,~~; self-insurers~~,~~; fraternals; joint self-insurance plans regulated under chapter 62H; the private employers insurance program established in section 43A.317, effective July 1, 1993; and health maintenance organizations licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

Sec. 15. Minnesota Statutes 1990, section 62E.11, subdivision 9, is amended to read:

Subd. 9. Each contributing member that terminates individual health coverage ~~regulated under chapter 62A, 62C, 62D, or 64B~~ for reasons other than (a) nonpayment of premium; (b) failure to make copayments; (c) enrollee moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and does not provide or arrange for replacement coverage that meets the requirements of section 62D.121; shall pay a special assessment to the state plan based upon the number of terminated individuals who join the comprehensive health insurance plan as authorized under section 62E.14, subdivisions 1, paragraph (d), and 6. Such a contributing member shall pay the association an amount equal to the average cost of an enrollee in the state plan in the year in which the member terminated enrollees multiplied by the total number of terminated enrollees who enroll in the state plan.

The average cost of an enrollee in the state comprehensive health insurance plan shall be determined by dividing the state plan's total annual losses by the total number of enrollees from that year. This cost will be assessed to the contributing member who has terminated health coverage before the association makes the annual determination of each contributing member's liability as required under this section.

In the event that the contributing member is terminating health coverage because of a loss of health care providers, the commissioner may review whether or not the special assessment established under this subdivision will have an adverse impact on the contributing member or its enrollees or insureds, including but not limited to causing the contributing member to fall below statutory net worth requirements. If the commissioner determines that the special assessment would have an adverse impact on the contributing member or its enrollees or insureds, the commissioner may adjust the amount of the special assessment, or establish alternative payment arrangements to the state plan. For health maintenance organizations regulated under chapter 62D, the commissioner of health shall make the determination regarding any adjustment in the special assessment and shall transmit that determination to the commissioner of commerce.

Sec. 16. Minnesota Statutes 1990, section 62E.11, is amended by adding a subdivision to read:

Subd. 12. **FUNDING.** Notwithstanding subdivision 5, the claims expenses and operating and administrative expenses of the association incurred on or after January 1, 1994 shall be paid from the health care access account established in section 16A.724, to the extent appropriated for that purpose by the legislature. Any such expenses not paid from that account shall be paid as otherwise provided in this section. All contributing members shall adjust their premium rates to fully reflect funding provided under this subdivision. The commissioner of commerce or the commissioner of health, as appropriate, shall require contributing members to prove compliance with this rate adjustment requirement.

Sec. 17. **[62E.141] INCLUSION IN EMPLOYER-SPONSORED PLAN.**

No employee, or dependent of an employee, of an employer who offers a health benefit plan, under which the employee or dependent is eligible to enroll under chapter 62L, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation or exclusion under the employer's health benefit plan. This section does not apply to persons enrolled in the comprehensive health association as of June 30, 1993.

Sec. 18. Minnesota Statutes 1990, section 62H.01, is amended to read:

62H.01 **JOINT SELF-INSURANCE EMPLOYEE HEALTH PLAN.**

Any ~~three~~ two or more employers, excluding the state and its political subdivisions as described in section 471.617, subdivision 1, who are authorized to transact business in Minnesota may jointly self-insure employee health, dental, or short-term disability benefits. Joint plans must have a minimum of 250 covered employees and meet all conditions and terms of sections 62H.01 to 62H.08. Joint plans covering employers not resident in Minnesota must meet the

requirements of sections 62H.01 to 62H.08 as if the portion of the plan covering Minnesota resident employees was treated as a separate plan. A plan may cover employees resident in other states only if the plan complies with the applicable laws of that state.

A multiple employer welfare arrangement as defined in United States Code, title 29, section 1002(40)(a), is subject to this chapter to the extent authorized by the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 et seq.

Sec. 19. **REQUEST FOR ERISA EXEMPTION.**

The commissioner of commerce shall request and diligently pursue an exemption from the federal preemption of state laws relating to health coverage provided under employee welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1144. The scope of the exemption should permit the state to:

(1) require that employers participate in a state payroll withholding system designed to pay for health coverage for employees and dependents;

(2) regulate self-insured health plans to the same extent as insurance companies; and

(3) enact or adopt other state laws relating to health coverage that would, in the judgment of the commissioner of commerce, further the public policies of this state.

In determining the scope of the exemption request and in requesting and pursuing the exemption, the commissioner of commerce shall seek the advice and assistance of the legislative commission on health care access. The commissioner shall report in writing to that commission at least quarterly regarding the status of the exemption request.

Sec. 20. **COMMISSIONER OF COMMERCE STUDY.**

The commissioner of commerce shall study the operation of the individual market and shall file a report and recommendations with the legislature, no later than December 15, 1992. The study, report, and recommendations must:

(1) evaluate the extent to which the individual market and the state's regulation of it can achieve the goals provided in Minnesota Statutes, section 62L.01, subdivision 3;

(2) evaluate the need for and feasibility of a guaranteed issue requirement in the individual market;

(3) make recommendations regarding the future of the comprehensive health association.

Sec. 21. **REVIEW OF STANDARDIZED POLICY FORMS.**

The commissioner of commerce shall review the health care policies currently in use in the state, other than specialized and limited scope products such as dental insurance and hospital indemnity products, and make recommendations to the legislature by February 1, 1993, relating to standardized health care policy forms to be used by all insurers, health service plans, or other entities regulated under Minnesota Statutes, chapter 62A, 62C, 62E, or 62H.

Sec. 22. **STUDY OF HEALTHY LIFESTYLE PREMIUM REDUCTIONS.**

The commissioner of commerce shall study and make recommendations to the legislature regarding whether health benefits plans, as defined in Minnesota Statutes, section 62L.02, but including both individual and group plans, should be permitted or required to offer premium discounts in recognition of and to encourage healthy lifestyle behaviors. The commissioner shall file the recommendations with the legislature on or before December 15, 1992. The commissioner shall make recommendations regarding:

(1) the types of lifestyle behaviors, including but not limited to, nonuse of tobacco, nonuse of alcohol, and regular exercise appropriate to the person's age and health status, that should be eligible for premium discounts;

(2) the level or amounts of premium discounts that should be permitted or required, including appropriateness of premium discounts of up to 25 percent of the premium;

(3) the actuarial justification that the commissioner should require for premium reductions;

(4) the extent to which health carriers can monitor compliance with promised lifestyle behaviors and whether new legislation could increase the monitoring ability or reduce its cost; and

(5) any favorable or adverse impacts on the individual or small group market. Any data on individuals collected under this section and received by the commissioner, which has not previously been public data, is private data on individuals.

This section shall not be interpreted as prohibiting any premium discounts approved under current law by the commissioner of commerce or by the commissioner of health or permitted under this act.

Sec. 23. **REPEALER.**

Minnesota Statutes 1990, sections 62A.02, subdivisions 4 and 5, are repealed.

Sec. 24. **EFFECTIVE DATE.**

Section 11 is effective July 30, 1992. Sections 1 to 10, 12, 15, 16, 17, 18, and 23 are effective July 1, 1993, except that section 1, subdivision 9, is effective the day following final enactment. Sections 19, 20, 21, and 22 are effective the day following final enactment.

ARTICLE 4

CHILDREN'S HEALTH PLAN EXPANSION

Section 1. **[256.362] REPORTS AND IMPLEMENTATION.**

Subdivision 1. **WELLNESS COMPONENT.** The commissioners of human services and health shall recommend to the legislature, by January 1, 1993, methods to incorporate discounts for wellness factors of up to 25 percent into the health right plan premium sliding scale. Beginning October 1, 1992, the commissioner of human services shall inform health right plan enrollees of the future availability of the wellness discount; and shall encourage enrollees to incorporate wellness factors into their lifestyles.

Subd. 2. **FEDERAL HEALTH INSURANCE CREDIT.** By October 1, 1992, the commissioners of human services and revenue shall apply for any federal waivers or approvals necessary to allow enrollees in state health care programs to assign the federal health insurance credit component of the earned income tax credit to the state.

Subd. 3. **COORDINATION OF MEDICAL ASSISTANCE AND THE HEALTH RIGHT PLAN.** The commissioner shall develop and implement a plan to combine medical assistance and health right plan application and eligibility procedures. The plan may include the following changes: (1) use of a single mail-in application; (2) elimination of the requirement for personal interviews; (3) postponing notification of paternity disclosure requirements; (4) modifying verification requirements for pregnant women and children; (5) using shorter forms for recertifying eligibility; (6) expedited and more efficient eligibility determinations for applicants; (7) expanded outreach efforts, including combined marketing of the two plans; and (8) other changes that improve access to services provided by the two programs. The plan may include seeking the following changes in federal law: (1) extension and expansion of exemptions for different eligibility groups from Medicaid quality control sanctions; (2) changing requirements for the redetermination of eligibility; (3) eliminating asset tests for all children; and (4) other changes that improve access to services provided by the two programs. The commissioner shall seek any necessary federal approvals, and any necessary changes in federal law. The commissioner shall implement each element of the plan as federal approval is received, and shall report to the legislature by January 1, 1993, on progress in implementing this plan.

Subd. 4. **PLAN FOR MANAGED CARE.** By January 1, 1993, the commissioner of human services shall present a plan to the legislature for providing all

medical assistance and health right plan services through managed care arrangements. The commissioner shall apply to the secretary of health and human services for any necessary federal waivers or approvals, and shall begin to implement the plan for managed care upon receipt of the federal waivers or approvals.

Subd. 5. **REPORT ON PURCHASES AT FULL COST.** By January 1, 1994, the commissioner shall report to the legislature on the effect on average overall premium cost for the health right plan of allowing families who are not eligible for a subsidy to enroll in the health right plan at 100 percent of premium cost. By January 1, 1995, the commissioner shall report to the legislature on the effect on average overall premium cost for the health right plan of allowing individuals who are not eligible for a subsidy to enroll in the health right plan at 100 percent of premium cost. The commissioner shall recommend whether enrollment for this group should begin.

Sec. 2. Minnesota Statutes 1990, section 256.936, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** For purposes of this section the following terms shall have the meanings given them:

(a) ~~"Eligible persons" means children who are one year of age or older but less than 18 years of age who have gross family incomes that are equal to or less than 185 percent of the federal poverty guidelines and who are not eligible for medical assistance under chapter 256B or general assistance medical care under chapter 256D and who are not otherwise insured for the covered services. The period of eligibility extends from the first day of the month in which the child's first birthday occurs to the last day of the month in which the child becomes 18 years old.~~

~~(b) "Covered services" means children's health services.~~

~~(c) "Children's health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, orthodontic services, medical transportation services, personal care assistant and case management services, hospice care services, nursing home or intermediate care facilities services, inpatient mental health services, outpatient mental health services in excess of $1,000 per enrolled child per 12-month eligibility period, and chemical dependency services. Outpatient mental health services covered under the children's health plan are limited to diagnostic assessments, psychological testing, explanation of findings, and individual, family, and group psychotherapy.~~

~~(d)~~ "Eligible providers" means those health care providers who provide ~~children's~~ covered health services to medical assistance recipients under rules established by the commissioner for that program. Reimbursement under this section shall be at the same rates and conditions established for medical assistance.

New language is indicated by underline, deletions by ~~strikeout~~.

~~(c)~~ (b) "Commissioner" means the commissioner of human services.

~~(f)~~ (c) "Gross family income" for farm and nonfarm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged. Applicants shall report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. The report may be in the form of percentage increase or decrease.

Sec. 3. Minnesota Statutes 1990, section 256.936, subdivision 2, is amended to read:

Subd. 2. **PLAN ADMINISTRATION.** The ~~children's~~ health right plan is established to promote access to appropriate ~~primary~~ health care services to assure healthy children and adults. The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide ~~children's~~ covered health services for eligible persons. Payment for these services shall be made to all eligible providers. The commissioner ~~may~~ shall adopt rules to administer ~~this section~~ the health right plan. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the department of human services. A toll-free telephone number must be used to provide information about medical programs and to promote access to the covered services. The commissioner shall manage spending for the health right plan in a manner that maintains a minimum reserve equal to five percent of the expected cost of state premium subsidies. The commissioner must make a quarterly assessment of the expected expenditures for the covered services ~~and the appropriation~~ for the remainder of the current fiscal year and for the following two fiscal years. ~~Based on this assessment the commissioner may limit enrollments and target former aid to families with dependent children recipients. If sufficient money is not available to cover all costs incurred in one quarter, the commissioner may seek an additional authorization for funding from the legislative advisory committee.~~ The estimated expenditure shall be compared to an estimate of the revenues that will be deposited in the health care access fund. Based on this comparison, and after consulting with the chairs of the house appropriations committee and the senate finance committee, and the legislative commission on health care access, the commissioner shall make adjustments as necessary to ensure that expenditures remain within the limits of available revenues. The adjustments the commissioner may use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the health right plan; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent;

and fifth, require applicants to be uninsured for at least six months prior to eligibility in the health right plan. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner may further limit enrollment or decrease premium subsidies.

If the commissioner determines that, despite adjustments made as authorized under this subdivision, estimated costs will exceed the forecasted amount of available revenues other than the reserve, the commissioner may, with the approval of the commissioner of finance, use all or part of the reserve to cover the costs of the program.

The commissioner may adopt emergency rules to govern implementation of this section. Notwithstanding section 14.35, the emergency rules adopted under this section shall remain in effect for 720 days.

Sec. 4. Minnesota Statutes 1990, section 256.936, is amended by adding a subdivision to read:

Subd. 2a. **COVERED HEALTH SERVICES.** (a) **COVERED SERVICES.** "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, orthodontic services, medical transportation services, personal care assistant and case management services, hospice care services, nursing home or intermediate care facilities services, inpatient mental health services, outpatient mental health services in excess of $1,000 per adult enrollee and $2,500 per child enrollee per 12-month eligibility period, and chemical dependency services. Outpatient mental health services covered under the health right plan are limited to diagnostic assessments, psychological testing, explanation of findings, and individual, family, and group psychotherapy. Medication management by a physician is not subject to the $1,000 and $2,500 limitations on outpatient mental health services. Covered health services shall be expanded as provided in this subdivision.

(b) **ALCOHOL AND DRUG DEPENDENCY.** Beginning October 1, 1992, covered health services shall include up to ten hours per year of individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program. Two hours of group treatment count as one hour of individual treatment.

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

(c) **INPATIENT HOSPITAL SERVICES.** Beginning July 1, 1993, covered health services shall include inpatient hospital services, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. The inpatient hospital benefit for adult enrollees not eligible for medical assistance is subject to an annual benefit limit of $10,000. The commissioner shall provide enrollees with at least 60 days' notice of coverage for inpatient hospital services and any premium increase associated with the inclusion of this benefit.

(d) **EMERGENCY MEDICAL TRANSPORTATION SERVICES.** Beginning July 1, 1993, covered health services shall include emergency medical transportation services.

(e) **FEDERAL WAIVERS AND APPROVALS.** The commissioner shall coordinate the provision of hospital inpatient services under the health right plan with enrollee eligibility under the medical assistance spend-down, and shall apply to the secretary of health and human services for any necessary federal waivers or approvals.

(f) **COPAYMENTS AND COINSURANCE.** The health right benefit plan shall include the following copayments and coinsurance requirements:

(1) ten percent for inpatient hospital services for adult enrollees not eligible for medical assistance, subject to an annual out-of-pocket maximum of $2,000 per individual and $3,000 per family;

(2) 50 percent for adult dental services, except for preventive services;

(3) $3 per prescription for adult enrollees; and

(4) $25 for eyeglasses for adult enrollees.

Enrollees who would be eligible for medical assistance with a spenddown must pay the coinsurance amount up to the spenddown limit or the coinsurance amount, whichever is less, in order to become eligible for the medical assistance program.

