CHAPTER 237—S.F.No. 960

An act relating to health care; providing for patient protection; requiring certain disclosures; prohibiting certain provider contracts; providing for continuity of care and specialty care; prohibiting certain exclusive arrangements; modifying dispute resolution provisions; requiring identification of health care providers; requiring studies; requiring emergency services coverage; establishing a consumer advisory board; providing civil penalties; amending Minnesota Statutes 1996, sections 62Q.105, subdivision 1; 62Q.30; 181.932, subdivision 1; and 214.16, subdivisions 1 and 3; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; and 144; repealing Minnesota Statutes 1996, sections 62J.2911; 62J.2912; 62J.2913; 62J.2914; 62J.2915; 62J.2916; 62J.2917; 62J.2918; 62J.2919; 62J.2920; and 62J.2921.

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

Section 1. **[62J.695] CITATION.**

Sections 62J.695 to 62J.76 may be cited as the "Patient Protection Act."

Sec. 2. **[62J.70] DEFINITIONS.**

Subdivision 1. **APPLICABILITY.** For purposes of sections 62J.70 to 62J.76, the terms defined in this section have the meanings given them.

Subd. 2. **HEALTH CARE PROVIDER OR PROVIDER.** "Health care provider" or "provider" means:

(1) a physician, nurse, or other provider as defined under section 62J.03;

(2) a hospital as defined under section 144.696, subdivision 3;

(3) an individual or entity that provides health care services under the medical assistance, general assistance medical care, MinnesotaCare, or state employee group insurance program; and

(4) an association, partnership, corporation, limited liability corporation, or other organization of persons or entities described in clause (1) or (2) organized for the purposes of providing, arranging, or administering health care services or treatment.

This section does not apply to trade associations, membership associations of health care professionals, or other organizations that do not directly provide, arrange, or administer health care services or treatment.

Subd. 3. **HEALTH PLAN COMPANY.** "Health plan company" means health plan company as defined in section 62Q.01, subdivision 4.

Subd. 4. **ENROLLEE.** "Enrollee" means an individual covered by a health plan company or health insurance or health coverage plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Sec. 3. **[62J.71] PROHIBITED PROVIDER CONTRACTS.**

Subdivision 1. **PROHIBITED AGREEMENTS AND DIRECTIVES.** The following types of agreements and directives are contrary to state public policy, are prohibited under this section, and are null and void:

(1) any agreement that prohibits a health care provider from communicating with an enrollee with respect to the enrollee's health status, health care, or treatment options, if the health care provider is acting in good faith and within the provider's scope of practice as defined by law;

(2) any agreement or directive that prohibits a health care provider from making a recommendation regarding the suitability or desirability of a health plan company, health insurer, or health coverage plan for an enrollee, unless the provider has a financial conflict of interest in the enrollee's choice of health plan company, health insurer, or health coverage plan;

(3) any agreement or directive that prohibits a provider from providing testimony, supporting or opposing legislation, or making any other contact with state or federal legislators or legislative staff or with state and federal executive branch officers or staff;

(4) any agreement or directive that prohibits a health care provider from disclosing accurate information about whether services or treatment will be paid for by a patient's health plan company or health insurer or health coverage plan; and

(5) any agreement or directive that prohibits a health care provider from informing an enrollee about the nature of the reimbursement methodology used by an enrollee's health plan company, health insurer, or health coverage plan to pay the provider.

Subd. 2. **PERSONS AND ENTITIES AFFECTED.** The following persons and entities shall not enter into any agreement or directive that is prohibited under this section:

(1) a health plan company;

(2) a health care network cooperative as defined under section 62R.04, subdivision 3; or

(3) a health care provider as defined in section 62J.70, subdivision 2.

Subd. 3. **RETALIATION PROHIBITED.** No person, health plan company, or other organization may take retaliatory action against a health care provider solely on the grounds that the provider:

(1) refused to enter into an agreement or provide services or information in a manner that is prohibited under this section or took any of the actions listed in subdivision 1;

(2) disclosed accurate information about whether a health care service or treatment is covered by an enrollee's health plan company, health insurer, or health coverage plan; or

(3) expressed personal disagreement with a decision made by a person, organization, or health care provider regarding treatment or coverage provided to a patient of the provider, or assisted the patient in seeking reconsideration of such a decision, provided the health care provider makes it clear that the provider is acting in a personal capacity and not as a representative of or on behalf of the entity that made the decision.

