CHAPTER 247—S.F.No. 419

An act relating to health care; modifying and making corrections to the health right act; amending Minnesota Statutes 1992, sections 43A.317, subdivisions 2, 7, and 10; 62A.011, subdivision 3; 62A.02, subdivision 1; 62A.65, subdivision 5; 62J.04, subdivisions 2, 3, 4, 5, 6, and 7; 62J.09, subdivisions 1, 2, and 6; 62J.15, subdivision 2; 62J.17, subdivisions 2, 4, 5, and 6; 62J.19; 62J.23; 62J.29, subdivisions 1 and 4; 62J.30, subdivisions 4, 7, 8, and 10; 62J.31, subdivisions 2 and 3; 62J.32, subdivisions 1 and 4; 62J.34, subdivisions 2 and 3; 62L.02, subdivisions 8, 11, 15, and 16, and by adding a subdivision; 62L.03, subdivisions 2 and 5; 62L.05, subdivision 10; 62L.09, subdivision 2; 62L.13, subdivisions 1, 3, and 4; 62L.14, subdivisions 1, 2, 3, 4, 5, 6, 7, and 9; 62L.15, subdivision 2; 62L.16, subdivision 5, and by adding a subdivision; 62L.17, subdivisions 1 and 4; 62L.19; 62L.20, subdivisions 1 and 2; 144.147, subdivision 4; 144.1481, subdivision 1; 144.1486; 256.045, subdivision 10; 256.9353, subdivisions 2, 6, and by adding a subdivision; 256.9354; 256.9355, subdivision 3; 256.9356, subdivision 2; 256.9357; 256B.0644; Laws 1992, chapter 549, articles 1, section 15; 2, sections 24 and 25; 3, section 24; and 4, section 18; proposing coding for new law in Minnesota Statutes, chapter 62J; repealing Minnesota Statutes 1992, sections 62J.05, subdivision 5; 62J.09, subdivision 3; and 62J.21.

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

ARTICLE 1

COST CONTAINMENT

Section 1. Minnesota Statutes 1992, section 62J.04, subdivision 2, is amended to read:

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 licensing 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 private or nonpublic, ~~trade~~

~~secret information under section 13.37~~ except to the extent that it is given a different classification elsewhere in this chapter. 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, or as permitted elsewhere in this chapter.

Sec. 2. Minnesota Statutes 1992, section 62J.04, subdivision 3, is amended to read:

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 referral 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 Laws 1992, chapter 549, 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.

Sec. 3. Minnesota Statutes 1992, section 62J.04, subdivision 4, is amended to read:

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 on health care access of the commissioner's intent to depart from the recommendations of the Minnesota health care commission. The notice to the legislative ~~oversight~~ commission on health care access 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 on health care access at the earliest possible time.

Sec. 4. Minnesota Statutes 1992, section 62J.04, subdivision 5, is amended to read:

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

Sec. 5. Minnesota Statutes 1992, section 62J.04, subdivision 6, is amended to read:

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~~.

Sec. 6. Minnesota Statutes 1992, section 62J.04, subdivision 7, is amended to read:

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~~ commissioner, 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. 7. **[62J.06] IMMUNITY FROM LIABILITY.**

No member of the Minnesota health care commission established under section 62J.05, regional coordinating boards established under section 62J.09, health planning advisory committee established under section 62J.15, data collection advisory committee established under section 62J.30, or practice parameter advisory committee established under section 62J.32 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.

Sec. 8. Minnesota Statutes 1992, section 62J.09, subdivision 1, is amended to read:

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~~ approve 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.

Sec. 9. Minnesota Statutes 1992, section 62J.09, subdivision 2, is amended to read:

Subd. 2. **MEMBERSHIP.** (a) Each regional ~~health care management~~ coordinating board consists of ~~16~~ 17 members as provided in this subdivision. A member may designate a representative to act as a member of the ~~commission~~ board 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~~ four 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.

Sec. 10. Minnesota Statutes 1992, section 62J.09, subdivision 6, is amended to read:

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

Sec. 11. Minnesota Statutes 1992, section 62J.15, subdivision 2, is amended to read:

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~~ boards 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 referral 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. 12. Minnesota Statutes 1992, section 62J.17, subdivision 2, is amended to read:

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, or that makes a major spending commitment to become regularly engaged in providing health care services in Minnesota.

Sec. 13. Minnesota Statutes 1992, section 62J.17, subdivision 4, is amended to read:

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 within 60 days of making the major spending commitment 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.