Sec. 5. Minnesota Statutes 1990, section 256.936, is amended by adding a subdivision to read:

Subd. 2b. **ELIGIBLE PERSONS.** (a) **CHILDREN.** "Eligible persons" means children who are one year of age or older but less than 18 years of age who have gross family incomes that are equal to or less than 185 percent of the federal poverty guidelines and who are not eligible for medical assistance under chapter 256B and who are not otherwise insured for the covered services. The period of eligibility extends from the first day of the month in which the child becomes 18 years old. Eligibility for the health right plan shall be expanded as provided in paragraphs (b) to (e). Under paragraphs (b) to (e), parents who enroll in the health right plan must also enroll their children and dependent siblings, if the

children and their dependent siblings are eligible. Children and dependent siblings may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. Families cannot choose to enroll only certain uninsured members. For purposes of this subdivision, a "dependent sibling" means an unmarried child who is a full-time student under the age of 25 years who is financially dependent upon his or her parents. Proof of school enrollment will be required.

(b) **FAMILIES WITH CHILDREN.** Beginning October 1, 1992, "eligible persons" means children eligible under paragraph (a), and parents and dependent siblings residing in the same household as a child eligible under paragraph (a). Individuals who initially enroll in the health right plan under the eligibility criteria in this paragraph shall remain eligible for the health right plan, regardless of age, place of residence within Minnesota, or the presence or absence of children in the same household, as long as all other eligibility requirements are met and continuous enrollment in the health right plan or medical assistance is maintained.

(c) **CONTINUATION OF ELIGIBILITY.** Beginning October 1, 1992, individuals who initially enrolled in the health right plan under the eligibility criteria in paragraph (a) or (b) remain eligible even if their gross income after enrollment exceeds 185 percent of the federal poverty guidelines, subject to any premium required under subdivision 4a, as long as all other eligibility requirements are met and continuous enrollment in the health right plan or medical assistance is maintained.

(d) **FAMILIES WITH CHILDREN; ELIGIBILITY BASED ON PERCENTAGE OF INCOME PAID FOR HEALTH COVERAGE.** Beginning January 1, 1993, "eligible persons" means children, parents, and dependent siblings residing in the same household who are not eligible for medical assistance under chapter 256B. These persons are eligible for coverage through the health right plan but must pay a premium as determined under subdivisions 4a and 4b. Individuals and families whose income is greater than the limits established under subdivision 4b may not enroll in the health right plan. Individuals who initially enroll in the health right plan under the eligibility criteria in this paragraph remain eligible for the health right plan, regardless of age, place of residence within Minnesota, or the presence or absence of children in the same household, as long as all other eligibility requirements are met and continuous enrollment in the health right plan or medical assistance is maintained.

(e) **ADDITION OF SINGLE ADULTS AND HOUSEHOLDS WITH NO CHILDREN.** Beginning July 1, 1994, "eligible persons" means all families and individuals who are not eligible for medical assistance under chapter 256B. These persons are eligible for coverage through the health right plan but must pay a premium as determined under subdivisions 4a and 4b. Individuals and families whose income is greater than the limits established under subdivision 4b may not enroll in the health right plan.

Sec. 6. Minnesota Statutes 1990, section 256.936, subdivision 3, is amended to read:

Subd. 3. **APPLICATION PROCEDURES.** Applications and other information must be made available to provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, and Women, Infants and Children (WIC) program sites. These sites may accept applications, collect the enrollment fee or initial premium fee, and forward the forms and fees to the commissioner. Otherwise, applicants may apply directly to the commissioner. The commissioner ~~may~~ shall use individuals' social security numbers as identifiers for purposes of administering the plan and conduct data matches to verify income. Applicants shall submit evidence of family income, earned and unearned, that ~~will be used~~ is necessary to verify income eligibility. The commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the department of revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the health right plan. The effective date of coverage is the first day of the month following the month in which a complete application is entered to the eligibility file and the first premium payment has been received. Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage. Notwithstanding any other law to the contrary, benefits under this section are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

Sec. 7. Minnesota Statutes 1990, section 256.936, subdivision 4, is amended to read:

Subd. 4. **ENROLLMENT AND PREMIUM FEE.** (a) **ENROLLMENT FEE.** Until October 1, 1992, an annual enrollment fee of $25, not to exceed $150 per family, is required from eligible persons for ~~children's~~ covered health services.

(b) **PREMIUM PAYMENTS.** Beginning October 1, 1992, the commissioner shall require health right plan enrollees to pay a premium based on a sliding scale, as established under subdivision 4a. Applicants who are eligible under subdivision 2b, paragraph (a), are exempt from this requirement until July 1, 1993, if the application is received by the health right plan staff on or before September 30, 1992. Before July 1, 1993, these individuals shall continue to pay the annual enrollment fee required by paragraph (a).

(c) **ADMINISTRATION.** Enrollment and premium fees are dedicated to the commissioner for the ~~children's~~ health right plan ~~program~~. The commis-

sioner shall make an annual redetermination of continued eligibility and identify people who may become eligible for medical assistance. The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon changes in enrollee income; and (3) disenroll enrollees from the health right plan for failure to pay required premiums. Premiums are calculated on a calendar month basis and may be paid on a monthly or quarterly basis, with the first payment due upon notice from the commissioner of the premium amount required. Premium payment is required before enrollment is complete and to maintain eligibility in the health right plan. Nonpayment of the premium will result in disenrollment from the plan within one calendar month after the due date. Persons disenrolled for nonpayment may not reenroll until four calendar months have elapsed.

Sec. 8. Minnesota Statutes 1990, section 256.936, is amended by adding a subdivision to read:

Subd. 4a. **ELIGIBILITY FOR SUBSIDIZED PREMIUMS BASED ON SLIDING SCALE.** (a) **GENERAL REQUIREMENTS.** Families and individuals who enroll on or after October 1, 1992, are eligible for subsidized premium payments based on a sliding scale under subdivision 4b only if the family or individual meets the requirements in paragraphs (b) to (d). Children already enrolled in the health right plan as of September 30, 1992, are eligible for subsidized premium payments without meeting these requirements, as long as they maintain continuous coverage in the health right plan or medical assistance.

Families and individuals who initially enrolled in the health right plan under subdivision 2b, and whose income increases above the limits established in subdivision 4b, may continue enrollment and pay the full cost of coverage.

(b) **MUST NOT HAVE ACCESS TO EMPLOYER-SUBSIDIZED COVERAGE.** To be eligible for subsidized premium payments based on a sliding scale, a family or individual must not have access to subsidized health coverage through an employer, and must not have had access to subsidized health coverage through an employer for the 18 months prior to application for subsidized coverage under the health right plan. The requirement that the family or individual must not have had access to employer-subsidized coverage during the previous 18 months does not apply if employer-subsidized coverage was lost for reasons that would not disqualify the individual for unemployment benefits under section 268.09 and the family or individual has not had access to employer-subsidized coverage since the layoff. For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee, excluding dependent coverage, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans as qualified employer subsidies toward the cost of health coverage for employees for purposes of this paragraph.

(c) **PERIOD UNINSURED.** To be eligible for subsidized premium payments based on a sliding scale, families and individuals initially enrolled in the health right plan under subdivision 2b, paragraphs (d) and (e), must have had no health coverage for at least four months prior to application. The commissioner may change this eligibility criterion for sliding scale premiums without complying with rulemaking requirements in order to remain within the limits of available appropriations. The requirement of at least four months of no health coverage prior to application for the health right plan does not apply to families, children, and individuals who want to apply for the health right plan upon termination from the medical assistance program, general assistance medical care program, or coverage under a regional demonstration project for the uninsured funded under section 256B.73, the Hennepin county assured care program, or the Group Health, Inc., community health plan. This paragraph does not apply to families and individuals initially enrolled under subdivision 2b, paragraphs (a) and (b).

Sec. 9. Minnesota Statutes 1990, section 256.936, is amended by adding a subdivision to read:

Subd. 4b. **PREMIUMS.** (a) Each individual or family enrolled in the health right plan shall pay a premium determined according to a sliding fee based on the cost of coverage as a percentage of the individual's or family's gross family income.

(b) The commissioner shall establish sliding scales to determine the percentage of gross family income that households at different income levels must pay to obtain coverage through the health right plan. The sliding scale must be based on the enrollee's gross family income, as defined in subdivision 1, paragraph (c), during the previous four months. The sliding scale must provide separate sliding scales for individuals, two-person households, and households of three or more.

(c) Beginning July 1, 1993, the sliding scales begin with a premium of 1.5 percent of gross family income for individuals with incomes below the limits for the medical assistance program set at 133-1/3 percent of the AFDC payment standard and proceed through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit to a gross monthly income of $1,600 for an individual, $2,160 for a household of two, $2,720 for a household of three, $3,280 for a household of four, $3,840 for a household of five, and $4,400 for households of six or more persons. For the period October 1, 1992 through June 30, 1993, the commissioner shall employ a sliding scale that sets required premiums at percentages of gross family income equal to two-thirds of the percentages specified in this paragraph.

(d) An individual or family whose gross monthly income is above the amount specified in paragraph (c) is not eligible for the plan.

(e) The premium for coverage under the health right plan may be collected through wage withholding with the consent of the employer and the employee.

(f) The sliding fee scale and percentages are not subject to the provisions of chapter 14.

Sec. 10. Minnesota Statutes 1990, section 256.936, is amended by adding a subdivision to read:

Subd. 4c. **RESIDENCY.** (a) The legislature finds that the enactment of a comprehensive health plan for uninsured Minnesotans creates a risk that persons needing medical care will migrate to the state for the primary purpose of obtaining medical care subsidized by the state. The risk of migration undermines the state's ability to provide to legitimate state residents a valuable and necessary health care program which is an important component of the state's comprehensive cost containment and health care system reform plan. Intent-based residency requirements, which are expressly authorized under decisions of the United States Supreme Court, are an unenforceable and ineffective method of denying benefits to those persons the Supreme Court has stated may legitimately be denied eligibility for state programs. If the state is unable to limit eligibility to legitimate permanent residents of the state, the state faces a significant risk that it will be forced to reduce the eligibility and benefits it would otherwise provide to Minnesotans. The legislature finds that a durational residence requirement is a legitimate, objective, enforceable standard for determining whether a person is a permanent resident of the state. The legislature also finds low-income persons who have not lived in the state for the required time period will have access to necessary health care services through the general assistance medical care program, the medical assistance program, and public and private charity care programs.

(b) To be eligible for health coverage under the health right program, families and individuals must be permanent residents of Minnesota.

(c) For purposes of this subdivision, a permanent Minnesota resident is a person who has demonstrated, through persuasive and objective evidence, that the person is domiciled in the state and intends to live in the state permanently.

(d) To be eligible, all applicants must demonstrate the requisite intent to live in the state permanently by:

(1) showing that the applicant maintains a residence at a verified address other than a place of public accommodation, through the use of evidence of residence described in section 256D.02, subdivision 12a, clause (1);

(2) demonstrating that the applicant has been continuously domiciled in the state for no less than 180 days immediately before the application; and

(3) signing an affidavit declaring that (A) the applicant currently resides in the state and intends to reside in the state permanently; and (B) the applicant did not come to the state for the primary purpose of obtaining medical coverage or treatment.

(e) An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a pre-existing condition is not a permanent resident.

(f) If the 180-day requirement in paragraph (d), clause (2), is determined by a court to be unconstitutional, the commissioner of human services shall impose a 12-month pre-existing condition exclusion on coverage for persons who have been domiciled in the state for less than 180 days.

(g) If any paragraph, sentence, clause, or phrase of this subdivision is for any reason determined by a court to be unconstitutional, the decision shall not affect the validity of the remaining portions of the subdivision. The legislature declares that it would have passed each paragraph, sentence, clause, and phrase in this subdivision, irrespective of the fact that any one or more paragraphs, sentences, clauses, or phrases is declared unconstitutional.

Sec. 11. Minnesota Statutes 1991 Supplement, section 256.936, subdivision 5, is amended to read:

Subd. 5. **APPEALS.** If the commissioner suspends, reduces, or terminates eligibility for the ~~children's~~ health right plan, or services provided under the ~~children's~~ health right plan, the commissioner must provide notification according to the laws and rules governing the medical assistance program. A ~~children's~~ health right plan applicant or enrollee aggrieved by a determination of the commissioner has the right to appeal the determination according to section 256.045.

Sec. 12. Minnesota Statutes 1990, section 256B.057, is amended by adding a subdivision to read:

Subd. 2a. **NO ASSET TEST FOR CHILDREN.** Eligibility for medical assistance for a person under age 21 must be determined without regard to asset standards established in section 256B.056.

Sec. 13. **[256B.0644] PARTICIPATION REQUIRED FOR REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.**

A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and the health right plan as a condition of participating as a provider in health insurance plans or contractor for state employees established under section 43A.18, the public employees insurance plan under section 43A.316, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.17. For providers other than health maintenance organizations, participation in the medical assistance program means that (1) the provider accepts new medical assistance patients or (2) at least 20 percent of the provider's patients are covered by medical assistance, general assistance

medical care, or the health right plan as their primary source of coverage. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program.

Sec. 14. **PROVIDER PAYMENT INCREASES.**

Subdivision 1. **HOSPITAL OUTPATIENT REIMBURSEMENT.** For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

Subd. 2. **PHYSICIAN AND DENTAL REIMBURSEMENT.** (a) The physician reimbursement increase provided in Minnesota Statutes, section 256B.74, subdivision 2, shall not be implemented. Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," caesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in Minnesota Statutes, section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) The dental reimbursement increase provided in Minnesota Statutes, section 256B.74, subdivision 5, shall not be implemented. Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

Subd. 3. **CONTINGENT ON ENACTMENT OF APPROPRIATIONS.** Subdivisions 1 and 2 are effective only if money is appropriated to the commissioner of human services to cover the entire state cost of the increases.

Sec. 15. **COORDINATION OF STATE HEALTH CARE PURCHASING.**

The commissioner of administration shall convene an interagency task force to develop a plan for coordinating the health care programs administered by state agencies and local governments in order to improve the efficiency and quality of health care delivery and make the most effective use of the state's market leverage and expertise in contracting and working with health plans and health care providers. The commissioner shall present to the legislature, by January 1, 1994, recommendations to: (1) improve the effectiveness of public health care purchasing; and (2) streamline and consolidate health care delivery, through merger, transfer, or reconfiguration of existing health care and health coverage programs. At the request of the commissioner of administration, the commissioners of other state agencies and units of local government shall provide assistance in evaluating and coordinating existing state and local health care programs.

Sec. 16. **STUDY ON PREMIUMS AND BENEFITS.**

The commissioner of human services shall study the cost of health right premiums and the level of premium subsidies in relationship to the benefits provided. This study must include a comparison of the additional enrollee premium costs associated with the provision of an inpatient hospital benefit beginning July 1, 1993. Based on this analysis, the commissioner shall report to the legislative commission on health care access by January 15, 1993, on whether the premiums and subsidy level for the health right plan should be adjusted.

Sec. 17. **PHASE-OUT OF THE CHILDREN'S HEALTH PLAN.**

Notwithstanding contrary provisions of Minnesota Statutes, section 256.936, the commissioner shall continue to accept enrollments in the children's health plan until July 1, 1993, using the eligibility and coverage requirements in effect prior to October 1, 1992, until the commissioner projects that the total

enrollment in the children's health plan will exhaust the fiscal year 1993 appropriation for the children's health plan. These enrollees pay the annual fee established in Minnesota Statutes, section 256.936, subdivision 4, until July 1, 1993.

Sec. 18. **IMPACT OF HEALTH RIGHT ON CHILDREN'S HEALTH PLAN ENROLLEE.**

The commissioner of human services shall examine the impact of health right plan premium costs on access to health care for children's health plan enrollees. The commissioner shall examine whether health right plan premiums are affordable for children's health plan enrollees, and shall examine the degree to which children's health plan enrollees fail to continue coverage through the health right plan for financial reasons. The commissioner shall present recommendations to the legislature by February 15, 1993, on methods to ensure continued access to health care coverage for children's health plan enrollees.

Sec. 19. **INSTRUCTION TO REVISOR.**

(a) The revisor of statutes is directed to change the words "children's health plan" to "health right plan" wherever they appear in the next edition of Minnesota Statutes.

(b) The revisor of statutes is directed to recodify the subdivisions of Minnesota Statutes, section 256.936 as separate sections in chapter 256, and to recodify paragraphs as subdivisions within these sections.

Sec. 20. **EFFECTIVE DATE.**

Section 13, relating to participation in state health care programs, is effective October 1, 1992.