Subd. 4. **EXCLUSION.** (a) Nothing in this section prohibits a health plan from taking action against a provider if the health plan has evidence that the provider's actions are illegal, constitute medical malpractice, or are contrary to accepted medical practices.

(b) Nothing in this section prohibits a contract provision or directive that requires any contracting party to keep confidential or to not use or disclose the specific amounts paid to a provider, provider fee schedules, provider salaries, and other proprietary information of a specific health plan or health plan company.

Sec. 4. **[62J.72] DISCLOSURE OF HEALTH CARE PROVIDER INFORMATION.**

Subdivision 1. **WRITTEN DISCLOSURE.** (a) A health plan company, as defined under section 62J.70, subdivision 3, a health care network cooperative as defined under section 62R.04, subdivision 3, and a health care provider as defined under section 62J.70, subdivision 2, shall, during open enrollment, upon enrollment, and annually thereafter, provide enrollees with a description of the general nature of the reimbursement methodologies used by the health plan company, health insurer, or health coverage plan to pay providers. This description may be incorporated into the member handbook, subscriber contract, certificate of coverage, or other written enrollee communication. The general reimbursement methodology shall be made available to employers at the time of open enrollment.

(b) Health plan companies and providers must, upon request, provide an enrollee with specific information regarding the reimbursement methodology, including, but not limited to, the following information:

(1) a concise written description of the provider payment plan, including any incentive plan applicable to the enrollee;

(2) a written description of any incentive to the provider relating to the provision of health care services to enrollees, including any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee, or the number of referrals to or utilization of specialists; and

(3) a written description of any incentive plan that involves the transfer of financial risk to the health care provider.

(c) The disclosure statement describing the general nature of the reimbursement methodologies must comply with the Readability of Insurance Policies Act in chapter 72C. Notwithstanding any other law to the contrary, the disclosure statement may voluntarily be filed with the commissioner for approval.

(d) A disclosure statement that has voluntarily been filed with the commissioner for approval under chapter 72C or voluntarily filed with the commissioner for approval for purposes other than pursuant to chapter 72C is deemed approved 30 days after the date of filing, unless approved or disapproved by the commissioner on or before the end of that 30–day period.

(e) The disclosure statement describing the general nature of the reimbursement methodologies must be provided upon request in English, Spanish, Vietnamese, and Hmong. In addition, reasonable efforts must be made to provide information contained in the disclosure statement to other non–English–speaking enrollees.

(f) Health plan companies and providers may enter into agreements to determine how to respond to enrollee requests received by either the provider or the health plan company. This subdivision does not require disclosure of specific amounts paid to a pro-

vider, provider fee schedules, provider salaries, or other proprietary information of a specific health plan company or health insurer or health coverage plan or provider.

Subd. 2. **ADDITIONAL WRITTEN DISCLOSURE OF PROVIDER INFORMATION.** In the event a health plan company prepares a written disclosure as specified in subdivision 1, in a manner that explicitly makes a comparison of the financial incentives between the providers with whom it contracts, it must describe the incentives that occur at the provider level.

Subd. 3. **INFORMATION ON PATIENTS' MEDICAL BILLS.** A health plan company and health care provider shall provide patients and enrollees with a copy of an explicit and intelligible bill whenever the patient or enrollee is sent a bill and is responsible for paying any portion of that bill. The bills must contain descriptive language sufficient to be understood by the average patient or enrollee. This subdivision does not apply to a flat co–pay paid by the patient or enrollee at the time the service is required.

Subd. 4. **NONAPPLICABILITY.** Health care providers as defined in section 62J.70, subdivision 2, clause (1), need not individually provide information required under this section if it has been provided by another individual or entity that is subject to this section.