Sec. 14. Minnesota Statutes 1992, section 62J.17, subdivision 5, is amended to read:

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~~ boards 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 lawful collaborative arrangements; the commissioner shall require those health care providers to follow the procedures for prospective review and approval established in subdivision 6.

Sec. 15. Minnesota Statutes 1992, section 62J.17, subdivision 6, is amended to read:

Subd. 6. **PROSPECTIVE REVIEW AND APPROVAL.** (a) **REQUIRE-**

MENT. 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. 16. Minnesota Statutes 1992, section 62J.19, is amended to read:

62J.19 **SUBMISSION OF REGIONAL PLAN TO COMMISSIONER.**

Each regional coordinating board 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 boards exist, the commissioner has the authority to establish a public regional coordinating board for purposes of establishing a regional plan which will achieve the objectives. The public regional coordinating board shall be appointed by the commissioner and under the commissioner's direction.~~

Sec. 17. Minnesota Statutes 1992, section 62J.23, is amended to read:

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~~ person benefits financially by referring a patient to another ~~provider~~ person, recommending another ~~provider~~ person, 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~~ persons in the state, regardless of whether the ~~provider~~ person 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~~ person who is in violation of this section that provides a reasonable time for the ~~provider~~ person to modify prohibited practices or divest financial interests in other ~~providers~~ persons in order to come into compliance with this section. Transition plans that identify individuals are private data. Transition plans that do not identify individuals are nonpublic data.

Subd. 3. **PENALTY.** The commissioner may assess a fine against a ~~provider~~ person who violates this section. The amount of the fine is $1,000 or 110 percent of the estimated financial benefit that the ~~provider~~ person realized as a result of the prohibited financial arrangement or payment relationship, whichever is greater. A ~~provider~~ person 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. 18. Minnesota Statutes 1992, section 62J.29, subdivision 1, is amended to read:

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~~ may 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, and that this approval will make relationships immune from state and federal antitrust liability.

Sec. 19. Minnesota Statutes 1992, section 62J.29, subdivision 4, is amended to read:

Subd. 4. **STATE ANTITRUST LAW.** Notwithstanding the Minnesota antitrust law of 1971, as amended, in 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 sections 325D.49 to 325D.66. Approval by the ~~state commission~~ commissioner is an absolute defense against any action under state antitrust laws.

Sec. 20. Laws 1992, chapter 549, article 1, section 15, is amended to read:

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. 21. **REPEALER.**

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

Minnesota Statutes 1992, sections 62J.05, subdivision 5; 62J.09, subdivision 3; and 62J.21, are repealed.

Sec. 22. **EFFECTIVE DATE.**

Sections 1 to 21 are effective the day following final enactment.

ARTICLE 2

SMALL EMPLOYER INSURANCE REFORM

Section 1. Minnesota Statutes 1992, section 62L.02, subdivision 8, is amended to read:

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. For purposes of sections 62L.13 to 62L.22, "commissioner" means the commissioner of commerce.

Sec. 2. Minnesota Statutes 1992, section 62L.02, subdivision 11, is amended to read:

Subd. 11. **DEPENDENT.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 19 years, unmarried child under the age of 25 years 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.

Sec. 3. Minnesota Statutes 1992, section 62L.02, is amended by adding a subdivision to read:

Subd. 11a. **DISCOUNTED ELIGIBLE CHARGES.** "Discounted eligible charges" means, as determined by the board of directors, eligible charges reduced by the average difference between eligible charges and the expected liability of the health carrier for services performed. The board of directors, in its discretion, may determine additional different discounts, based upon geographic area and type of delivery system.

Sec. 4. Minnesota Statutes 1992, section 62L.02, subdivision 15, is amended to read:

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~~ as defined in section 62B.02;

(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) a long-term care ~~insurance~~ policy 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~~.~~; or

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health benefit plan.

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.

Sec. 5. Minnesota Statutes 1992, section 62L.02, subdivision 16, is amended to read:

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, sec-

tion 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 health 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 health carrier.

Sec. 6. Minnesota Statutes 1992, section 62L.03, subdivision 2, is amended to read:

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~~ health carrier participating in the small employer market 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~~ health carrier participating in the small employer market in a financially impaired condition, provided, however, that a ~~small employer~~ health carrier participating in the small employer market 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~~ health carrier is not financially impaired and that offering coverage or accepting applications under subdivision 1 would not cause the health carrier to ~~be~~ become financially impaired.