ARTICLE 5

RURAL HEALTH INITIATIVES

Section 1. Minnesota Statutes 1990, section 16A.124, is amended by adding a subdivision to read:

Subd. 4a. **INVOICE ERRORS; DEPARTMENT OF HUMAN SERVICES.** For purposes of department of human services payments to hospitals receiving reimbursement under the medical assistance and general assistance medical care programs, if an invoice is incorrect, defective, or otherwise improper, the department of human services must notify the hospital of all errors, within 30 days of discovery of the errors.

Sec. 2. Minnesota Statutes 1990, section 43A.17, subdivision 9, is amended to read:

Subd. 9. **POLITICAL SUBDIVISION SALARY LIMIT.** The salary of a person employed by a statutory or home rule charter city, county, town, school district, metropolitan or regional agency, or other political subdivision of this state, or employed under section 422A.03, may not exceed 95 percent of the salary of the governor as set under section 15A.082, except as provided in this subdivision. Deferred compensation and payroll allocations to purchase an individual annuity contract for an employee are included in determining the employee's salary. The salary of a medical doctor or doctor of osteopathy occupying a position that the governing body of the political subdivision has determined requires an M.D. or D.O. degree is excluded from the limitation in this subdivision. The commissioner may increase the limitation in this subdivision for a position that the commissioner has determined requires special expertise necessitating a higher salary to attract or retain a qualified person. The commissioner shall review each proposed increase giving due consideration to salary rates paid to other persons with similar responsibilities in the state. The commissioner may not increase the limitation until the commissioner has presented the proposed increase to the legislative commission on employee relations and received the commission's recommendation on it. The recommendation is advisory only. If the commission does not give its recommendation on a proposed increase within 30 days from its receipt of the proposal, the commission is deemed to have recommended approval.

Sec. 3. **[62A.66] PARTICIPATING PROVIDERS.**

Subdivision 1. **HEALTH PLAN COMPANY.** For purposes of this section, "health plan company" means any entity governed by chapter 62A, 62C, 62D, 62E, 62H, or 64B, or section 471.617, subdivision 2, that offers, sells, issues, or renews health coverage in this state. Health plan company does not include an entity that sells only policies designed primarily to provide coverage on a per diem, fixed indemnity, or nonexpense-incurred basis, or policies that provide only accident coverage.

Subd. 2. **ACCEPTANCE AS PARTICIPATING PROVIDER.** A health plan company shall not exclude, as a participating provider, a physician who is licensed under chapter 147 and meets the requirements of section 147.02, subdivision 1, paragraph (b), solely because the physician has not completed a full residency or is not board certified, if:

(1) the physician meets all other requirements for serving as a participating provider;

(2) the physician has completed a minimum of two years residency in any specialty;

(3) the physician has not been disciplined by the board of medical practice under section 147.091;

(4) the physician is credentialed by and has staff privileges at a hospital, or is employed by a medical clinic, located in an area designated by the federal

government as either a health personnel shortage area or a medically underserved area;

(5) the medical clinic at which the physician practices was part of the provider network of a health plan company, and that health plan company provides health care services to a significant number of persons residing in the community in which the medical clinic is located, many of whom had formerly received services at the medical clinic; and

(6) the medical clinic and the hospital at which the physician has staff privileges are the only providers of 24-hour emergency services in the county.

Sec. 4. Minnesota Statutes 1990, section 144.147, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 5,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 100 or fewer beds;

(3) ~~has experienced net income losses in at least two of the three most recent consecutive hospital fiscal years for which audited financial information is available;~~

~~(4)~~ is not for profit; and

~~(5)~~ (4) has not been awarded a grant under the federal rural health transition grant program.

Sec. 5. Minnesota Statutes 1990, section 144.147, subdivision 3, is amended to read:

Subd. 3. **CONSIDERATION OF GRANTS.** In determining which hospitals will receive grants under this section, the commissioner shall take into account:

(1) improving community access to hospital or health services;

(2) changes in service populations;

(3) demand for ambulatory and emergency services;

(4) the extent that the health needs of the community are not currently being met by other providers in the service area;

(5) the need to recruit and retain health professionals; ~~and~~

(6) the involvement and extent of support of the community and local health care providers; and

(7) the financial condition of the hospital.

Sec. 6. Minnesota Statutes 1990, section 144.147, subdivision 4, is amended to read:

Subd. 4. **ALLOCATION OF GRANTS.** (a) Eligible hospitals must apply to the commissioner no later than September 1, ~~1990,~~ of each year for grants awarded ~~in the 1991 state fiscal year; and no later than September 1, 1990, for grants awarded in the 1992 state~~ for the fiscal year beginning the following July 1.

(b) ~~The commissioner may award at least two grants for each fiscal year.~~ The commissioner must make a final decision on the funding of each application within 60 days of the deadline for receiving applications.

(c) Each relevant community health board has 30 days in which to review and comment to the commissioner on grant applications from hospitals in their community health service area.

(d) In determining which hospitals will receive grants under this section, the commissioner shall consider the following factors:

(1) Description of the problem, description of the project, and the likelihood of successful outcome of the project. The applicant must explain clearly the nature of the health services problems in their service area, how the grant funds will be used, what will be accomplished, and the results expected. The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations.

(2) The extent of community support for the hospital and this proposed project. The applicant should demonstrate support for the hospital and for the proposed project from other local health service providers and from local community and government leaders. Evidence of such support may include past commitments of financial support from local individuals, organizations, or government entities; and commitment of financial support, in-kind services or cash, for this project.

(3) The comments, if any, resulting from a review of the application by the community health board in whose community health service area the hospital is located.

(e) In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning the maximum of 70 points for an applicant's understanding of the problem, description of the project, and likelihood of successful outcome of the project; and a maximum of 30 points for the extent of community support for the hospital and this project. The commissioner may also take into account other relevant factors.

(f) A grant to a hospital, including hospitals that submit applications as consortia, may not exceed $50,000 a year and may not exceed a term of two years. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one-half of the amount, which may include in-kind services, is available for the same purposes from nonstate sources. A hospital receiving a grant under this section may use the grant for any expenses incurred in the development of strategic plans or the implementation of transition projects with respect to which the grant is made. Project grants may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

Sec. 7. **[144.1481] RURAL HEALTH ADVISORY COMMITTEE.**

Subdivision 1. **ESTABLISHMENT; MEMBERSHIP.** The commissioner of health shall establish a 15-member rural health advisory committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathy licensed under chapter 147;

(7) a midlevel practitioner;

(8) a registered nurse or licensed practical nurse;

(9) a licensed health care professional from an occupation not otherwise represented on the committee;

(10) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

(11) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

The commissioner will make recommendations for committee membership.

Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The terms, compensation, and removal of members are governed by section 15.059.

Subd. 2. **DUTIES.** The advisory committee shall:

(1) advise the commissioner and other state agencies on rural health issues;

(2) provide a systematic and cohesive approach toward rural health issues and rural health care planning, at both a local and statewide level;

(3) develop and evaluate mechanisms to encourage greater cooperation among rural communities and among providers;

(4) recommend and evaluate approaches to rural health issues that are sensitive to the needs of local communities; and

(5) develop methods for identifying individuals who are underserved by the rural health care system.

Subd. 3. **STAFFING; OFFICE SPACE; EQUIPMENT.** The commissioner shall provide the advisory committee with staff support, office space, and access to office equipment and services.

Sec. 8. **[144.1482] OFFICE OF RURAL HEALTH.**

Subdivision 1. **DUTIES.** The office of rural health in conjunction with the University of Minnesota medical schools and other organizations in the state which are addressing rural health care problems shall:

(1) establish and maintain a clearinghouse for collecting and disseminating information on rural health care issues, research findings, and innovative approaches to the delivery of rural health care;

(2) coordinate the activities relating to rural health care that are carried out by the state to avoid duplication of effort;

(3) identify federal and state rural health programs and provide technical assistance to public and nonprofit entities, including community and migrant health centers, to assist them in participating in these programs;

(4) assist rural communities in improving the delivery and quality of health care in rural areas and in recruiting and retaining health professionals; and

(5) carry out the duties assigned in section 144.1483.

Subd. 2. **CONTRACTS.** To carry out these duties, the office may contract with or provide grants to public and private, nonprofit entities.

Sec. 9. **[144.1483] RURAL HEALTH INITIATIVES.**

The commissioner of health, through the office of rural health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the higher education coordinating board, and other state agencies, shall:

(1) develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services;

(2) develop and implement a program to assist rural communities in establishing community health centers, as required by section 144.1486;

(3) administer the program of financial assistance established under section 144.1484 for rural hospitals in isolated areas of the state that are in danger of closing without financial assistance, and that have exhausted local sources of support;

(4) develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

(5) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a data base on health care personnel as required under section 144.1485;

(6) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

(7) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages;

(8) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas;

(9) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs;

(10) coordinate the development of a statewide plan for emergency medical services, in cooperation with the emergency medical services advisory council; and

(11) carry out other activities necessary to address rural health problems.

Sec. 10. **[144.1484] RURAL HOSPITAL FINANCIAL ASSISTANCE GRANTS.**

Subdivision 1. **SOLE COMMUNITY HOSPITAL FINANCIAL ASSISTANCE GRANTS.** The commissioner of health shall award financial assistance grants to rural hospitals in isolated areas of the state. To qualify for a grant, a hospital must: (1) be eligible to be classified as a sole community hospital according to the criteria in Code of Federal Regulations, title 42, section 412.92 or be located in a community with a population of less than 5,000; (2) have experienced net income losses in the two most recent consecutive hospital fiscal years for which audited financial information is available; (3) consist of 30 or fewer licensed beds; and (4) have exhausted local sources of support. Before applying for a grant, the hospital must have developed a strategic plan. The commissioner shall award grants in equal amounts.

Subd. 2. **GRANTS TO AT-RISK RURAL HOSPITALS TO OFFSET THE IMPACT OF THE HOSPITAL TAX.** The commissioner of health shall award financial assistance grants to rural hospitals that would otherwise close as a direct result of the hospital tax in article 9, section 7. To be eligible for a grant, a hospital must have 50 or fewer beds and must not be located in a city of the first class. To receive a grant, the hospital must demonstrate to the satisfaction of the commissioner of health that the hospital will close in the absence of state assistance under this subdivision and that the hospital tax is the principal reason for the closure. The amount of the grant must not exceed the amount of the tax the hospital would pay under article 9, section 7, based on the previous year's hospital revenues.

Sec. 11. **[144.1485] DATA BASE ON HEALTH PERSONNEL.**

The commissioner of health shall develop and maintain a data base on health services personnel. The commissioner shall use this information to assist local communities and units of state government to develop plans for the recruitment and retention of health personnel. Information collected in the data base must include, but is not limited to, data on levels of educational preparation, specialty, and place of employment. The commissioner may collect information through the registration and licensure systems of the state health licensing boards.

Sec. 12. **[144.1486] RURAL COMMUNITY HEALTH CENTERS.**

The commissioner of health shall develop and implement a program to establish community health centers in rural areas of Minnesota that are underserved by health care providers. The program shall provide rural communities and community organizations with technical assistance, capital grants for start-up costs, and short-term assistance with operating costs. The technical assistance component of the program must provide assistance in review of practice management, market analysis, practice feasibility analysis, medical records

system analysis, and scheduling and patient flow analysis. The program must: (1) include a local match requirement for state dollars received; (2) require local communities, through nonprofit boards comprised of local residents, to operate and own their community's health care program; (3) encourage the use of midlevel practitioners; and (4) incorporate a quality assurance strategy that provides regular evaluation of clinical performance and allows peer review comparisons for rural practices. The commissioner shall report to the legislature on implementation of the program by February 15, 1994.

Sec. 13. Minnesota Statutes 1990, section 144.581, subdivision 1, is amended to read:

Subdivision 1. **NONPROFIT CORPORATION POWERS.** A municipality, political subdivision, state agency, or other governmental entity that owns or operates a hospital authorized, organized, or operated under chapters 158, 250, 376, and 397, or under sections 246A.01 to 246A.27, 412.221, 447.05 to 447.13, 447.31, or 471.59, or under any special law authorizing or establishing a hospital or hospital district shall, relative to the delivery of health care services, have, in addition to any authority vested by law, the authority and legal capacity of a nonprofit corporation under chapter 317A, including authority to

(a) enter shared service and other cooperative ventures,

(b) join or sponsor membership in organizations intended to benefit the hospital or hospitals in general,

(c) enter partnerships,

(d) incorporate other corporations,

(e) have members of its governing authority or its officers or administrators serve as directors, officers, or employees of the ventures, associations, or corporations,

(f) own shares of stock in business corporations,

(g) offer, directly or indirectly, products and services of the hospital, organization, association, partnership, or corporation to the general public, and

(h) ~~provide funds for payment of educational expenses of up to $20,000 per individual, if the hospital or hospital district has at least $1,000,000 in reserve and depreciation funds at the time of payment, and these reserve and depreciation funds were obtained solely from the operating revenues of the hospital or hospital district, and~~

~~(i) provide funds of up to $50,000 per year per individual for a maximum of two years to supplement the incomes of family practice physicians, up to a maximum of $100,000 in annual income, if the hospital or hospital district has at least $250,000 in reserve and depreciation funds at the time of payment, and these reserve and depreciation funds were obtained solely from the operating~~

~~revenues of the hospital or hospital district~~ expend funds, including public funds in any form, or devote the resources of the hospital or hospital district to recruit or retain physicians whose services are necessary or desirable for meeting the health care needs of the population, and for successful performance of the hospital or hospital district's public purpose of the promotion of health. Allowable uses of funds and resources include the retirement of medical education debt, payment of one-time amounts in consideration of services rendered or to be rendered, payment of recruitment expenses, payment of moving expenses, and the provision of other financial assistance necessary for the recruitment and retention of physicians, provided that the expenditures in whatever form are reasonable under the facts and circumstances of the situation.

Sec. 14. Minnesota Statutes 1990, section 144.8093, is amended to read:

144.8093 **EMERGENCY MEDICAL SERVICES FUND.**

Subdivision 1. **CITATION.** This section is the "Minnesota emergency medical services system support act."

Subd. 2. **ESTABLISHMENT AND PURPOSE.** In order to develop, maintain, and improve regional emergency medical services systems, the department of health shall establish an emergency medical services system fund. The fund shall be used for the general purposes of promoting systematic, cost-effective delivery of emergency medical care throughout the state; identifying common local, regional, and state emergency medical system needs and providing assistance in addressing those needs; ~~undertaking special~~ providing discretionary grants for emergency medical service projects ~~of statewide significance that will enhance the provision of emergency medical care in Minnesota~~ with potential regionwide significance; providing for public education about emergency medical care; promoting the exchange of emergency medical care information; ensuring the ongoing coordination of regional emergency medical services systems; and establishing and maintaining training standards to ensure consistent quality of emergency medical services throughout the state.

Subd. 3. **USE AND RESTRICTIONS.** Designated regional emergency medical services systems may use emergency medical services system funds to support local and regional emergency medical services as determined within the region, with particular emphasis given to supporting and improving emergency trauma and cardiac care and training. No part of a region's share of the fund may be used to directly subsidize any ambulance service operations or rescue service operations or to purchase any vehicles or parts of vehicles for an ambulance service or a rescue service.

Subd. 4. **DISTRIBUTION.** Money from the fund shall be distributed according to this subdivision. ~~Eighty~~ Ninety-three and one-third percent of the fund shall be distributed annually on a contract for services basis with each of the eight regional emergency medical services systems designated by the commissioner of health. The systems shall be governed by a body consisting of appointed representatives from each of the counties in that region and shall also

include representatives from emergency medical services organizations. The commissioner shall contract with a regional entity only if the contract proposal satisfactorily addresses proposed emergency medical services activities in the following areas: personnel training, transportation coordination, public safety agency cooperation, communications systems maintenance and development, public involvement, health care facilities involvement, and system management. If each of the regional emergency medical services systems submits a satisfactory contract proposal, then this part of the fund shall be distributed evenly among the regions. If one or more of the regions does not contract for the full amount of its even share or if its proposal is unsatisfactory, then the commissioner may reallocate the unused funds to the remaining regions on a pro rata basis. Six and two-thirds percent of the fund shall be used by the commissioner to support regionwide reporting systems and to provide other regional administration and technical assistance. ~~Thirteen and one-third percent shall be distributed by the commissioner as discretionary grants for special emergency medical services projects with potential statewide significance.~~

Sec. 15. Minnesota Statutes 1990, section 447.31, subdivision 1, is amended to read:

Subdivision 1. **RESOLUTIONS.** Any ~~four~~ two or more cities and towns, however organized, except cities of the first class, may create a hospital district. They must do so by resolutions adopted by their respective governing bodies or electors. A hospital district may be reorganized according to sections 447.31 to 447.37. Reorganization must be by resolutions adopted by the district's hospital board and the governing body or voters of each city and town in the district.