Sec. 5. **[62J.73] PROHIBITION ON EXCLUSIVE ARRANGEMENTS.**

Subdivision 1. **PROHIBITION ON EXCLUSIVE RELATIONSHIPS.** No provider, group of providers, or health plan company shall restrict a person's right to provide health services or procedures to another provider, group of providers, or health plan company, unless the person is an employee.

Subd. 2. **PROHIBITION ON RESTRICTIVE CONTRACT TERMS.** No provider, group of providers, or person providing goods or health services to a provider shall enter into a contract or subcontract with a health plan company or group of providers on terms that require the provider, group of providers, or person not to contract with another health plan company, unless the provider or person is an employee.

Subd. 3. **PROHIBITION REGARDING ESSENTIAL FACILITIES AND SERVICES.** (a) No health plan company, provider, or group of providers may withhold from its competitors health care services, which are essential for competition between health care providers within the meaning of the essential facilities doctrine as interpreted by the federal courts.

(b) This subdivision should be construed as an instruction to state court in interpreting federal law.

Subd. 4. **VIOLATIONS.** Any provider or other individual who believes provisions of this section may have been violated may file a complaint with the attorney general's office regarding a possible violation of this section.

Sec. 6. **[62J.74] ENFORCEMENT.**

Subdivision 1. **AUTHORITY.** The commissioners of health and commerce shall each periodically review contracts and arrangements among health care providing entities and health plan companies they regulate to determine compliance with sections 62J.70 to 62J.73. Any person may submit a contract or arrangement to the relevant com-

missioner for review if the person believes sections 62J.70 to 62J.73 have been violated. Any provision of a contract or arrangement found by the relevant commissioner to violate this section is null and void, and the relevant commissioner may assess civil penalties against the health plan company in an amount not to exceed $2,500 for each day the contract or arrangement is in effect, and may use the enforcement procedures otherwise available to the commissioner. All due process rights afforded under chapter 14 apply to this section.

Subd. 2. **ASSISTANCE TO LICENSING BOARDS.** A health-related licensing board as defined under section 214.01, subdivision 2, shall submit a contract or arrangement to the relevant commissioner for review if the board believes sections 62J.70 to 62J.73 have been violated. If the commissioner determines that any provision of a contract or arrangement violates those sections, the board may take disciplinary action against any person who is licensed or regulated by the board who entered into the contract arrangement.

Sec. 7. **[62J.75] CONSUMER ADVISORY BOARD.**

(a) The consumer advisory board consists of 18 members appointed in accordance with paragraph (b). All members must be public, consumer members who:

(1) do not have and never had a material interest in either the provision of health care services or in an activity directly related to the provision of health care services, such as health insurance sales or health plan administration;

(2) are not registered lobbyists; and

(3) are not currently responsible for or directly involved in the purchasing of health insurance for a business or organization.

(b) The governor, the speaker of the house of representatives, and the subcommittee on committees of the committee on rules and administration of the senate shall each appoint two members. The Indian affairs council, the council on affairs of Chicano/Latino people, the council on Black Minnesotans, the council on Asian-Pacific Minnesotans, mid-Minnesota legal assistance, and the Minnesota chamber of commerce shall each appoint one member. The member appointed by the Minnesota chamber of commerce must represent small business interests. The health care campaign of Minnesota, Minnesotans for affordable health care, and consortium for citizens with disabilities shall each appoint two members. Members serve without compensation or reimbursement for expenses.

(c) The board shall advise the commissioners of health and commerce on the following: (1) the needs of health care consumers and how to better serve and educate the consumers on health care concerns and recommend solutions to identified problems; and (2) consumer protection issues in the self-insured market, including, but not limited to, public education needs.

The board also may make recommendations to the legislature on these issues.

(d) The board and this section expire June 30, 2001.

Sec. 8. **[62J.76] NONPREEMPTION.**

Nothing in the Patient Protection Act preempts or replaces requirements related to patient protections that are more protective of patient rights than the requirements established by the Patient Protection Act.