Sec. 7. Minnesota Statutes 1992, section 62L.03, subdivision 5, is amended to read:

Subd. 5. **CANCELLATIONS AND FAILURES TO RENEW.** (a) 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~~ persons covered or to be covered by the health benefit plan. 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 under section 62L.09; 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.

(b) A health carrier need not renew a health benefit plan, and shall not renew a small employer plan, if an employer ceases to qualify as a small employer as defined in section 62L.02. If a health benefit plan, other than a small employer plan, provides terms of renewal that do not exclude an employer that is no longer a small employer, the health benefit plan may be renewed according to its own terms. If a health carrier issues or renews a health plan to an employer that is no longer a small employer, without interruption of coverage, the health plan is subject to section 60A.082.

Sec. 8. Minnesota Statutes 1992, section 62L.05, subdivision 10, is amended to read:

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~~ diagnosis-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.

Sec. 9. Minnesota Statutes 1992, section 62L.09, subdivision 2, is amended to read:

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 health carrier.

Sec. 10. Minnesota Statutes 1992, section 62L.13, subdivision 1, is amended to read:

Subdivision 1. **CREATION.** The health coverage reinsurance association ~~is established as a nonprofit corporation~~ may operate as a nonprofit unincorporated association, but is authorized to incorporate under chapter 317A. 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.

Sec. 11. Minnesota Statutes 1992, section 62L.13, subdivision 3, is amended to read:

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. Directors and 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 directors and members of the association.

Sec. 12. Minnesota Statutes 1992, section 62L.13, subdivision 4, is amended to read:

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~~ may operate under the plan of operation approved by the board and shall be governed in accordance with this chapter and may operate in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation meets the requirements of filing articles.

Sec. 13. Minnesota Statutes 1992, section 62L.14, subdivision 1, is amended to read:

Subdivision 1. **COMPOSITION OF BOARD.** The association shall exercise its powers through a board of 13 directors. Four ~~members~~ directors must be public members appointed by the commissioner. The public ~~members~~ directors must not be employees of or otherwise affiliated with any member of the association. The nonpublic ~~members of the board~~ directors 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. Directors are automatically removed if they fail to satisfy this qualification.

Sec. 14. Minnesota Statutes 1992, section 62L.14, subdivision 2, is amended to read:

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~~ until the annual meeting in 1994. Except for the public ~~members~~ directors, 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~~ plan of operation, subject to approval by the commissioner. Members of the association may vote in person or by proxy. The public ~~members~~ directors shall continue to be appointed by the commissioner to terms meeting the requirements of subdivision 3.

Sec. 15. Minnesota Statutes 1992, section 62L.14, subdivision 3, is amended to read:

Subd 3. **TERM OF OFFICE.** ~~The first annual meeting must be held by December 1, 1992.~~ After the ~~initial two-year period~~ annual meeting in 1994, each director shall serve a three-year term, except that the board shall make appropriate arrangements to stagger the terms of the ~~board members~~ directors 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.

Sec. 16. Minnesota Statutes 1992, section 62L.14, subdivision 4, is amended to read:

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. If a vacancy occurs for a public director, the commissioner shall appoint a new public director for the duration of the unexpired term.

Sec. 17. Minnesota Statutes 1992, section 62L.14, subdivision 5, is amended to read:

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.

Sec. 18. Minnesota Statutes 1992, section 62L.14, subdivision 6, is amended to read:

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.

Sec. 19. Minnesota Statutes 1992, section 62L.14, subdivision 7, is amended to read:

Subd. 7. **COMPENSATION.** ~~Members of the board~~ Public directors 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.

Sec. 20. Minnesota Statutes 1992, section 62L.14, subdivision 9, is amended to read:

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

Sec. 21. Minnesota Statutes 1992, section 62L.15, subdivision 2, is amended to read:

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 public directors, 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.

Sec. 22. Minnesota Statutes 1992, section 62L.16, subdivision 5, is amended to read:

Subd. 5. **AUDITS.** The board of directors may conduct periodic audits to verify the accuracy of financial data and reports submitted by the administrator. The board may establish in the plan of operation a uniform audit program. All costs of the uniform audit program and any additional audits conducted by the board to verify the accuracy of claims submissions are the responsibility of the health carrier. Failure of a health carrier to comply with the requirements of the audit program, including the failure to pay the costs of an audit, may subject the health carrier to the penalties described in section 62L.11.