Sec. 16. Minnesota Statutes 1990, section 447.31, subdivision 3, is amended to read:

Subd. 3. **CONTENTS OF RESOLUTION.** A resolution under subdivision 1 must state that a hospital district is authorized to be created under sections 447.31 to 447.37, or that an existing hospital district is authorized to be reorganized under sections 447.31 to 447.37, in order to acquire, improve, and run hospital and nursing home facilities that the hospital board decides are necessary and expedient in accordance with sections 447.31 to 447.37. The resolution must name the ~~four~~ two or more cities or towns included in the district. The resolution must be adopted by a two-thirds majority of the members-elect of the governing body or board acting on it, or by the voters of the city or town as provided in this section.

Each resolution adopted by the governing body of a city or town must be published in its official newspaper and takes effect 40 days after publication, unless a petition for referendum on the resolution is filed with the governing body within 40 days. A petition for referendum must be signed by at least five percent of the number of voters voting at the last election of officers. If a petition is filed, the resolution does not take effect until approved by a majority of voters voting on it at a regular municipal election or a special election which the governing body may call for that purpose.

The resolution may also be initiated by petition filed with the governing body of the city or town, signed by at least ten percent of the number of voters voting at the last general election. A petition must present the text of the proposed resolution and request an election on it. If the petition is filed, the governing body shall call a special election for the purpose, to be held within 30 days after the filing of the petition, or may submit the resolution to a vote at a regular municipal election that is to be held within the 30-day period. The resolution takes effect if approved by a majority of voters voting on it at the election. Only one election shall be held within any given 12-month period upon resolutions initiated by petition. The notice of the election and the ballot used must contain the text of the resolution, followed by the question: "Shall the above resolution be approved?"

Sec. 17. **SPECIAL STUDIES.**

(a) The commissioner of health, through the office of rural health, shall:

(1) investigate the adequacy of access to perinatal services in rural Minnesota and report findings and recommendations to the legislature by January 15, 1994; and

(2) study the impact of current reimbursement provisions for midlevel practitioners on the use of midlevel practitioners in rural practice settings, examining reimbursement provisions in state programs, federal programs, and private sector health plans, and report findings and recommendations to the legislature by January 1, 1993.

(b) The commissioner of administration, through the statewide telecommunications access routing program and its advisory council, and in cooperation with the commissioner of health and the rural health advisory committee, shall investigate and develop recommendations regarding the use of advanced telecommunications technologies to improve rural health education and health care delivery. The commissioner of administration shall report findings and recommendations to the legislature by January 15, 1994.

Sec. 18. **REPORT ON RURAL HOSPITAL FINANCIAL ASSISTANCE GRANTS.**

The commissioner of health shall examine the eligibility criteria for rural hospital financial assistance grants under Minnesota Statutes, section 144.1484, and report to the legislature by February 1, 1993, on any needed modifications.

Sec. 19. **STUDY OF BASIC AND ADVANCED LIFE SUPPORT REIMBURSEMENT.**

The commissioner of human services, in consultation with the commissioner of health, shall study the mechanisms and rates of reimbursement for advanced and basic life support ambulance and special transportation service calls under medical assistance and general assistance medical care. The study shall examine methods of simplifying the claims process, interpretation of the

"medically necessary" criteria and prior approval in light of the statutory mandate that ambulance service may not be denied, and other issues that create impediments to reasonable and fair reimbursement. The commissioner shall report findings and offer recommendations to the legislature by January 1, 1993, on means of maximizing potential reimbursement levels.

Sec. 20. **STUDY OF AMBULANCE SUBSCRIPTION PLANS.**

The commissioner of commerce and the commissioner of health shall study prepaid ambulance service plans that allow a person to prepay for ambulance services on a yearly basis. The commissioners shall study plans offered in other states and shall study the cost effectiveness and feasibility of offering these plans in Minnesota. The commissioners shall study methods of funding the plans. The commissioners shall also address the issue of whether these plans should be regulated as insurance, health maintenance organizations, or as another type of entity. The commissioners shall conduct the study in conjunction with the attorney general. The commissioners shall report the findings of the study to the legislature by January 1, 1993.

Sec. 21. **REPEALER.**

Section 3 expires July 1, 1994, or one year after the date upon which a Minnesota program, established to conduct quality assurance and certification activities related to the participation of rural family practice physicians in health plan company provider networks, becomes operational, whichever occurs first.

Sec. 22. **EFFECTIVE DATE.**

Section 1 relating to invoice errors is effective for the department of human services July 1, 1993, or on the implementation date of the upgrade to the Medicaid management information system, whichever is later.

Section 7 creating the rural health advisory committee is effective January 1, 1993.

ARTICLE 6

HEALTH PROFESSIONAL EDUCATION

Section 1. Minnesota Statutes 1990, section 136A.1355, subdivision 2, is amended to read:

Subd. 2. **ELIGIBILITY.** To be eligible to participate in the program, a prospective physician must submit a letter of interest to the higher education coordinating board ~~while attending medical school. Before completing the first year of residency,~~. A student or resident who is accepted must sign a contract to agree to serve at least three of the first five years following residency in a designated rural area.

Sec. 2. Minnesota Statutes 1990, section 136A.1355, subdivision 3, is amended to read:

Subd. 3. **LOAN FORGIVENESS.** Prior to June 30, 1992, the higher education coordinating board may accept up to eight applicants who are fourth year medical students, up to eight applicants who are first year residents, and up to eight applicants who are second year residents for participation in the loan forgiveness program. For the period July 1, 1992 through June 30, 1995, the higher education coordinating board may accept up to eight applicants who are fourth year medical students per fiscal year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed $10,000, as a qualified loan. For each year that a participant serves as a physician in a designated rural area, up to a maximum of four years, the higher education coordinating board shall annually pay an amount equal to one year of qualified loans ~~and the interest accrued on these loans~~. Participants who move their practice from one designated rural area to another remain eligible for loan repayment. In addition, if a resident participating in the loan forgiveness program serves at least four weeks during a year of residency substituting for a rural physician to temporarily relieve the rural physician of rural practice commitments to enable the rural physician to take a vacation, engage in activities outside the practice area, or otherwise be relieved of rural practice commitments, the participating resident may designate up to an additional $2,000, above the $10,000 maximum, for each year of residency during which the resident substitutes for a rural physician for four or more weeks.

Sec. 3. **[136A.1356] MIDLEVEL PRACTITIONER EDUCATION ACCOUNT.**

Subdivision 1. **DEFINITIONS.** For purposes of this section, the following definitions apply:

(a) "Designated rural area" has the definition developed in rule by the higher education coordinating board.

(b) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(c) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advance practice as nurse-midwives.

(d) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advance practice as nurse practitioners.

(e) "Physician assistant" means a person meeting the definition in Minnesota Rules, part 5600.2600, subpart 11.

Subd. 2. **CREATION OF ACCOUNT.** A midlevel practitioner education account is established. The higher education coordinating board shall use money from the account to establish a loan forgiveness program for midlevel practitioners agreeing to practice in designated rural areas.

Subd. 3. **ELIGIBILITY.** To be eligible to participate in the program, a prospective midlevel practitioner must submit a letter of interest to the higher education coordinating board prior to or while attending a program of study designed to prepare the individual for service as a midlevel practitioner. Before completing the first year of this program, a midlevel practitioner must sign a contract to agree to serve at least two of the first four years following graduation from the program in a designated rural area.

Subd. 4. **LOAN FORGIVENESS.** The higher education coordinating board may accept up to eight applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of midlevel practitioner study, up to a maximum of two years, an agreed amount, not to exceed $7,000, as a qualified loan. For each year that a participant serves as a midlevel practitioner in a designated rural area, up to a maximum of four years, the higher education coordinating board shall annually repay an amount equal to one-half a qualified loan. Participants who move their practice from one designated rural area to another remain eligible for loan repayment.

Subd. 5. **PENALTY FOR NONFULFILLMENT.** If a participant does not fulfill the service commitment required under subdivision 4 for full repayment of all qualified loans, the higher education coordinating board shall collect from the participant 100 percent of any payments made for qualified loans and interest at a rate established according to section 270.75. The higher education coordinating board shall deposit the money collected in the midlevel practitioner education account. The board shall allow waivers of all or part of the money owed the board if emergency circumstances prevented fulfillment of the required service commitment.

Sec. 4. **[137.38] EDUCATION AND TRAINING OF PRIMARY CARE PHYSICIANS.**

Subdivision 1. **CONDITION.** If the board of regents accepts the funding appropriated for sections 137.38 to 137.40, it shall comply with the duties for which the appropriations are made.

Subd. 2. **PRIMARY CARE.** For purposes of sections 137.38 to 137.40, "primary care" means a type of medical care delivery that assumes ongoing responsibility for the patient in both health maintenance and illness treatment. It is personal care involving a unique interaction and communication between the patient and the physician. It is comprehensive in scope, and includes all the overall coordination of the care of the patient's health care problems including biological, behavioral, and social problems. The appropriate use of consultants and community resources is an important aspect of effective primary care.

Subd. 3. **GOALS.** The board of regents of the University of Minnesota, through the University of Minnesota medical school, is requested to implement the initiatives required by sections 137.38 to 137.40 in order to increase the number of graduates of residency programs of the medical school who practice primary care by 20 percent over an eight-year period. The initiatives must be designed to encourage newly graduated primary care physicians to establish practices in areas of rural Minnesota that are medically underserved.

Subd. 4. **GRANTS.** The board of regents is requested to seek grants from private foundations and other nonstate sources for the medical school initiatives outlined in sections 137.38 to 137.40.

Subd. 5. **REPORTS.** The board of regents is requested to report annually to the legislature on progress made in implementing sections 137.38 to 137.40, beginning January 15, 1993, and each succeeding January 15.

Sec. 5. **[137.39] MEDICAL SCHOOL INITIATIVES.**

Subdivision 1. **MODIFIED SCHOOL INITIATIVES.** The University of Minnesota medical school is requested to study the demographic characteristics of students that are associated with a primary care career choice. The medical school is requested to modify the selection process for medical students based on the results of this study, in order to increase the number of medical school graduates choosing careers in primary care.

Subd. 2. **DESIGN OF CURRICULUM.** The medical school is requested to ensure that its curriculum provides students with early exposure to primary care physicians and primary care practice. The medical school is requested to also support premedical school educational initiatives that provide students with greater exposure to primary care physicians and practices.

Subd. 3. **CLINICAL EXPERIENCES IN PRIMARY CARE.** The medical school, in consultation with medical school faculty at the University of Minnesota, Duluth, is requested to develop a program to provide students with clinical experiences in primary care settings in internal medicine and pediatrics. The program must provide training experiences in medical clinics in rural Minnesota communities, as well as in community clinics and health maintenance organizations in the Twin Cities metropolitan area.

Sec. 6. **[137.40] RESIDENCY AND OTHER INITIATIVES.**

Subdivision 1. **PRIMARY CARE AND RURAL ROTATIONS.** The University of Minnesota medical school is requested to increase the opportunities for general medicine, pediatrics, and family practice residents to serve rotations in primary care settings. These settings must include community clinics, health maintenance organizations, and practices in rural communities.

Subd. 2. **RURAL RESIDENCY TRAINING PROGRAM IN FAMILY PRACTICE.** The medical school is requested to establish a rural residency training program in family practice. The program shall provide an initial year of

training in a metropolitan-based hospital and family practice clinic. The second and third years of the residency program shall be based in rural communities, utilizing local clinics and community hospitals, with specialty rotations in nearby regional medical centers.

Subd. 3. **CONTINUING MEDICAL EDUCATION.** The medical school is requested to develop continuing medical education programs for primary care physicians that are comprehensive, community-based, and accessible to primary care physicians in all areas of the state.

Sec. 7. **[136A.1357] EDUCATION ACCOUNT FOR NURSES WHO AGREE TO PRACTICE IN A NURSING HOME.**

Subdivision 1. **CREATION OF THE ACCOUNT.** An education account in the general fund is established for a loan forgiveness program for nurses who agree to practice nursing in a nursing home. The account consists of money appropriated by the legislature and repayments and penalties collected under subdivision 4. Money from the account must be used for a loan forgiveness program.

Subd. 2. **ELIGIBILITY.** To be eligible to participate in the loan forgiveness program, a person planning to enroll or enrolled in a program of study designed to prepare the person to become a registered nurse or licensed practical nurse must submit a letter of interest to the board before completing the first year of study of a nursing education program. Before completing the first year of study, the applicant must sign a contract in which the applicant agrees to practice nursing for at least one of the first two years following completion of the nursing education program providing nursing services in a licensed nursing home.

Subd. 3. **LOAN FORGIVENESS.** The board may accept up to ten applicants a year. Applicants are responsible for securing their own loans. For each year of nursing education, for up to two years, applicants accepted into the loan forgiveness program may designate an agreed amount, not to exceed $3,000, as a qualified loan. For each year that a participant practices nursing in a nursing home, up to a maximum of two years, the board shall annually repay an amount equal to one year of qualified loans. Participants who move from one nursing home to another remain eligible for loan repayment.

Subd. 4. **PENALTY FOR NONFULFILLMENT.** If a participant does not fulfill the service commitment required under subdivision 3 for full repayment of all qualified loans, the commissioner shall collect from the participant 100 percent of any payments made for qualified loans and interest at a rate established according to section 270.75. The board shall deposit the collections in the general fund to be credited to the account established in subdivision 1. The board may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

Subd. 5. **RULES.** The board shall adopt rules to implement this section.

Sec. 8. **STUDY OF OBSTETRICAL ACCESS.**

The commissioner of health shall study access to obstetrical services in Minnesota and report to the legislature by January 1, 1993. The study must examine the number of physicians discontinuing obstetrical care in recent years and the effects of high malpractice costs and low government program reimbursement for obstetrical services, and must identify areas of the state where access to obstetrical services is most greatly affected. The commissioner shall recommend ways to reduce liability costs and to encourage physicians to continue to provide obstetrical services.

Sec. 9. **GRANT PROGRAM FOR MIDLEVEL PRACTITIONER TRAINING.**

The higher education coordinating board may award grants to Minnesota schools or colleges that educate, or plan to educate midlevel practitioners, in order to establish and administer midlevel practitioner training programs in areas of rural Minnesota with the greatest need for midlevel practitioners. The program must address rural health care needs, and incorporate innovative methods of bringing together faculty and students, such as the use of telecommunications, and must provide both clinical and lecture components.

Sec. 10. **GRANTS FOR CONTINUING EDUCATION.**

The higher education coordinating board shall establish a competitive grant program for schools of nursing and other providers of continuing nurse education, in order to develop continuing education programs for nurses working in rural areas of the state. The programs must complement, and not duplicate, existing continuing education activities, and must specifically address the needs of nurses working in rural practice settings. The board shall award two grants for the fiscal year ending June 30, 1993.

ARTICLE 7

DATA COLLECTION AND RESEARCH INITIATIVES

Section 1. **[62J.30] HEALTH CARE ANALYSIS UNIT.**

Subdivision 1. **DEFINITIONS.** For purposes of sections 62J.30 to 62J.34, the following definitions apply:

(a) "Practice parameter" means a statement intended to guide the clinical decision making of health care providers and patients that is supported by the results of appropriately designed outcomes research studies, including those studies sponsored by the federal agency for health care policy and research, or has been adopted for use by a national medical society.

(b) "Outcomes research" means research designed to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition, in order to determine the most appropriate and cost-effective means to prevent, diagnose, treat, or manage the condition, or in order to develop and test methods for reducing inappropriate or unnecessary variations in the type and frequency of interventions.