Sec. 9. Minnesota Statutes 1996, section 62Q.105, subdivision 1, is amended to read:

Subdivision 1. **ESTABLISHMENT.** Each health plan company shall establish and make available to enrollees, by July 1, ~~1997~~ 1998, an informal complaint resolution process that meets the requirements of this section. A health plan company must make reasonable efforts to resolve enrollee complaints, and must inform complainants in writing of the company's decision within 30 days of receiving the complaint. The complaint resolution process must treat the complaint and information related to it as required under sections 72A.49 to 72A.505.

Sec. 10. Minnesota Statutes 1996, section 62Q.30, is amended to read:

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

The commissioner shall establish an expedited fact finding and dispute resolution process to assist enrollees of health plan companies with contested treatment, coverage, and service issues to be in effect July 1, ~~1997~~ 1998. ~~The commissioner may order an integrated service network or an all-payer insurer to provide or pay for a service that is within the standard health coverage.~~ If the disputed issue relates to whether a service is appropriate and necessary, the commissioner shall issue an order only after consulting with appropriate experts knowledgeable, trained, and practicing in the area in dispute, reviewing pertinent literature, and considering the availability of satisfactory alternatives. The commissioner shall take steps including but not limited to fining, suspending, or revoking the license of a health plan company that is the subject of repeated orders by the commissioner that suggests a pattern of inappropriate underutilization.

Sec. 11. **[62Q.55] EMERGENCY SERVICES.**

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

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

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

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

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

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

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

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

Sec. 12. **[62Q.56] CONTINUITY OF CARE.**

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

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

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

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

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

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

(b) If the contract termination was not for cause, enrollees can request a referral to the terminating provider for up to 120 days if they have special medical needs or have other special circumstances, such as cultural or language barriers. The health plan company can require medical records and other supporting documentation in support of the requested referral. Each request for referral to a terminating provider shall be considered by the health plan company on a case–by–case basis.

(c) If the contract termination was for cause, enrollees must be notified of the change and transferred to participating providers in a timely manner so that health care services remain available and accessible to the affected enrollees. The health plan company is not

required to refer an enrollee back to the terminating provider if the termination was for cause.

Subd. 2. **CHANGE IN HEALTH PLANS.** (a) The health plan company shall prepare a written plan that provides a process for coverage determinations for continuity of care for new enrollees with special needs, special risks, or other special circumstances, such as cultural or language barriers, who request continuity of care with their former provider for up to 120 days. The written plan must explain the criteria that will be used for determining special needs cases, and how continuity of care will be provided.

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

Subd. 3. **DISCLOSURES.** The written plans required under this section must be made available upon request to enrollees or prospective enrollees.

Sec. 13. **[62Q.58] ACCESS TO SPECIALTY CARE.**

Subdivision 1. **STANDING REFERRAL.** A health plan company shall establish a procedure by which an enrollee may apply for a standing referral to a health care provider who is a specialist if a referral to a specialist is required for coverage. This procedure for a standing referral must specify the necessary criteria and conditions, which must be met in order for an enrollee to obtain a standing referral.

Subd. 2. **COORDINATION OF SERVICES.** A primary care provider or primary care group shall remain responsible for coordinating the care of an enrollee who has received a standing referral to a specialist. The specialist shall not make any secondary referrals related to primary care services without prior approval by the primary care provider or primary care group. However, an enrollee with a standing referral to a specialist may request primary care services from that specialist. The specialist, in agreement with the enrollee and primary care provider or primary care group, may elect to provide primary care services to that enrollee according to procedures established by the health plan company.

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

Sec. 14. **[62Q.64] DISCLOSURE OF EXECUTIVE COMPENSATION.**

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

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

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

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

Sec. 15. **[144.6585] IDENTIFICATION OF HEALTH CARE PROVIDERS.**

Any health care provider who is licensed, credentialed, or registered by a health-related licensing board as defined under section 214.01, subdivision 2, must wear a name

tag that indicates by words, letters, abbreviations, or insignia the profession or occupation of the individual. The name tag must be worn whenever the health care provider is rendering health services to a patient, unless wearing the name tag would create a safety or health risk to the patient. The failure to wear a name tag is not reportable under chapter 214.