Sec. 23. Minnesota Statutes 1992, section 62L.16, is amended by adding a subdivision to read:

Subd. 7. **INDEMNIFICATION.** The association shall indemnify members, directors, officers, employees, and agents to the same extent that persons may be indemnified by corporations under section 317A.521.

Sec. 24. Minnesota Statutes 1992, section 62L.17, subdivision 1, is amended to read:

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~~ have its business reinsured by the association.

Sec. 25. Minnesota Statutes 1992, section 62L.17, subdivision 4, is amended to read:

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 under this subdivision.

Sec. 26. Minnesota Statutes 1992, section 62L.19, is amended to read:

62L.19 **ALLOWED REINSURANCE BENEFITS.**

A health carrier may reinsure through the association only those benefits described in section 62L.05. The board may establish guidelines to clarify what coverage is included within the benefits described in this chapter. If a health plan conforms to those benefits as clarified by the board, the benefits are considered to be in accordance with this chapter for purposes of the association's obligations.

Sec. 27. Minnesota Statutes 1992, section 62L.20, subdivision 1, is amended to read:

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~~ $55,000, 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 discounted eligible charges. The board may establish an audit process to assure consistency in the submission of charge calculations by health carriers to the association. The association shall determine the amount to be paid to the health carrier for claims submitted based on discounted eligible charges. The board may establish upper limits on the amount paid by the association based on a usual and customary determination. The board shall establish in the plan of operation a procedure for determining the discounted eligible charge.

Sec. 28. Minnesota Statutes 1992, section 62L.20, subdivision 2, is amended to read:

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 health carrier's conversion factor is equivalent to the association's standardized conversion table, the association shall accept the health carrier's conversion factor.

Sec. 29. Laws 1992, chapter 549, article 2, section 24, is amended to read:

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 April 1, 1995. The commissioner shall file with the legislature a written preliminary progress report no later than December 1, 1994.

Sec. 30. Laws 1992, chapter 549, article 2, section 25, is amended to read:

Sec. 25. **EFFECTIVE DATES.**

Sections ~~1~~ 3 to 12 and 23 are effective July 1, 1993, except that section 10, subdivision 5, is effective the day following final enactment. Sections 1, 2, and 13 to 22 are effective the day following final enactment.

Sec. 31. **EFFECTIVE DATES.**

Sections 1 to 30 are effective the day following final enactment.

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

ARTICLE 3

INSURANCE REFORM: INDIVIDUAL MARKET AND MISCELLANEOUS

Section 1. Minnesota Statutes 1992, section 43A.317, subdivision 2, is amended to read:

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~~ an employee of an eligible employer. "Employee" includes a sole proprietor, partner of a partnership, member of a limited liability company, or independent contractor.

(g) **EMPLOYER.** "Employer" means a private person, firm, corporation, partnership, limited liability company, 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.

Sec. 2. Minnesota Statutes 1992, section 43A.317, subdivision 7, is amended to read:

Subd. 7. **COVERAGE.** Coverage is available through the program beginning on July 1, 1993. ~~At least annually,~~ Until an arrangement is in place to provide coverage through a transfer of risk to one or more carriers regulated under chapter 62A, 62C, or 62D, the commissioner shall solicit bids under section 43A.23, 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.

Sec. 3. Minnesota Statutes 1992, section 43A.317, subdivision 10, is amended to read:

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.~~

Sec. 4. Minnesota Statutes 1992, section 62A.011, subdivision 3, is amended to read:

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. Health 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 as defined in section 62B.02;

(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) a long-term care policy 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;

(11) workers' compensation insurance; or

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan.

Sec. 5. Minnesota Statutes 1992, section 62A.02, subdivision 1, is amended to read:

Subdivision 1. **FILING.** For purposes of this section, "health plan" means a health plan as defined in section 62A.011 or a policy of accident and sickness insurance as defined in section 62A.01. No 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 with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner. The filing for nongroup health plan forms shall include a statement of actuarial reasons and data to support the rate. 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 issu-

ance 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. 6. Minnesota Statutes 1992, section 62A.65, subdivision 5, is amended to read:

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~~ individual 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.

Sec. 7. Laws 1992, chapter 549, article 3, section 24, is amended to read:

Sec. 24. **EFFECTIVE DATE.**

Section 11 is effective July 30, 1992. Sections 1, 3 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 2, 19, 20, 21, and 22 are effective the day following final enactment.