Subd. 2. **ESTABLISHMENT.** The commissioner of health, in consultation with the Minnesota health care commission, shall establish a health care analysis unit to conduct data and research initiatives in order to improve the efficiency and effectiveness of health care in Minnesota.

Subd. 3. **GENERAL DUTIES; IMPLEMENTATION DATE.** The commissioner, through the health care analysis unit, shall:

(1) conduct applied research using existing and newly established health care data bases, and promote applications based on existing research;

(2) establish the condition-specific data base required under section 62J.31;

(3) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health carriers, as defined in section 62L.02, subdivision 16;

(4) work closely with health carriers and health care providers to promote improvements in health care efficiency and effectiveness;

(5) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management;

(6) provide technical assistance to health plan and health care purchasers, as required by section 62J.33;

(7) develop outcome-based practice parameters as required under section 62J.34; and

(8) provide technical assistance as needed to the health planning advisory committee and the regional coordinating boards.

Subd. 4. **CRITERIA FOR UNIT INITIATIVES.** Data and research initiatives by the health care analysis unit must:

(1) serve the needs of the general public, public sector health care programs, employers and other purchasers of health care, health care providers, including providers serving large numbers of low-income people, and health carriers;

(2) promote a significantly accelerated pace of publicly disseminated, applied research on health care delivery, outcomes, costs, quality, and management;

(3) conduct research and promote health care applications based on scientifically sound and statistically valid methods;

(4) be statewide in scope, in order to benefit health care purchasers and providers in all parts of Minnesota and to ensure a broad and representative data base for research, comparisons, and applications;

(5) emphasize data that is useful, relevant, and nonredundant of existing data. The initiatives may duplicate existing private activities, if this is necessary to ensure that the data collected will be in the public domain;

(6) be structured to minimize the administrative burden on health carriers, health care providers, and the health care delivery system, and minimize any privacy impact on individuals; and

(7) promote continuous improvement in the efficiency and effectiveness of health care delivery.

Subd. 5. **CRITERIA FOR PUBLIC SECTOR HEALTH CARE PROGRAMS.** Data and research initiatives related to public sector health care programs must:

(1) assist the state's current health care financing and delivery programs to deliver and purchase health care in a manner that promotes improvements in health care efficiency and effectiveness;

(2) assist the state in its public health activities, including the analysis of disease prevalence and trends and the development of public health responses;

(3) assist the state in developing and refining its overall health policy, including policy related to health care costs, quality, and access; and

(4) provide a data source that allows the evaluation of state health care financing and delivery programs.

Subd. 6. **DATA COLLECTION PROCEDURES.** The health care analysis unit shall collect data from health care providers, health carriers, and individuals in the most cost-effective manner, which does not unduly burden providers. The unit may require health care providers and health carriers to collect and provide patient health records, provide mailing lists of patients who have consented to release of data, and cooperate in other ways with the data collection process. For purposes of this chapter, the health care analysis unit shall assign, or require health care providers and health carriers to assign, a unique identification number to each patient to safeguard patient identity.

Subd. 7. **DATA CLASSIFICATION.** (a) Data collected through the large-scale data base initiatives of the health care analysis unit required by section 62J.31 that identify individuals are private data on individuals. Data not on individuals are nonpublic data. The commissioner may release private data on individuals and nonpublic data to researchers affiliated with university research

centers or departments who are conducting research on health outcomes, practice parameters, and medical practice style; researchers working under contract with the commissioner; and individuals purchasing health care services for health carriers and groups. Prior to releasing any nonpublic or private data under this paragraph that identify or relate to a specific health carrier, medical provider, or health care facility, the commissioner shall provide at least 30 days' notice to the subject of the data, including a copy of the relevant data, and allow the subject of the data to provide a brief explanation or comment on the data which must be released with the data. To the extent reasonably possible, release of private or confidential data under this chapter shall be made without releasing data that could reveal the identity of individuals and should instead be released using the identification numbers required by subdivision 6.

(b) Summary data derived from data collected through the large-scale data base initiatives of the health care analysis unit may be provided under section 13.05, subdivision 7, and may be released in studies produced by the commissioner.

(c) The commissioner shall adopt rules to establish criteria and procedures to govern access to and the use of data collected through the initiatives of the health care analysis unit.

Subd. 8. **DATA COLLECTION ADVISORY COMMITTEE.** The commissioner shall convene a 15-member data collection advisory committee consisting of health service researchers, health care providers, health carrier representatives, representatives of businesses that purchase health coverage, and consumers. Six members of this committee must be health care providers. The advisory committee shall evaluate methods of data collection and shall recommend to the commissioner methods of data collection that minimize administrative burdens, address data privacy concerns, and meet the needs of health service researchers. The advisory committee is governed by section 15.059.

Subd. 9. **FEDERAL AND OTHER GRANTS.** The commissioner shall seek federal funding, and funding from private and other nonstate sources, for the initiatives of the health care analysis unit.

Subd. 10. **CONTRACTS AND GRANTS.** To carry out the duties assigned in sections 62J.30 to 62J.34, the commissioner may contract with or provide grants to private sector entities. Any contract or grant must require the private sector entity to maintain the data on individuals which it receives according to the statutory provisions applicable to the data.

Subd. 11. **RULEMAKING.** The commissioner may adopt permanent and emergency rules to implement sections 62J.30 to 62J.34.

Sec. 2. **[62J.31] LARGE-SCALE DATA BASE.**

Subdivision 1. **ESTABLISHMENT.** The health care analysis unit shall establish a large-scale data base for a limited number of health conditions. This initiative must meet the requirements of this section.

Subd. 2. **SPECIFIC HEALTH CONDITIONS.** (a) The data must be collected for specific health conditions, rather than specific procedures, types of health care providers, or services. The health care analysis unit shall designate a limited number of specific health conditions for which data shall be collected during the first year of operation. For subsequent years, data may be collected for additional specific health conditions. The number of specific conditions for which data is collected is subject to the availability of appropriations.

(b) The initiative must emphasize conditions that account for significant total costs, when considering both the frequency of a condition and the unit cost of treatment. The initial emphasis must be on the study of conditions commonly treated in hospitals on an inpatient or outpatient basis, or in freestanding outpatient surgical centers. This initial emphasis may be expanded to include entire episodes of care for a given condition, whether or not treatment includes use of a hospital or a freestanding outpatient surgical center, if adequate data collection and evaluation techniques are available for that condition.

Subd. 3. **INFORMATION TO BE COLLECTED.** The data collected must include information on health outcomes, including information on mortality, morbidity, patient functional status and quality of life, symptoms, and patient satisfaction. The data collected must include information necessary to measure and make adjustments for differences in the severity of patient condition across different health care providers, and may include data obtained directly from the patient or from patient medical records. The data must be collected in a manner that allows comparisons to be made between providers, health carriers, public programs, and other entities.

Subd. 4. **DATA COLLECTION AND REVIEW.** Data collection for any one condition must continue for a sufficient time to permit: adequate analysis by researchers and appropriate providers, including providers who will be impacted by the data; feedback to providers; and monitoring for changes in practice patterns. The health care analysis unit shall annually review all specific health conditions for which data is being collected, in order to determine if data collection for that condition should be continued.

Subd. 5. **USE OF EXISTING DATA BASES.** (a) The health care analysis unit shall negotiate with private sector organizations currently collecting data on specific health conditions of interest to the unit, in order to obtain required data in a cost-effective manner and minimize administrative costs. The unit shall attempt to establish linkages between the large scale data base established by the unit and existing private sector data bases and shall consider and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

(b) The health care analysis unit shall use existing public sector data bases, such as those existing for medical assistance and Medicare, to the greatest extent possible. The unit shall establish linkages between existing public sector data bases and consider and implement methods to streamline public sector data collection in order to reduce public and private sector administrative costs.

Sec. 3. **[62J.32] ANALYSIS AND USE OF DATA COLLECTED THROUGH THE LARGE-SCALE DATA BASE.**

Subdivision 1. **DATA ANALYSIS.** The health care analysis unit shall analyze the data collected on specific health conditions using existing practice parameters and newly researched practice parameters, including those established through the outcomes research studies of the federal government. The unit may use the data collected to develop new practice parameters, if development and refinement is based on input from and analysis by practitioners, particularly those practitioners knowledgeable about and impacted by practice parameters. The unit may also refine existing practice parameters, and may encourage or coordinate private sector research efforts designed to develop or refine practice parameters.

Subd. 2. **EDUCATIONAL EFFORTS.** The health care analysis unit shall maintain and improve the quality of health care in Minnesota by providing practitioners in the state with information about practice parameters. The unit shall promote, support, and disseminate parameters for specific, appropriate conditions, and the research findings on which these parameters are based, to all practitioners in the state who diagnose or treat the medical condition.

Subd. 3. **PEER REVIEW.** The unit may require peer review by the Minnesota Medical Association, Minnesota Chiropractic Association or appropriate health licensing board for specific health care conditions for which practice in all or part of the state deviates from practice parameters. The commissioner may also require peer review by the Minnesota Medical Association, Minnesota Chiropractic Association or appropriate health licensing board for specific conditions for which there are large variations in treatment method or frequency of treatment in all or part of the state. Peer review may be required for all practitioners statewide, or limited to practitioners in specific areas of the state. The peer review must determine whether the procedures conducted by practitioners are necessary and appropriate, and within acceptable and prevailing practice parameters that have been disseminated by the health care analysis unit in conjunction with the appropriate professional organizations. If a practitioner continues to perform procedures that are inappropriate, even after educational efforts by the review panel, the practitioner may be reported to the appropriate professional licensing board.

Subd. 4. **PRACTICE PARAMETER ADVISORY COMMITTEE.** The commissioner shall convene a 15-member practice parameter advisory committee comprised of eight health care professionals, and representatives of the research community and the medical technology industry. The committee shall present recommendations on the adoption of practice parameters to the commissioner and the Minnesota health care commission and provide technical assistance as needed to the commissioner and the commission. The advisory committee is governed by section 15.059, but does not expire.

Sec. 4. **[62J.33] TECHNICAL ASSISTANCE FOR PURCHASERS.**

The health care analysis unit shall provide technical assistance to health plan and health care purchasers. The unit shall collect information about:

(1) premiums, benefit levels, managed care procedures, health care outcomes, and other features of popular health plans and health carriers; and

(2) prices, outcomes, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses.

The commissioner shall publicize this information in an easily understandable format.

Sec. 5. **[62J.34] OUTCOME-BASED PRACTICE PARAMETERS.**

Subdivision 1. **PRACTICE PARAMETERS.** The health care analysis unit may develop, adopt, revise, and disseminate practice parameters, and disseminate research findings, that are supported by medical literature and appropriately controlled studies to minimize unnecessary, unproven, or ineffective care. Among other appropriate activities relating to the development of practice parameters, the health care analysis unit shall:

(1) determine uniform specifications for the collection, transmission, and maintenance of health outcomes data; and

(2) conduct studies and research on the following subjects:

(i) new and revised practice parameters to be used in connection with state health care programs and other settings;

(ii) the comparative effectiveness of alternative modes of treatment, medical equipment, and drugs;

(iii) the relative satisfaction of participants with their care, determined with reference to both provider and mode of treatment;

(iv) the cost versus the effectiveness of health care treatments; and

(v) the impact on cost and effectiveness of health care of the management techniques and administrative interventions used in the state health care programs and other settings.

Subd. 2. **APPROVAL.** The commissioner of health, after receiving the advice and recommendations of the Minnesota health care commission, may approve practice parameters that are endorsed, developed, or revised by the health care analysis unit. The commissioner is exempt from the rulemaking requirements of chapter 14 when approving practice parameters approved by the federal agency for health care policy and research, practice parameters adopted for use by a national medical society, or national medical specialty society. The commissioner shall use rulemaking to approve practice parameters that are newly developed or substantially revised by the health care analysis unit.

Practice parameters adopted without rulemaking must be published in the State Register.

Subd. 3. **MEDICAL MALPRACTICE CASES.** (a) In an action against a provider for malpractice, error, mistake, or failure to cure, whether based in contract or tort, adherence to a practice parameter approved by the commissioner of health under subdivision 2 is an absolute defense against an allegation that the provider did not comply with accepted standards of practice in the community.

(b) Evidence of a departure from a practice parameter is admissible only on the issue of whether the provider is entitled to an absolute defense under paragraph (a).

(c) Paragraphs (a) and (b) apply to claims arising on or after August 1, 1993, or 90 days after the date the commissioner approves the applicable practice parameter, whichever is later.

(d) Nothing in this section changes the standard or burden of proof in an action alleging a delay in diagnosis, a misdiagnosis, inappropriate application of a practice parameter, failure to obtain informed consent, battery or other intentional tort, breach of contract, or product liability.

Sec. 6. Minnesota Statutes 1991 Supplement, section 145.61, subdivision 5, is amended to read:

Subd. 5. "Review organization" means a nonprofit organization acting according to clause (k) or a committee whose membership is limited to professionals, administrative staff, and consumer directors, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of professionals, by an organization of professionals from a particular area or medical institution, by a health maintenance organization as defined in chapter 62D, by a nonprofit health service plan corporation as defined in chapter 62C, by a professional standards review organization established pursuant to United States Code, title 42, section 1320c-1 et seq., or by a medical review agent established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), or by the department of human services, to gather and review information relating to the care and treatment of patients for the purposes of:

(a) evaluating and improving the quality of health care rendered in the area or medical institution;

(b) reducing morbidity or mortality;

(c) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(d) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(e) developing and publishing guidelines designed to keep within reasonable bounds the cost of health care;

(f) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations, health service plans, and insurance companies;

(g) acting as a professional standards review organization pursuant to United States Code, title 42, section 1320c-1 et seq.;

(h) determining whether a professional shall be granted staff privileges in a medical institution, membership in a state or local association of professionals, or participating status in a nonprofit health service plan corporation, health maintenance organization, or insurance company, or whether a professional's staff privileges, membership, or participation status should be limited, suspended or revoked;

(i) reviewing, ruling on, or advising on controversies, disputes or questions between:

(1) health insurance carriers, nonprofit health service plan corporations, or health maintenance organizations and their insureds, subscribers, or enrollees;

(2) professional licensing boards ~~acting under their powers including disciplinary, license revocation or suspension procedures~~ and health providers licensed by them ~~when the matter is referred to a review committee by the professional licensing board~~;

(3) professionals and their patients concerning diagnosis, treatment or care, or the charges or fees therefor;

(4) professionals and health insurance carriers, nonprofit health service plan corporations, or health maintenance organizations concerning a charge or fee for health care services provided to an insured, subscriber, or enrollee;

(5) professionals or their patients and the federal, state, or local government, or agencies thereof;

(j) providing underwriting assistance in connection with professional liability insurance coverage applied for or obtained by dentists, or providing assistance to underwriters in evaluating claims against dentists;

(k) acting as a medical review agent under section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b); ~~or~~

(l) providing recommendations on the medical necessity of a health service, or the relevant prevailing community standard for a health service; or

(m) reviewing a provider's professional practice as requested by the health care analysis unit under section 62J.32.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 7. Minnesota Statutes 1991 Supplement, section 145.64, subdivision 2, is amended to read:

Subd. 2. **PROVIDER DATA.** The restrictions in subdivision 1 shall not apply to professionals requesting or seeking through discovery, data, information, or records relating to their medical staff privileges, membership, or participation status. However, any data so disclosed in such proceedings shall not be admissible in any other judicial proceeding than those brought by the professional to challenge an action relating to the professional's medical staff privileges or participation status.

Sec. 8. **[214.16] DATA COLLECTION; HEALTH CARE PROVIDER TAX.**

Subdivision 1. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given them.

(a) "Board" means the boards of medical practice, chiropractic examiners, nursing, optometry, dentistry, pharmacy, and podiatry.

(b) "Regulated person" means a licensed physician, chiropractor, nurse, optometrist, dentist, pharmacist, or podiatrist.

Subd. 2. **BOARD COOPERATION REQUIRED.** The board shall assist the commissioner of health and the data analysis unit in data collection activities required under this article and shall assist the commissioner of revenue in activities related to collection of the health care provider tax required under article 9. Upon the request of the commissioner, the data analysis unit, or the commissioner of revenue, the board shall make available names and addresses of current licensees and provide other information or assistance as needed.