Sec. 16. Minnesota Statutes 1996, section 181.932, subdivision 1, is amended to read:

Subdivision 1. **PROHIBITED ACTION.** An employer shall not discharge, discipline, threaten, otherwise discriminate against, or penalize an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because:

(a) the employee, or a person acting on behalf of an employee, in good faith, reports a violation or suspected violation of any federal or state law or rule adopted pursuant to law to an employer or to any governmental body or law enforcement official;

(b) the employee is requested by a public body or office to participate in an investigation, hearing, inquiry; ~~or~~

(c) the employee refuses an employer's order to perform an action that the employee has an objective basis in fact to believe violates any state or federal law or rule or regulation adopted pursuant to law, and the employee informs the employer that the order is being refused for that reason; or

(d) the employee, in good faith, reports a situation in which the quality of health care services provided by a health care facility, organization, or health care provider violates a standard established by federal or state law or a professionally recognized national clinical or ethical standard and potentially places the public at risk of harm.

Sec. 17. Minnesota Statutes 1996, section 214.16, subdivision 1, is amended to read:

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

(a) "Board" means the boards of medical practice, chiropractic examiners, nursing, optometry, dentistry, pharmacy, psychology, social work, marriage and family therapy, and podiatry.

(b) "Regulated person" means a licensed physician, chiropractor, nurse, optometrist, dentist, pharmacist, psychologist, social worker, marriage and family therapist, or podiatrist.

Sec. 18. Minnesota Statutes 1996, section 214.16, subdivision 3, is amended to read:

Subd. 3. **GROUNDS FOR DISCIPLINARY ACTION.** The board shall take disciplinary action, which may include license revocation, against a regulated person for:

(1) intentional failure to provide the commissioner of health with the data required under chapter 62J;

(2) intentional failure to provide the commissioner of revenue with data on gross revenue and other information required for the commissioner to implement sections 295.50 to 295.58; ~~and~~

(3) intentional failure to pay the health care provider tax required under section 295.52; and

(4) entering into a contract or arrangement that is prohibited under sections 62J.70 to 62J.73.

Sec. 19. **CONSOLIDATION AND COORDINATION OF CONSUMER ASSISTANCE AND ADVOCACY OFFICES.**

The commissioners of health and commerce, in consultation with the commissioners of human services and employee relations, shall study the feasibility and desirability of consolidating and improving coordination of some or all existing state consumer assistance, ombudsperson, and advocacy activities. The commissioners shall submit a report with recommendations, and draft legislation to the legislature by January 15, 1998.

Sec. 20. **COMPLAINT PROCESS STUDY.**

The commissioners of health and commerce, in consultation with the consumer advisory board and other affected parties, shall make recommendations to the legislature by January 15, 1998, on developing a complaint resolution process for health plan companies to make available for enrollees.

Sec. 21. **CONSIDERATION.**

The consumer advisory board shall consider the use of physicians by utilization review organizations, including whether only Minnesota licensed physicians should be used for utilization review, whether appropriate types of medical practitioners are being used for utilization review, and whether Minnesota's utilization review statutes afford adequate consumer protection. The consumer advisory board may report findings to the legislature prior to the 1998 legislative session.

Sec. 22. **REPEALER; ANTITRUST EXEMPTION PROCESS.**

Minnesota Statutes 1996, sections 62J.2911, 62J.2912, 62J.2913, 62J.2914, 62J.2915, 62J.2916, 62J.2917, 62J.2918, 62J.2919, 62J.2920, and 62J.2921 are repealed.

Sec. 23. **EFFECTIVE DATE.**

Sections 3, 17, and 18 are effective January 1, 1998, and apply to contracts entered into or renewed on or after the effective date. Sections 1, 7 to 10, 16, 20, and 22 are effective the day following final enactment. Sections 4, 11, 12, and 13 are effective January 1, 1998, and apply to contracts or coverage issued or renewed on or after the effective date.

Presented to the governor May 29, 1997

Signed by the governor June 2, 1997, 2:22 p.m.

CHAPTER 238—H.F.No. 268

An act relating to corrections; amending the appropriation to build a close–custody correctional facility of at least 800 beds; providing that the new facility shall be at custody level four; deleting certain construction bid requirements; authorizing construction of an access road; forbidding