Sec. 8. **EFFECTIVE DATES.**

Sections 1 to 7 are effective the day following final enactment.

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

ARTICLE 4

CHILDREN'S HEALTH PLAN EXPANSION

Section 1. Minnesota Statutes 1992, section 256.045, subdivision 10, is amended to read:

Subd. 10. **PAYMENTS PENDING APPEAL.** If the commissioner of human services or district court orders monthly assistance or aid or services paid or provided in any proceeding under this section, it shall be paid or provided pending appeal to the commissioner of human services, district court, court of appeals, or supreme court. The human services referee may order the local human services agency to reduce or terminate medical assistance or general assistance medical care to a recipient before a final order is issued under this section if: (1) the human services referee determines at the hearing that the sole issue on appeal is one of a change in state or federal law; and (2) the commissioner or the local agency notifies the recipient before the action. The state or county agency has a claim for food stamps, cash payments, medical assistance, ~~and~~ general assistance medical care, and MinnesotaCare plan payments made to or on behalf of a recipient or former recipient while an appeal is pending if the recipient or former recipient is determined ineligible for the food stamps, cash payments, medical assistance, ~~or~~ general assistance medical care, or MinnesotaCare as a result of the appeal, except for medical assistance and general assistance medical care made on behalf of a recipient pursuant to a court order. In enforcing a claim on MinnesotaCare plan payments, the state or county agency shall reduce the claim amount by the value of any premium payments made by a recipient or former recipient during the period for which the recipient or former recipient has been determined to be ineligible.

Sec. 2. Minnesota Statutes 1992, section 256.9353, subdivision 2, is amended to read:

Subd. 2. **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.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare plan after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Sec. 3. Minnesota Statutes 1992, section 256.9353, subdivision 6, is amended to read:

Subd. 6. **COPAYMENTS AND COINSURANCE.** The ~~health right~~ MinnesotaCare 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 inpatient out-of-pocket maximum of ~~$2,000~~ $1,000 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 spend-down shall be financially responsible for the coinsurance amount up to the spend-down limit or the coinsurance amount, whichever is less, in order to become eligible for the medical assistance program.

Sec. 4. Minnesota Statutes 1992, section 256.9353, is amended by adding a subdivision to read:

Subd. 7. **LIEN.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015.

Sec. 5. Minnesota Statutes 1992, section 256.9354, is amended to read:

256.9354 **ELIGIBLE PERSONS.**

Subdivision 1. **CHILDREN; EXPANSION AND CONTINUATION OF ELIGIBILITY.** (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's first birthday occurs to the last day of the month in which the child becomes 18 years old.

(b) **EXPANSION OF ELIGIBILITY.** Eligibility for the ~~health right~~ MinnesotaCare plan shall be expanded as provided in subdivisions 2 to 5. The enrollment requirements in this paragraph apply to enrollment under subdivisions 2 to 5~~;~~. Parents who enroll in the ~~health right~~ MinnesotaCare 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. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members. For purposes of this section, a "dependent sibling" means an unmarried child who is a full-time student under the age of 25 years who is financially dependent upon a parent. Proof of school enrollment will be required.

(c) **CONTINUATION OF ELIGIBILITY.** Individuals who initially enroll in the MinnesotaCare plan under the eligibility criteria in subdivisions 2 to 5 remain eligible for the MinnesotaCare plan, regardless of age, place of residence, or the presence or absence of children in the same household, as long as all other eligibility criteria are met and residence in Minnesota and continuous enrollment in the MinnesotaCare plan or medical assistance are maintained. In order for either parent or either spouse in a household to remain enrolled, both must remain enrolled, unless other insurance is available.

Subd. 1a. **COOPERATION.** To be eligible for MinnesotaCare, individuals must cooperate with the state agency to identify potentially liable third party payers and assist the state in obtaining third party payments. "Cooperation" includes, but is not limited to, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third party payments.

Subd. 2. **FAMILIES WITH CHILDREN.** Beginning October 1, 1992, "eligible persons" means children eligible under subdivision 1, and parents and dependent siblings residing in the same household as a child eligible under subdivision 1. ~~Individuals who initially enroll in the health right plan under the eligibility criteria in this subdivision 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.~~

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

Subd. 3. **CONTINUATION OF ELIGIBILITY.** Beginning October 1, 1992, individuals who initially enrolled in the ~~health right~~ MinnesotaCare plan under the eligibility criteria in subdivision 1 or 2 remain eligible even if their gross income after enrollment exceeds 185 percent of the federal poverty guidelines, subject to any premium required under section 256.9357, as long as all other eligibility requirements are met and continuous enrollment in the ~~health right~~ MinnesotaCare plan or medical assistance is maintained.