Subd. 3. **GROUNDS FOR DISCIPLINARY ACTION.** The board shall take disciplinary action against a regulated person for:

(1) failure to provide the commissioner of health with data on gross patient revenue as required under section 62J.04;

(2) failure to provide the health care analysis unit with data as required under this article;

(3) failure to provide the commissioner of revenue with data on gross revenue and other information required for the commissioner to implement sections 295.50 to 295.58; and

(4) failure to pay the health care provider tax required under section 295.52.

Sec. 9. **STUDY OF ADMINISTRATIVE COSTS.**

The health care analysis unit shall study costs and requirements incurred by health carriers, group purchasers, and health care providers that are related to

the collection and submission of information to the state and federal government, insurers, and other third parties. The unit shall recommend to the commissioner of health and the Minnesota health care commission by January 1, 1994, any reforms that may reduce these costs without compromising the purposes for which the information is collected.

ARTICLE 8

MEDICAL MALPRACTICE

Section 1. Minnesota Statutes 1990, section 145.682, subdivision 4, is amended to read:

Subd. 4. **IDENTIFICATION OF EXPERTS TO BE CALLED.** (a) The affidavit required by subdivision 2, clause (2), must be signed by each expert listed in the affidavit and by the plaintiff's attorney and state the identity of each person whom plaintiff expects to call as an expert witness at trial to testify with respect to the issues of malpractice or causation, the substance of the facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. Answers to interrogatories that state the information required by this subdivision satisfy the requirements of this subdivision if they are signed by the plaintiff's attorney and by each expert listed in the answers to interrogatories and served upon the defendant within 180 days after commencement of the suit against the defendant.

(b) The parties or the court for good cause shown, may by agreement, provide for extensions of the time limits specified in subdivision 2, 3, or this subdivision. Nothing in this subdivision may be construed to prevent either party from calling additional expert witnesses or substituting other expert witnesses.

(c) In any action alleging medical malpractice, all expert interrogatory answers must be signed by the attorney for the party responding to the interrogatory and by each expert listed in the answers. The court shall include in a scheduling order a deadline prior to the close of discovery for all parties to answer expert interrogatories for all experts to be called at trial. No additional experts may be called by any party without agreement of the parties or by leave of the court for good cause shown.

Sec. 2. **[604.11] MEDICAL MALPRACTICE CASES.**

Subdivision 1. **DISCOVERY.** Pursuant to the time limitations set forth in the Minnesota rules of civil procedure, the parties to any medical malpractice action may exchange the uniform interrogatories in subdivision 3 and ten additional nonuniform interrogatories. Any subparagraph of a nonuniform interrogatory will be treated as one nonuniform interrogatory. By stipulation of the parties, or by leave of the court upon a showing of good cause, more than ten additional nonuniform interrogatories may be propounded by a party. In addi-

tion, the parties may submit a request for production of documents pursuant to rule 34 of the Minnesota rules of civil procedure.

Subd. 2. **ALTERNATIVE DISPUTE RESOLUTION.** At the time a trial judge orders a case for trial, the court shall require the parties to discuss and determine whether a form of alternative dispute resolution would be appropriate or likely to resolve some or all of the issues in the case. Alternative dispute resolution may include arbitration, mediation, summary jury trial, or other alternatives suggested by the court or parties, and may be either binding or nonbinding. All parties must agree unanimously before alternative dispute resolution proceeds.

Subd. 3. **UNIFORM INTERROGATORIES.** (a) Uniform plaintiff's interrogatories to the defendant are as follows:

PLAINTIFF'S INTERROGATORIES TO DEFENDANT

INTERROGATORY NO. 1:

Please attach a complete curriculum vitae for Dr. (.....), M.D., which should include, but is not limited to, the following information:

a. Name;

b. Office address;

c. Name of practice;

d. Identities of partners or associates, including their names, specialties, and how long they have been associated with Dr. (.....);

e. Specialty of Dr. (.....);

f. Age;

g. The names and dates of attendance at any medical schools;

h. Full information as to internship or residency, including the place and dates of the internship or residency as well as any specialized fields of practice engaged in during such internship or residency;

i. The complete history of the practice of Dr. (.....) from and after medical school, setting forth the places where Dr. (.....) practiced medicine, the persons with whom Dr. (.....) was associated, the dates of the practice, and the reasons for leaving the practice;

j. Full information as to any board certifications Dr. (.....) may hold, including the field of specialty and the dates of the certifications and any recertifications;

k. Identifying the medical societies and organizations to which Dr. (.....) belongs, giving full information as to any offices held in the organizations;

l. Identifying all professional journal articles, treatises, textbooks, abstracts, speeches, or presentations which Dr. (.....) has authored or contributed to; and

m. Any other information which describes or explains the training and experience of Dr. (.....) for the practice of medicine.

INTERROGATORY NO. 2:

Has Dr. (.....) been the subject of any professional disciplinary actions of any kind and, if so:

State whether Dr. (.....'s) license to practice medicine has ever been revoked or publicly limited in any way and, if so, give the date and the reasons for such revocation or restriction.

INTERROGATORY NO. 3:

Please set forth a listing by author, title, publisher, and date of publication of all the medical texts referred to by Dr. (.....) with respect to the practice of medicine during the past five years.

INTERROGATORY NO. 4:

Please set forth a complete listing of the medical and professional journals to which Dr. (.....) subscribes or has subscribed within the past five years.

INTERROGATORY NO. 5:

As to each expert whom you expect to call as a witness at trial, please state:

a. The expert's name, address, occupation, and title;

b. The expert's field of expertise, including subspecialties, if any;

c. The expert's education background;

d. The expert's work experience in the field of expertise;

e. All professional societies and associations of which the expert is a member;

f. All hospitals at which the expert has staff privileges of any kind;

g. All written publications of which the expert is the author, giving the title of the publication and when and where it was published.

INTERROGATORY NO. 6:

With respect to each person identified in answer to the foregoing interrogatory, state:

a. The subject matter on which the person is expected to testify;

b. The substance of the facts and opinions to which the person is expected to testify; and

c. A summary of the grounds for each opinion, including the specific factual data upon which the opinion will be based.

INTERROGATORY NO. 7:

Please state whether there is any policy of insurance that will provide coverage to the defendant should liability attach on the basis of the allegations contained in the plaintiff's Complaint. If so, state with regard to each policy applicable:

a. The name and address of the insurer;

b. The exact limits of coverage applicable;

c. Whether any reservation of rights or controversy or coverage dispute exists between you and the insurance company.

Please attach copies of each policy to your Answers.

INTERROGATORY NO. 8:

State the full name, present address, occupation, age, present employer, and the present employer's address of each physician, nurse, or other medical personnel in the employ of the defendant or defendant's professional association who treated, cared for, examined, or otherwise attended (name) from (date 1), through (date 2). With regard to every individual, please state:

a. Each date upon which the individual attended (name);

b. The nature of the treatment or care rendered (name) on each date;

c. The qualifications and area of specialty of each individual; and

d. The present address of each individual.

In responding to this interrogatory, referring plaintiff's counsel to medical records will not be deemed to be a sufficient answer as plaintiff's counsel has reviewed the medical records and is not able to determine the identity of the individuals.

INTERROGATORY NO. 9: (Hospital defendant only)

Please state the name, address, telephone number, and last known employer of the nursing supervisor for the shifts set forth in the preceding interrogatory.

INTERROGATORY NO. 10:

Please identify by name and current or last known address and telephone number each and every person who has or claims to have knowledge of any facts relevant to the issues in this lawsuit, stating in detail all facts each person has or claims to have knowledge of.

INTERROGATORY NO. 11:

a. Have any statements been taken from nonparties or the plaintiff(s) pertaining to this claim? For purposes of this request, a statement previously made is (1) a written statement signed or otherwise adopted or approved by the person making it, or (2) a stenographic, mechanical, electrical, or other recording, or a transcription thereof, which is a substantial verbatim recital or an oral statement by the person making it and contemporaneously recorded. With regard to each statement, state:

1. The name and address of each person making a statement;

2. The date on which the statement was made;

3. The name and address of the person or persons taking each statement; and

4. The subject matter of each statement.

b. Attach a copy of each statement to the answers to these interrogatories.

c. If you claim that any information, document, or thing sought or requested is privileged, protected by the work product doctrine, or otherwise not discoverable, please:

1. Identify each document or thing by date, author, subject matter, and recipient;

2. State in detail the legal and factual basis for asserting said privilege, work product protection, or objection, or refusing to provide discovery as requested.

INTERROGATORY NO. 12:

Do you or anyone acting on your behalf know of any photographs, films, or videotapes depicting .....? If so, state:

a. The number of photographs or feet of film or videotape;

b. The places, objects, or persons photographed, filmed, or videotaped;

c. The date the photographs, film, or videotapes were taken;

d. The name, address, and telephone number of each person who has the original or copy.

Please attach copies of any photographs or videotapes.

New language is indicated by underline, deletions by ~~strikeout~~.

INTERROGATORY NO. 13:

If you claim that injuries to plaintiff complained of in plaintiff's Complaint were contributed to or caused by plaintiff or any other person, including any other physician, hospital, nurse, or other health care provider, please state:

a. The facts upon which you base the claim;

b. The name, current address, and current employer of each person whom you allege was or may have been negligent.

INTERROGATORY No. 14:

Please state the name or names of the individuals supplying the information contained in your Answers to these Interrogatories. In addition, please state these individuals' current addresses, places of employment, and their current position at their place of employment.

INTERROGATORY NO. 15:

Does defendant have knowledge of any conversations or statements made by the plaintiff(s) concerning any subject matter relative to this action? If so, please state:

a. The name and last known address of each person who claims to have heard such conversations or statements;

b. The date of such conversations or statements;

c. The summary or the substance of each conversation or statement.

INTERROGATORY NO. 16:

Did the defendant, the defendant's agents, or employees conduct a surveillance of the plaintiff(s)? If so, state:

a. Name, address, and occupation of the person who conducted each surveillance;

b. Name and address of the person who requested each surveillance to be made;

c. Date or dates on which each surveillance was conducted;

d. Place or places where each surveillance was performed;

e. Information or facts discovered in the surveillance;

f. Name and address of the person now having custody of each written report, photographs, videotapes, or other documents concerning each surveillance.

INTERROGATORY NO. 17:

Are you aware of any person you may call as a witness at the trial of this action who may have or claims you have any information concerning the medical, mental, or physical condition of the plaintiff(s) prior to the incident in question? ..... If so, state:

a. The name and last know address of each person and your means of ascertaining the present whereabouts of each person;

b. The occupation and employer of each person;

c. The subject and substance of the information each person claims to have.

INTERROGATORY NO. 18:

As to any affirmative defenses you allege, state the factual basis of and describe each affirmative defense, the evidence which will be offered at trial concerning any alleged affirmative defense, including the names of any witnesses who will testify in support thereof, and the descriptions of any exhibits which will be offered to establish each affirmative defense.

INTERROGATORY NO. 19:

Do you contend that any entries in the answering defendant's medical/hospital records are incorrect or inaccurate? If so, state:

a. The precise entry(ies) that you think are incorrect or inaccurate;

b. What you contend the correct or accurate entry(ies) should have been;

c. The name, address, and employer of each and every person who has knowledge pertaining to a. and b.;

d. A description, including the author and title of each and every document that you claim supports your answer to a. and b.;

e. The name, address, and telephone number of each and every person you intend to call as a witness in support of your contention.

(b) Uniform defendant's interrogatories to the plaintiff for personal injury cases are as follows:

DEFENDANT'S INTERROGATORIES TO PLAINTIFF (PERSONAL INJURY)

1. State your full name, address, date of birth, marital status, and social security number.

2. If you have been employed at any time in the past ten years, with respect to this period state the names and addresses of each of your employers, describe the nature of your work, and state the approximate dates of each employment.

3. If you have ever been a party to a lawsuit where you claimed damages for injury to your person, state the title of the suit, the court file number, the date of filing, the name and address of any involved insurance carrier, the kind of claim, and the ultimate disposition of the same. (This is meant to include workers' compensation and social security disability claims.)

4. Identify by name and address each and every physician, surgeon, medical practitioner, or other health care practitioner whom you consulted or who provided advice, treatment, or care for you at any time within the last ten years and, with respect to each contract, consultation, treatment, or advice, describe the same with particularity and indicate the reasons for the same.

5. State the name and address of each and every hospital, treatment facility, or institution in which plaintiff has been confined for any reason at any time, and set forth with particularity the reasons for each confinement and/or treatment and the dates of each.

6. Itemize all special damages which you claim in this case and specify, where appropriate, the basis and reason for your calculation as to each item of special damages.

7. List all payments related to the injury or disability in question that have been made to you, or on your behalf, from "collateral sources" as that term is defined in Minnesota Statutes, section 548.36.

8. List all amounts that have been paid, contributed, or forfeited by, or on behalf of, you or members of your immediate family for the two-year period immediately before the accrual of this action to secure the right to collateral source benefits that have been made to you or on your behalf.

9. Do you contend any of the following:

a. That defendant did not possess that degree of skill and learning which is normally possessed and used by medical professionals in good standing in a similar practice and under like circumstances;

b. That defendant did not exercise that degree of skill and learning which is normally used by medical professionals in good standing in a similar practice and under like circumstances.

10. If your answer to any part of the foregoing interrogatory is yes, with respect to each answer:

a. Specify in detail each contention;

b. Specify in detail each act or omission of defendant which you contend was a departure from the degree of skill and learning normally used by medical professionals in a similar practice and under like circumstances;

c. Specify in detail the conduct of defendant as you claim it should have been;

d. Specify in detail each fact known to you and your attorneys upon which you base your answers to interrogatories 9 and 10.

11. If you claim defendant failed to disclose to you any risk concerning the involved medical care and treatment which, if disclosed, would have resulted in your refusing to consent to the medical care or treatment, then:

a. State in detail each and every thing defendant did tell you concerning the risks of the involved medical care and treatment, giving the approximate dates thereof and identifying all persons in attendance;

b. Describe each and every risk which you claim defendant should have, but failed to, disclose to you;

c. Describe in detail precisely what you claim defendant should have said to you, but failed to say, concerning the risks of the involved medical care and treatment;

d. Explain in detail all facts and reasons upon which you base the claim that, if the foregoing risks were explained to you, you would not have consented to the involved medical care and treatment.

12. Please identify by name and current or last known address and telephone number each and every person who has or claims to have any knowledge of any facts relevant to the issues in this lawsuit, stating in detail all facts each person has or claims to have knowledge of.

13. As to each expert whom you expect to call as a witness at trial, please state:

a. The expert's name, address, occupation, and title;

b. The expert's field of expertise, including subspecialties, if any;

c. The expert's education background;

d. The expert's work experience in the field of expertise;

e. All professional societies and associations of which the expert is a member;

f. All hospitals at which the expert has staff privileges of any kind;

g. All written publications of which the expert is the author, giving the title of the publication and when and where it was published.

14. With respect to each person identified in answer to the foregoing interrogatory, state:

a. The subject matter on which the expert is expected to testify;

b. The substance of the facts and opinions to which the expert is expected to testify; and

c. A summary of the grounds for each opinion, including the specific factual data upon which the opinion will be based.

15. Have any statements been taken from any defendant or nonparty pertaining to this claim? For purposes of this request, a statement previously made is: (1) a written statement signed or otherwise adopted or approved by the person making it, or (2) a stenographic, mechanical, electrical, or other recording, or a transcription thereof, which is a substantial verbatim recital or an oral statement by the person making it and contemporaneously recorded. With regard to each statement, state:

a. The name and address of each person making a statement;

b. The date on which the statement was made;

c. The name and address of the person or persons taking each statement; and

d. The subject matter of the statement;

e. Attach a copy of each statement to the answers to these interrogatories.

f. If you claim that any information, document, or thing sought or requested is privileged, protected by the work product doctrine, or otherwise not discoverable, please:

1. Identify each document or thing by date, author, subject matter, and recipient;

2. State in detail the legal and factual basis for asserting said privilege, work product protection, or objection, or refusing to provide discovery as requested.

(c) Uniform defendant's interrogatories to the plaintiff for wrongful death cases are as follows:

DEFENDANT'S INTERROGATORIES TO PLAINTIFF (WRONGFUL DEATH)

1. State the full name, age, present occupation, business address, present residence address, and address for a period of ten years prior to the present date for each heir or next of kin (including the Trustee) on whose behalf this action has been commenced.

2. Set forth the date of birth and place of birth of the decedent.

3. Set forth the date of birth and place of birth of the decedent's surviving spouse.

4. Set forth the names, date of birth, and places of birth of any children of decedent.

5. Set forth the names, addresses, and dates of birth of all heirs and next of kin of decedent and set forth the relationship of each individual to decedent.

6. Set forth the date of marriage between decedent and decedent's surviving spouse and the place of the marriage.

7. Set forth whether or not there were any proceedings for a legal separation or divorce instituted between decedent and decedent's surviving spouse and, if so, set forth the dates that the proceedings were instituted, the result of the proceedings, and the court in which the proceedings were instituted.

8. Set forth whether or not decedent was ever married to anyone other than decedent's surviving spouse and if so, set forth the names of any other spouse or spouses and the inclusive dates of any other marriages.

9. Set forth whether or not decedent's surviving spouse has ever been married to anyone other than decedent and, if so, set forth the names of any other spouses and the inclusive dates of any other marriages.

10. If you claim defendant failed to disclose to you any risk concerning the involved medical care and treatment which, if disclosed, would have resulted in the decedent's refusing to consent to the medical care or treatment, then:

a. State in detail each and every thing defendant did tell you concerning the risks of the involved medical care and treatment, giving the approximate dates thereof and identify all persons in attendance;

b. Describe each and every risk which you claim defendants should have, but failed to, disclose to you;

c. Describe in detail precisely what you claim defendant should have said to you, but failed to say, concerning the risks of the involved medical care and treatment;

d. Explain in detail all facts and reasons upon which you base the claim that, if the foregoing risks were explained to you, you would not have consented to the involved medical care and treatment.

11. Was the deceased employed at the time of death?

12. If the answer to Interrogatory No. 10 is yes, indicate the following:

a. The name and address of the deceased's employer and the nature of the employment;

b. The amount of earnings from the employment;

c. Defendant requests copies of the decedent's federal and state income tax return for the past five years.

13. If decedent was self-employed for any period of time during the ten-year period of time immediately preceding decedent's death, set forth the following:

a. The inclusive dates of the self-employment;

b. A specific and detailed description of the nature of the self-employment;

c. The business name and address under which decedent operated; and

d. A specific and detailed description of decedent's earnings from the self-employment.

14. Set forth in detail a chronological education history of decedent including the name and address of each school attended, the inclusive dates of attendance, the date of graduation, a description of any degrees awarded, a description of the major area of study and the grade point average upon graduation.

15. Did the decedent make any contribution of money, property, or other items having a money worth toward the support, maintenance, or well-being of any next of kin and, if so, please itemize the following:

a. The amount and nature of the contribution;

b. The date(s) upon which each contribution was made;

c. The persons(s) receiving each contribution;

d. The period of time over which the contributions were made;

e. The regularity or irregularity of the contributions;

f. Identify by date, author, type, recipient, and present custodian each and every document referring to or otherwise evidencing each contribution.

16. Identify by name and address each and every physician, surgeon, medical practitioner, or other health care practitioner whom the decedent consulted or who provided advice, treatment, or care for the decedent at any time within ten years prior to death and, with respect to the contact, consultation, treatment, or advice, describe the same with particularity and indicate the reasons for the same.

17. State the name and address of each and every hospital, treatment facility, or institution in which the decedent has been confined for any reason at any time, and set forth with particularity the reasons for each confinement and/or treatment and the dates of each.

18. Itemize all special damages which you claim in this case and specify, where appropriate, the basis and reason for your calculation as to each item of special damages.

19. List any payment related to the injury or disability in question made to you, or on your behalf, from "collateral sources" as that term is defined in Minnesota Statutes, section 548.36.

20. List all amounts that have been paid, contributed or forfeited by, or on behalf of, you or members of your immediate family for the two-year period immediately before the accrual of this action to secure the right to collateral source benefits that have been made to you or on your behalf.

21. Do you contend any of the following:

a. That any of the defendants did not possess that degree of skill and learning which is normally possessed and used by medical professionals in good standing in a similar practice and under like circumstances? If so, identify the defendants;

b. That any of the defendants did not exercise that degree of skill and learning which is normally used by medical professionals in good standing in a similar practice and under like circumstances? If so, identify the defendants.

22. If your answer to any part of the foregoing interrogatory is yes, with respect to each answer:

a. Specify in detail your contention;

b. Specify in detail each act or omission of each defendant which you contend was a departure from that degree of skill and learning normally used by medical professionals in a similar practice and under like circumstances.

23. Please identify by name and current or last known address and telephone number of each and every person who has or claims to have any knowledge of any facts relevant to the issues in this lawsuit, stating in detail all facts each person has or claims to have knowledge of.

24. As to each expert whom you expect to call as a witness at trial, please state:

a. The expert's name, address, occupation, and title;

b. The expert's field of expertise, including subspecialties, if any;

c. The expert's education background;

d. The expert's work experience in the field of expertise;

e. All professional societies and associations of which the expert is a member;

f. All hospitals at which the expert has staff privileges of any kind;

g. All written publications of which the expert is the author, giving the title of the publication and when and where it was published.

25. With respect to each person identified in the foregoing interrogatory, state:

a. The subject matter on which the expert is expected to testify;

b. The substance of the facts and opinions to which the expert is expected to testify; and

c. A summary of the grounds for each opinion, including the specific factual data upon which the opinion will be based.

26. Set forth in detail anything said or written by which plaintiff claims to be relevant to any of the issues in this lawsuit, identifying the time and place of each statement, who was present, and what was said by each person who was present.

27. Have any statements been taken from any defendant or nonparty pertaining to this claim? For purposes of this request, a statement previously made is: (1) a written statement signed or otherwise adopted or approved by the person making it, or (2) a stenographic, mechanical, electrical, or other recording, or a transcription thereof, which is a substantial verbatim recital or an oral statement by the person making it and contemporaneously recorded. With regard to each statement, state:

a. The name and address of each person making a statement;

b. The date on which the statement was made;

c. The name and address of the person or persons taking each statement; and

d. The subject matter of each statement;

e. Attach a copy of each statement to the answers to these interrogatories;

f. If you claim that any information, document or thing sought or requested is privileged, protected by the work product doctrine, or otherwise not discoverable, please:

1. Identify each document or thing by date, author, subject matter, and recipient;

2. State in detail the legal and factual basis for asserting said privilege, work product protection, or objection, or refusing to provide discovery as requested.

ARTICLE 9

FINANCING

Section 1. **[16A.724] HEALTH CARE ACCESS FUND.**

A health care access fund is created in the state treasury. The fund is a direct appropriated special revenue fund. The commissioner shall deposit to the credit of the fund money made available to the fund.

Sec. 2. Minnesota Statutes 1990, section 60A.15, subdivision 1, is amended to read:

Subdivision 1. **DOMESTIC AND FOREIGN COMPANIES.** (a) On or before April 15, June 15, and December 15 of each year, every domestic and foreign company, including town and farmers' mutual insurance companies ~~and~~, domestic mutual insurance companies, health maintenance organizations, and nonprofit health service corporations, shall pay to the commissioner of revenue installments equal to one-third of the insurer's total estimated tax for the current year. Except as provided in ~~paragraph~~ paragraphs (b) and (e), installments must be based on a sum equal to two percent of the premiums described in paragraph (c).

(b) For town and farmers' mutual insurance companies and mutual property and casualty insurance companies other than those (i) writing life insurance, or (ii) whose total assets on December 31, 1989, exceeded $1,600,000,000, the installments must be based on an amount equal to the following percentages of the premiums described in paragraph (c):

(1) for premiums paid after December 31, 1988, and before January 1, 1992, one percent; and

(2) for premiums paid after December 31, 1991, one-half of one percent.

(c) Installments under paragraph (a) ~~or~~, (b), or (e) are percentages of gross premiums less return premiums on all direct business received by the insurer in this state, or by its agents for it, in cash or otherwise, during such year, excepting premiums written for marine insurance as specified in subdivision 6.

(d) Failure of a company to make payments of at least one-third of either (1) the total tax paid during the previous calendar year or (2) 80 percent of the actual tax for the current calendar year shall subject the company to the penalty and interest provided in this section, unless the total tax for the current tax year is $500 or less.

(e) For health maintenance organizations and nonprofit health services corporations, the installments must be based on an amount equal to one percent of premiums described in paragraph (c) that are paid after December 31, 1995.

(f) Premiums under the children's health plan, the health right plan, and

Minnesota comprehensive health insurance plan are not subject to tax under this section.

Sec. 3. Minnesota Statutes 1990, section 62C.01, subdivision 3, is amended to read:

Subd. 3. **SCOPE.** Every foreign or domestic nonprofit corporation organized for the purpose of establishing or operating a health service plan in Minnesota whereby health services are provided to subscribers to the plan under a contract with the corporation shall be subject to and governed by Laws 1971, chapter 568, and shall not be subject to the laws of this state relating to insurance, except section 60A.15 and as otherwise specifically provided. Laws 1971, chapter 568 shall apply to all health service plan corporations incorporated after August 1, 1971, and to all existing health service plan corporations, except as otherwise provided. Nothing in sections 62C.01 to 62C.23 shall apply to prepaid group practice plans. A prepaid group practice plan is any plan or arrangement other than a service plan, whereby health services are rendered to certain patients by providers who devote their professional effort primarily to members or patients of the plan, and whereby the recipients of health services pay for the services on a regular, periodic basis, not on a fee for service basis.

Sec. 4. Minnesota Statutes 1990, section 290.01, subdivision 19b, is amended to read:

Subd. 19b. **SUBTRACTIONS FROM FEDERAL TAXABLE INCOME.** For individuals, estates, and trusts, there shall be subtracted from federal taxable income:

(1) interest income on obligations of any authority, commission, or instrumentality of the United States to the extent includable in taxable income for federal income tax purposes but exempt from state income tax under the laws of the United States;

(2) if included in federal taxable income, the amount of any overpayment of income tax to Minnesota or to any other state, for any previous taxable year, whether the amount is received as a refund or as a credit to another taxable year's income tax liability;

(3) the amount paid to others not to exceed $650 for each dependent in grades kindergarten to 6 and $1,000 for each dependent in grades 7 to 12, for tuition, textbooks, and transportation of each dependent in attending an elementary or secondary school situated in Minnesota, North Dakota, South Dakota, Iowa, or Wisconsin, wherein a resident of this state may legally fulfill the state's compulsory attendance laws, which is not operated for profit, and which adheres to the provisions of the Civil Rights Act of 1964 and chapter 363. As used in this clause, "textbooks" includes books and other instructional materials and equipment used in elementary and secondary schools in teaching only those subjects legally and commonly taught in public elementary and secondary schools in this state. "Textbooks" does not include instructional books and materials used

in the teaching of religious tenets, doctrines, or worship, the purpose of which is to instill such tenets, doctrines, or worship, nor does it include books or materials for, or transportation to, extracurricular activities including sporting events, musical or dramatic events, speech activities, driver's education, or similar programs. In order to qualify for the subtraction under this clause the taxpayer must elect to itemize deductions under section 63(e) of the Internal Revenue Code;

(4) to the extent included in federal taxable income, distributions from a qualified governmental pension plan, an individual retirement account, simplified employee pension, or qualified plan covering a self-employed person that represent a return of contributions that were included in Minnesota gross income in the taxable year for which the contributions were made but were deducted or were not included in the computation of federal adjusted gross income. The distribution shall be allocated first to return of contributions until the contributions included in Minnesota gross income have been exhausted. This subtraction applies only to contributions made in a taxable year prior to 1985;

(5) income as provided under section 290.0802;

(6) the amount of unrecovered accelerated cost recovery system deductions allowed under subdivision 19g; ~~and~~

(7) to the extent included in federal adjusted gross income, income realized on disposition of property exempt from tax under section 290.491~~.~~; and

(8) to the extent not deducted in determining federal taxable income, the amount paid for health insurance of self-employed individuals as determined under section 162(l) of the Internal Revenue Code, except that the 25 percent limit does not apply. If the taxpayer deducted insurance payments under section 213 of the Internal Revenue Code of 1986, the subtraction under this clause must be reduced by the lesser of:

(i) the total itemized deductions allowed under section 63(d) of the Internal Revenue Code, less state, local, and foreign income taxes deductible under section 164 of the Internal Revenue Code and the standard deduction under section 63(c) of the Internal Revenue Code; or

(ii) the lesser of (A) the amount of insurance qualifying as "medical care" under section 213(d) of the Internal Revenue Code to the extent not deducted under section 162(1) of the Internal Revenue Code or excluded from income or (B) the total amount deductible for medical care under section 213(a).

HOSPITALS AND HEALTH CARE PROVIDERS

Sec. 5. **[295.50] DEFINITIONS.**

Subdivision 1. **DEFINITIONS.** For purposes of sections 295.50 to 295.58, the following terms have the meanings given.

Subd. 2. **COMMISSIONER.** "Commissioner" is the commissioner of revenue.

Subd. 3. **GROSS REVENUES.** (a) "Gross revenues" are total amounts received in money or otherwise by:

(1) a resident hospital for inpatient or outpatient services as defined in Minnesota Rules, part 4650.0102, subparts 21 and 29;

(2) a nonresident hospital for inpatient or outpatient services as defined in Minnesota Rules, part 4650.0102, subparts 21 and 29, provided to patients domiciled in Minnesota;

(3) a resident health care provider, other than a health maintenance organization, for covered services listed in section 256B.0625;

(4) a nonresident health care provider for covered services listed in section 256B.0625 provided to an individual domiciled in Minnesota;

(5) a wholesale drug distributor for sale or distribution of prescription drugs that are delivered in Minnesota by the distributor or a common carrier, unless the prescription drugs are delivered to another wholesale drug distributor; and

(6) a health maintenance organization as gross premiums for enrollees, carrier copayments, and fees for covered services listed in section 256B.0625.

(b) Gross revenues do not include governmental, foundation, or other grants or donations to a hospital or health care provider for operating or other costs.

Subd. 4. **HEALTH CARE PROVIDER.** "Health care provider" is a vendor of medical care qualifying for reimbursement under the medical assistance program provided under chapter 256B, and includes health maintenance organizations but excludes hospitals and pharmacies.

Subd. 5. **HMO.** "Health maintenance organization" is a nonprofit corporation licensed and operated as provided in chapter 62D.

Subd. 6. **HOME HEALTH CARE SERVICES.** "Home health care services" are services:

(1) defined under the state medical assistance program as home health agency services, personal care services and supervision of personal care services, private duty nursing services, and waivered services; and

(2) provided at a recipient's residence, if the recipient does not live in a hospital, nursing facility, as defined in section 62A.46, subdivision 3, or intermediate care facility for persons with mental retardation as defined in section 256B.055, subdivision 12, paragraph (d).

Subd. 7. **HOSPITAL.** "Hospital" is a hospital licensed under chapter 144, a hospital providing inpatient or outpatient services licensed by any other state or province or territory of Canada or a surgical center.

Subd. 8. **NONRESIDENT HEALTH CARE PROVIDER.** "Nonresident health care provider" means a health care provider that is not a resident health care provider.

Subd. 9. **NONRESIDENT HOSPITAL.** "Nonresident hospital" means a hospital physically located outside Minnesota.

Subd. 10. **PHARMACY.** "Pharmacy" means a pharmacy, as defined in section 151.01, if the only goods or services the pharmacy sells that qualify for reimbursement under the medical assistance program under chapter 256B are drugs and prosthetics.

Subd. 11. **RESIDENT HEALTH CARE PROVIDER.** "Resident health care provider" means a health care provider whose principal place of dispensing health care is in Minnesota.

Subd. 12. **RESIDENT HOSPITAL.** "Resident hospital" means a hospital physically located inside Minnesota.

Subd. 13. **SURGICAL CENTER.** "Surgical center" is an outpatient surgical center as defined in Minnesota Rules, chapter 4675 or a similar facility located in any other state or province or territory of Canada.

Subd. 14. **WHOLESALE DRUG DISTRIBUTOR.** "Wholesale drug distributor" means a wholesale drug distributor required to be licensed under sections 151.42 to 151.51.

Sec. 6. **[295.51] MINIMUM CONTACTS REQUIRED FOR JURISDICTION TO TAX GROSS REVENUE.**

Subdivision 1. **BUSINESS TRANSACTIONS IN MINNESOTA.** A hospital or health care provider is subject to tax under sections 295.50 to 295.58 if it is "transacting business in Minnesota." A hospital or health care provider is transacting business in Minnesota only if it:

(1) maintains an office in Minnesota;

(2) has employees, representatives, or independent contractors conducting business in Minnesota;

(3) regularly sells covered services to customers that receive the covered services in Minnesota;

(4) regularly solicits business from potential customers in Minnesota;

(5) regularly performs services outside Minnesota the benefits of which are consumed in Minnesota;

(6) owns or leases tangible personal or real property physically located in Minnesota; or

(7) receives medical assistance payments from the state of Minnesota.

Subd. 2. **PRESUMPTION.** A hospital or health care provider is presumed to regularly solicit business within Minnesota if it receives gross receipts for covered services from 20 or more patients domiciled in Minnesota in a calendar year.

Sec. 7. **[295.52] TAXES IMPOSED.**

Subdivision 1. **HOSPITAL TAX.** A tax is imposed on each hospital equal to two percent of its gross revenues.

Subd. 2. **PROVIDER TAX.** A tax is imposed on each health care provider equal to two percent of its gross revenues.

Subd. 3. **WHOLESALE DRUG DISTRIBUTOR TAX.** A tax is imposed on each wholesale drug distributor equal to two percent of its gross revenues.

Subd. 4. **USE TAX; PRESCRIPTION DRUGS.** A person that receives prescription drugs for resale or use in Minnesota, other than from a wholesale drug distributor that paid the tax under subdivision 3, is subject to a tax equal to two percent of the price paid. Liability for the tax is incurred when prescription drugs are received in Minnesota by the person.

Sec. 8. **[295.53] EXEMPTIONS; SPECIAL RULES.**

Subdivision 1. **EXEMPTIONS.** The following payments are excluded from the gross revenues subject to the hospital or health care provider taxes under sections 295.50 to 295.57:

(1) payments received from the federal government for services provided under the Medicare program, excluding enrollee deductible and coinsurance payments;

(2) medical assistance payments;

(3) payments received for services performed by nursing homes licensed under chapter 144A, services provided in supervised living facilities and home health care services;

(4) payments received from hospitals for goods and services that are subject to tax under section 295.52;

(5) payments received from health care providers for goods and services that are subject to tax under section 295.52;

(6) amounts paid for prescription drugs to a wholesale drug distributor reduced by reimbursements received for prescription drugs under clauses (1), (2), (7), and (8);

(7) payments received under the general assistance medical care program;

(8) payments received for providing services under the health right program under article 4; and

(9) payments received by a resident health care provider or the wholly owned subsidiary of a resident health care provider for care provided outside Minnesota to a patient who is not domiciled in Minnesota.

Subd. 2. **DEDUCTIONS FOR HMOS.** (a) In addition to the exemptions allowed under subdivision 1, a health maintenance organization may deduct from its gross revenues for the year:

(1) amounts added to reserves, if total reserves do not exceed 25 percent of gross revenues for the prior year;

(2) assessments for the comprehensive health insurance plan under section 62E.11 paid during the year; and

(3) an allowance for administration and underwriting.

(b) The commissioner of health, in consultation with the commissioners of commerce and revenue, shall establish by rule under chapter 14 the percentage of health maintenance revenue that will be allowed as a deduction for administrative and underwriting expenses. The commissioner of health shall determine the percentage allowance based on the average expenses of health maintenance organizations that are equivalent to the claims administration and other underwriting services of third party payors. These expenses do not include the portion of health maintenance organization costs that are similar to the administrative costs of direct health care providers, rather than third party payors, and do not include costs deductible under paragraph (a), clauses (1) and (2). The commissioner of health may adopt emergency rules.

Subd. 3. **RESTRICTION ON ITEMIZATION.** A hospital or health care provider must not separately state the tax obligation under section 295.52 on bills provided to individual patients.

Sec. 9. **[295.54] CREDIT FOR TAXES PAID TO ANOTHER STATE.**

A resident hospital or resident health care provider who is liable for taxes payable to another state or province or territory of Canada measured by gross receipts and is subject to tax under section 295.52 is entitled to a credit for the tax paid to another state or province or territory of Canada to the extent of the lesser of (1) the tax actually paid to the other state or province or territory of Canada, or (2) the amount of tax imposed by Minnesota on the gross receipts subject to tax in the other taxing jurisdictions.

Sec. 10. **[295.55] PAYMENT OF TAX.**

Subdivision 1. **SCOPE.** The provisions of this section apply to the taxes imposed under sections 295.50 to 295.58.

Subd. 2. **ESTIMATED TAX; HOSPITALS.** (a) Each hospital must make estimated payments of the taxes for the calendar year in monthly installments to the commissioner within ten days after the end of the month.

(b) Estimated tax payments are not required if the tax for the calendar year is less than $500 or if the hospital has been allowed a grant under section 144.1484, subdivision 2 for the year.

(c) Underpayment of estimated installments bear interest at the rate specified in section 270.75, from the due date of the payment until paid or until the due date of the annual return at the rate specified in section 270.75. An underpayment of an estimated installment is the difference between the amount paid and the lesser of (1) 90 percent of one-twelfth of the tax for the calendar year or (2) the tax for the actual gross revenues received during the month.

Subd. 3. **ESTIMATED TAX; OTHER TAXPAYERS.** (a) Each taxpayer, other than a hospital, must make estimated payments of the taxes for the calendar year in quarterly installments to the commissioner by April 15, July 15, October 15, and January 15 of the following calendar year.

(b) Estimated tax payments are not required if the tax for the calendar year is less than $500.

(c) Underpayment of estimated installments bear interest at the rate specified in section 270.75, from the due date of the payment until paid or until the due date of the annual return at the rate specified in section 270.75. An underpayment of an estimated installment is the difference between the amount paid and the lesser of (1) 90 percent of one-quarter of the tax for the calendar year or (2) the tax for the actual gross revenues received during the quarter.

Subd. 4. **ELECTRONIC FUNDS TRANSFER PAYMENTS.** A taxpayer with an aggregate tax liability of $60,000 or more during a calendar quarter ending the last day of March, June, September, or December must thereafter remit all liabilities by means of a funds transfer as defined in section 336.4A-104, paragraph (a). The funds transfer payment date, as defined in section 336.4A-401, is on or before the date the tax is due. If the date the tax is due is not a funds-transfer business day, as defined in section 336.4A-105, paragraph (a), clause (4), the payment date is on or before the first funds-transfer business day after the date the tax is due.

Subd. 5. **ANNUAL RETURN.** The taxpayer must file an annual return reconciling the estimated payments by March 15 of the following calendar year.

Subd. 6. **FORM OF RETURNS.** The estimated payments and annual return must contain the information and be in the form prescribed by the commissioner.

Sec. 11. **[295.57] COLLECTION AND ENFORCEMENT; RULEMAKING; APPLICATION OF OTHER CHAPTERS.**

Unless specifically provided otherwise by sections 295.50 to 295.58, the enforcement, interest, and penalty provisions under chapter 294, appeal and criminal penalty provisions under chapter 289A, and collection and rulemaking provisions under chapter 270, apply to a liability for the taxes imposed under sections 295.50 to 295.58.

Sec. 12. **[295.58] DEPOSIT OF REVENUES.**

The commissioner shall deposit all revenues, including penalties and interest, derived from the taxes imposed by sections 295.50 to 295.57 and from the insurance premiums tax on health maintenance organizations and nonprofit health service corporations in the health care access fund in the state treasury.

Sec. 13. **[295.59] SEVERABILITY.**

If any section, subdivision, clause, or phrase of sections 295.50 to 295.58 is for any reason held to be unconstitutional or in violation of federal law, the decision shall not affect the validity of the remaining portions of sections 295.50 to 295.58. The legislature declares that it would have passed sections 295.50 to 295.58 and each section, subdivision, sentence, clause, and phrase thereof, irrespective of the fact that any one or more sections, subdivisions, sentences, clauses, or phrases is declared unconstitutional.

Sec. 14. Minnesota Statutes 1991 Supplement, section 297.02, subdivision 1, is amended to read:

Subdivision 1. **RATES.** A tax is hereby imposed upon the sale of cigarettes in this state or having cigarettes in possession in this state with intent to sell and upon any person engaged in business as a distributor thereof, at the following rates, subject to the discount provided in section 297.03:

(1) On cigarettes weighing not more than three pounds per thousand, ~~21.5~~ 24 mills on each such cigarette;

(2) On cigarettes weighing more than three pounds per thousand, ~~43~~ 48 mills on each such cigarette.

Sec. 15. Minnesota Statutes 1991 Supplement, section 297.03, subdivision 5, is amended to read:

Subd. 5. **SALE OF STAMPS.** The commissioner shall sell stamps to any person licensed as a distributor at a discount of ~~1.1~~ 1.0 percent from the face amount of the stamps for the first $1,500,000 of such stamps purchased in any fiscal year; and at a discount of ~~.65~~ .60 percent on the remainder of such stamps purchased in any fiscal year. The commissioner shall not sell stamps to any other person. The commissioner may prescribe the method of shipment of the stamps to the distributor as well as the quantities of stamps purchased.

Sec. 16. **FLOOR STOCKS TAX.**

Subdivision 1. **CIGARETTES.** A floor stocks tax is imposed on every person engaged in business in this state as a distributor, retailer, subjobber, vendor, manufacturer, or manufacturer's representative of cigarettes, on the stamped cigarettes in the person's possession or under the person's control at 12:01 a.m. on July 1, 1992. The tax is imposed at the following rates, subject to the discounts in section 297.03:

(1) on cigarettes weighing not more than three pounds a thousand, 2.5 mills on each cigarette; and

(2) on cigarettes weighing more than three pounds a thousand, five mills on each cigarette.

Each distributor, by July 8, 1992, shall file a report with the commissioner, in the form the commissioner prescribes, showing the cigarettes on hand at 12:01 a.m. on July 1, 1992, and the amount of tax due on the cigarettes. The tax imposed by this section is due and payable by August 1, 1992, and after that date bears interest at the rate of one percent a month.

Each retailer, subjobber, vendor, manufacturer, or manufacturer's representative shall file a return with the commissioner, in the form the commissioner prescribes, showing the cigarettes on hand at 12:01 a.m. on July 1, 1992, and pay the tax due thereon by August 1, 1992. Tax not paid by the due date bears interest at the rate of one percent a month.

Subd. 2. **AUDIT AND ENFORCEMENT.** The tax imposed by this section is subject to the audit, assessment, and collection provisions applicable to the taxes imposed under chapter 297C. The commissioner may require a distributor to receive and maintain copies of floor stock tax returns filed by all persons requesting a credit for returned cigarettes.

Subd. 3. **DEPOSIT OF PROCEEDS.** The revenue from the tax imposed under this section shall be deposited by the commissioner in the state treasury and credited to the health care access fund.

Sec. 17. **TEMPORARY DEPOSIT OF CIGARETTE TAX REVENUES.**

Notwithstanding the provisions of Minnesota Statutes, section 297.13, the revenue provided by 2.5 mills of the tax on cigarettes weighing not more than three pounds a thousand and five mills of the tax on cigarettes weighing more than three pounds a thousand must be credited to the health care access fund in the state treasury. This section applies only to revenue collected for sales after June 30, 1992, and before January 1, 1994. Revenue includes revenue from the tax, interest, and penalties collected under the provisions of Minnesota Statutes, sections 297.01 to 297.13.

This section expires June 30, 1994.

Sec. 18. **TRANSITION PROVISION; HOSPITAL TAX.**

For gross revenues taxable under section 7, subdivision 1, for calendar year 1993, the exclusions under section 8, subdivision 1, clauses (5) and (6) do not apply.

Sec. 19. **PASSTHROUGH.**

Subdivision 1. **AUTHORITY.** A hospital that is subject to a tax under section 7 may transfer additional expense generated by section 7 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. The expense must not exceed two percent of the gross revenues received under the third-party contract, including copayments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section 8. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapters 60A, 62A, 62C, 62D, 64B, or 62H, must pay the transferred expense in addition to any payments due under existing or future contracts with the hospital or health care provider, to the extent allowed under federal law. Nothing in this subdivision limits the ability of a hospital to recover all or part of the section 7 obligation by other methods, including increasing fees or charges.

Subd. 2. **EXPIRATION.** This section expires January 1, 1994.

Sec. 20. **STUDY.**

The commissioner of revenue, in consultation with the commissioner of health and the board of pharmacy, shall report to the legislature by November 1, 1992, on the expected impact of the wholesale drug distributor tax and the health care provider tax on pharmacies and pharmacists. If the commissioner determines that these taxes are not effective or equitable as applied to pharmacies and pharmacists, the commissioner shall recommend alternative methods of taxing prescription drugs.

Sec. 21. **FEDERAL WAIVER; HEALTH CARE RELATED TAX.**

The legislature finds that taxes imposed by this article are not subject to or in violation of the restrictions contained in the Social Security Act or other federal law. The tax is imposed solely to fund a state program and is not used to pay the state share of medical assistance. Nevertheless to avoid any ambiguity, the commissioner of human services shall apply to the secretary of the United States Department of Health and Human Services for a waiver to treat the tax imposed under section 7 as a broad-based health care related tax under section 1903 of the Social Security Act, 42 United States Code section 1396b.

Sec. 22. **EFFECTIVE DATE.**

Sections 1 and 16 to 21 are effective the day following final enactment. Section 4 is effective for taxable years beginning after December 31, 1992. Section 7, subdivision 1, is effective for gross revenues generated by services performed and goods sold after December 31, 1992. Section 7, subdivisions 2 to 4, are

effective for gross revenues generated by services performed and goods sold after December 31, 1993. Sections 14 and 15 are effective July 1, 1992.

ARTICLE 10

APPROPRIATIONS

Section 1. APPROPRIATIONS

Subdivision 1. The amounts specified in this section are appropriated from the health care access fund to the agencies and for the purposes indicated, to be available until June 30, 1993.

Subd. 2. Commissioner of Commerce	809,000
Subd. 3. Commissioner of Health	3,005,000
Subd. 4. Commissioner of Human Services	13,371,000
$20,000 of this appropriation is for a grant to the coalition responsible for establishing the demonstration project for low-income uninsured persons under Minnesota Statutes, section 256B.73, to provide consulting and marketing services related to the implementation of the health right program.	
Subd. 5. Higher Education Coordinating Board	189,000
This appropriation may be used as the required state match for any grants received by the University of Minnesota medical school.	
Subd. 6. Commissioner of Employee Relations	1,679,000
Subd. 7. Board of Regents of the University of Minnesota	2,200,000
Subd. 8. Commissioner of Revenue	917,000

Subd. 9. Legislature 125,000

This appropriation is for the legislative coordinating commission, to be divided between the senate and the house based on the recommendations of the legislative commission on health care access, for the purpose of adding staff in existing departments who will be assigned to the legislative commission.

Subd. 10. Commissioner of Administration 27,000

Sec. 2. **TRANSFER.**

The commissioner of finance shall transfer $4,368,000 from the health care access fund to the general fund for fiscal year 1993. For purposes of preparing the biennial budget recommendations, the commissioner shall assume a transfer of $4,605,000 for fiscal year 1994 and $5,467,000 for fiscal year 1995.

Sec. 3. **EFFECTIVE DATE.**

The appropriations in section 1 are effective July 1, 1992, except that $616,000 of the appropriation in section 1, subdivision 4, is available for fiscal year 1992.

Presented to the governor April 17, 1992

Signed by the governor April 23, 1992, 9:40 a.m.

CHAPTER 550—H.F.No. 2586

An act providing for a study of the civic and cultural functions of downtown Saint Paul.

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

Section 1. **CAPITAL CITY CULTURAL RESOURCES COMMISSION.**

Subdivision 1. The legislature finds that the capital city of Saint Paul:

(1) encourages the use of many of its downtown facilities for state agencies and their personnel;

(2) encourages a wide range of cultural attractions for tourists and visitors to the capital city that reflect its multicultural city and state community; and

(3) encourages the development of a strong link between the civic and cul-