Subd. 4. **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~~ MinnesotaCare plan but must pay a premium as determined under sections 256.9357 and 256.9358. Individuals and families whose income is greater than the limits established under section 256.9358 may not enroll in the ~~health right~~ MinnesotaCare plan. ~~Individuals who initially enroll in the health right plan under the eligibility criteria in this subdivision 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.~~

Subd. 5. **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~~ MinnesotaCare plan but must pay a premium as determined under sections 256.9357 and 256.9358. Individuals and families whose income is greater than the limits established under section 256.9358 may not enroll in the ~~health right~~ MinnesotaCare plan.

Sec. 6. Minnesota Statutes 1992, section 256.9355, subdivision 3, is amended to read:

Subd. 3. **EFFECTIVE DATE OF COVERAGE.** 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~~ is approved and the first premium payment has been received. The effective date of coverage for eligible newborns or eligible newly adoptive children added to a family receiving covered health services is the date of entry into the family. The effective date of coverage for other new recipients added to the family receiving covered health services is the first day of the month following the month in which eligibility is approved 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 sections 256.9351 to 256.9361 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 1992, section 256.9356, subdivision 2, is amended to read:

Subd. 2. **PREMIUM PAYMENTS.** Beginning October 1, 1992, the commissioner shall require ~~health right~~ MinnesotaCare plan enrollees to pay a premium based on a sliding scale, as established under section 256.9357. ~~Applicants who are eligible under section 256.9354, subdivision 1, 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.~~ The following applicants are exempt from this requirement until July 1, 1993:

(1) applicants who are eligible under section 256.9354, subdivision 1, if the application is received by MinnesotaCare staff on or before September 30, 1992; and

(2) children who enroll in the children's health plan after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17. Before July 1, 1993, these individuals shall continue to pay the annual enrollment fee required by subdivision 1.

Sec. 8. Minnesota Statutes 1992, section 256.9357, is amended to read:

256.9357 **ELIGIBILITY FOR SUBSIDIZED PREMIUMS BASED ON SLIDING SCALE.**

Subdivision 1. **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 section 256.9358 only if the family or individual meets the requirements in subdivisions 2 and 3. Children already enrolled in the ~~health right~~ MinnesotaCare plan as of September 30, 1992, and children who enroll in the children's health plan after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, are eligible for subsidized premium payments without meeting these requirements, as long as they maintain continuous coverage in the ~~health right~~ MinnesotaCare plan or medical assistance.

Families and individuals who initially enrolled in the ~~health right~~ MinnesotaCare plan under section 256.9354, and whose income increases above the limits established in section 256.9358, may continue enrollment and pay the full cost of coverage.

Subd. 2. **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 cover-

age 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~~ MinnesotaCare 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 subdivision.

Subd. 3. **PERIOD UNINSURED.** To be eligible for subsidized premium payments based on a sliding scale, families and individuals initially enrolled in the ~~health right~~ MinnesotaCare plan under section 256.9354, subdivisions 4 and 5, 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~~ MinnesotaCare plan does not apply to families, children, and individuals who want to apply for the ~~health right~~ MinnesotaCare 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 subdivision does not apply to families and individuals initially enrolled under sections 256.9354, subdivisions 1 and 2, or to children enrolled pursuant to Laws 1992, chapter 549, article 4, section 17.

Sec. 9. Minnesota Statutes 1992, section 256B.0644, is amended to read:

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~~ MinnesotaCare 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~~ MinnesotaCare 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. The commissioner of employee relations shall implement this section through contracts with participating health and dental carriers.

Sec. 10. Laws 1992, chapter 549, article 4, section 18, is amended to read:

Sec. 18. **IMPACT OF ~~HEALTH RIGHT~~ MINNESOTACARE ON CHILDREN'S HEALTH PLAN ENROLLEES.**

The commissioner of human services shall examine the impact of ~~health right~~ MinnesotaCare plan premium costs on access to health care for children's health plan enrollees. The commissioner shall examine whether ~~health right~~ MinnesotaCare 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~~ MinnesotaCare plan for financial reasons. The commissioner shall present recommendations to the legislature by ~~February 15, 1993~~ April 1, 1994, on methods to ensure continued access to health care coverage for children's health plan enrollees.

Sec. 11. **REVISOR INSTRUCTIONS.**

In the next edition of Minnesota Statutes, the revisor of statutes shall change the words "health right" to "MinnesotaCare," as appropriate, wherever they appear in Minnesota Statutes.

Sec. 12. **EFFECTIVE DATE.**

Sections 2 to 10 are effective the day following final enactment. Section 1 is effective for appeals filed on or after the day following final enactment.

ARTICLE 5

DATA INITIATIVES; RURAL HEALTH

Section 1. Minnesota Statutes 1992, section 62J.30, subdivision 4, is amended to read:

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, to the extent feasible, 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.

Sec. 2. Minnesota Statutes 1992, section 62J.30, subdivision 7, is amended to read:

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~~ individual patients or providers 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~~ health care provider, or health care facility, the com-

missioner 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, or nonpublic data under this chapter shall be made without releasing data that ~~could reveal the identity of individuals~~ identifies patients 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.

Sec. 3. Minnesota Statutes 1992, section 62J.30, subdivision 8, is amended to read:

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, except that its existence does not terminate and members do not receive per diem compensation.

Sec. 4. Minnesota Statutes 1992, section 62J.30, subdivision 10, is amended to read:

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.

Sec. 5. Minnesota Statutes 1992, section 62J.31, subdivision 2, is amended to read:

Subd. 2. **SPECIFIC HEALTH CONDITIONS.** (a) ~~The~~ Data collected under this section 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.

Sec. 6. Minnesota Statutes 1992, section 62J.31, subdivision 3, is amended to read:

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, as provided in section 62J.30, subdivisions 6 and 7. The data must be collected in a manner that allows comparisons to be made between providers, health carriers, public programs, and other entities.

Sec. 7. Minnesota Statutes 1992, section 62J.32, subdivision 1, is amended to read:

Subdivision 1. **DATA ANALYSIS.** The health care analysis unit shall analyze the data collected ~~on specific health conditions~~ through the large-scale data base 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.

Sec. 8. Minnesota Statutes 1992, section 62J.32, subdivision 4, is amended to read:

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 com-

missioner 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~~ except that its existence does not terminate and members do not receive per diem compensation.

Sec. 9. Minnesota Statutes 1992, section 62J.34, subdivision 2, is amended to read:

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. Notice of adoption of practice parameters adopted without rulemaking must be published in the State Register and must include a statement that the complete practice parameter is available free of charge from the commissioner.

Sec. 10. Minnesota Statutes 1992, section 62J.34, subdivision 3, is amended to read:

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. 11. Minnesota Statutes 1992, 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 of each fiscal year for grants awarded for ~~the~~ that fiscal year ~~beginning the following July 1~~. A grant may be awarded upon signing of a grant contract.

(b) 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.

(g) The commissioner may adopt rules to implement this section.

Sec. 12. Minnesota Statutes 1992, section 144.1481, subdivision 1, is amended to read:

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, except that the existence of the committee does not terminate and members do not receive per diem compensation.

Sec. 13. Minnesota Statutes 1992, section 144.1486, is amended to read:

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 instrumentalities of the state of Minnesota or 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. 14. **EFFECTIVE DATE.**

Sections 1 to 13 are effective the day following final enactment.

Presented to the governor May 14, 1993

Signed by the governor May 17, 1993, 4:42 p.m.

CHAPTER 248—S.F.No. 948

An act relating to insurance; property; regulating the FAIR plan; modifying its provisions; making various technical changes; amending Minnesota Statutes 1992, sections 60C.22; 65A.31; 65A.32; 65A.33, subdivisions 4, 5, and 6; 65A.34; 65A.35; 65A.36; 65A.37; 65A.375; 65A.38; 65A.39; 65A.40; 65A.41; and 65A.42; repealing Minnesota Statutes 1992, sections 65A.33, subdivision 8; and 65A.43.

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

Section 1. Minnesota Statutes 1992, section 60C.22, is amended to read:

60C.22 **NOTICE FOR POLICY OR CONTRACT NOT COVERED.**

A policy or contract not covered by the Minnesota Life and Health Insurance Guaranty Association or the Minnesota Insurance Guaranty Association must contain the following notice in 10-point type, stamped in red ink on the policy or contract and the application: