CHAPTER 62N

MINNESOTA INTEGRATED SERVICE NETWORK ACT

62N.01 CITATION AND PURPOSE.

Subdivision 1. **Citation.** This chapter may be cited as the "Minnesota integrated service network act."

Subd. 2. **Purpose.** This chapter allows the creation of integrated service networks that will be responsible for arranging for or delivering a full array of health care services, from routine primary and preventive care through acute inpatient hospital care, to a defined population for a fixed price from a purchaser.

Each integrated service network is accountable to keep its total revenues within the limit of growth set by the commissioner of health under section 62N.05, subdivision 2. Integrated service networks can be formed by health care providers, health maintenance organizations, insurance companies, employers, or other organizations. Competition between integrated service networks on the quality and price of health care services is encouraged.

History: *1993 c 345 art 1 s 2; 1Sp1993 c 6 s 36; 1994 c 625 art 8 s 33*

62N.02 DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to this chapter.

Subd. 2. **Accredited capitated provider.** "Accredited capitated provider" means a financially responsible health care providing entity paid by a network on a capitated basis.

Subd. 3. **Commission.** "Commission" means the health care commission established under section 62J.05.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health or the commissioner's designated representative.

Subd. 4a. **Community integrated service network.** (a) "Community integrated service network" or "community network" means a formal arrangement licensed by the commissioner under section 62N.25 for providing prepaid health services to enrolled populations of 50,000 or fewer enrollees, including enrollees who are residents of other states.

(b) Notwithstanding paragraph (a), an organization licensed as a community network that accepts payments for health care services on a capitated basis, or under another similar risk sharing agreement, from a program of self-insurance as described in section 60A.02, subdivision 3, paragraph (b), shall not be regulated as a community network with respect to the receipt of the payments. The payments are not premium revenues for the purpose of calculating the community network's liability for otherwise applicable state taxes, assessments, or surcharges, with the exception of:

(1) the MinnesotaCare provider tax;

(2) the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d); and

(3) effective July 1, 1995, assessments by the Minnesota comprehensive health association.

This paragraph applies only where:

(1) the community network does not bear risk in excess of 110 percent of the self-insurance program's expected costs;

(2) the employer does not carry stop loss, excess loss, or similar coverage with an attachment point lower than 120 percent of the self-insurance program's expected costs;

(3) the community network and the employer comply with the data submission and administrative simplification provisions of chapter 62J;

(4) the community network and the employer comply with the provider tax pass-through provisions of section 295.582;

(5) the community network's required minimum reserves reflect the risk borne by the community network under this paragraph, with an appropriate adjustment for the 110 percent limit on risk borne by the community network;

(6) on or after July 1, 1994, but prior to January 1, 1995, the employer has at least 1,500 current employees, as defined in section 62L.02, or, on or after January 1, 1995, the employer has at least 750 current employees, as defined in section 62L.02;

(7) the employer does not exclude any eligible employees or their dependents, both as defined in section 62L.02, from coverage offered by the employer, under this paragraph or any other health coverage, insured or self-insured, offered by the employer, on the basis of the health status or health history of the person.

This paragraph expires December 31, 1997.

Subd. 5. **Enrollee.** "Enrollee" means an individual, including a member of a group, to whom a network is obligated to provide health services under this chapter.

Subd. 6. **Health care providing entity.** "Health care providing entity" means a participating entity that provides health care to enrollees through an integrated service network.

Subd. 6a. **Health carrier.** "Health carrier" has the meaning given in section 62A.011.

Subd. 7. **Health plan.** "Health plan" means a health plan as defined in section 62A.011 or coverage by an integrated service network.

Subd. 8. **Integrated service network.** (a) "Integrated service network" means a formal arrangement permitted by this chapter and licensed by the commissioner for providing health services under this chapter to enrollees for a fixed payment per time period. Integrated service network does not include a community integrated service network.

(b) Notwithstanding paragraph (a), an organization licensed as an integrated service network that accepts payments for health care services on a capitated basis, or under another similar risk sharing agreement, from a program of self-insurance as described in section 60A.02, subdivision 3, paragraph (b), shall not be regulated as an integrated service network with respect to the receipt of the payments. The payments are not premium revenues for the purpose of calculating the integrated service network's liability for otherwise applicable state taxes, assessments, or surcharges, with the exception of:

(1) the MinnesotaCare provider tax;

(2) the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d); and

(3) effective July 1, 1995, assessments by the Minnesota comprehensive health association.

This paragraph applies only where:

(1) the integrated service network does not bear risk in excess of 110 percent of the self-insurance program's expected costs;

(2) the employer does not carry stop loss, excess loss, or similar coverage with an attachment point lower than 120 percent of the self-insurance program's expected costs;

(3) the integrated service network and the employer comply with the data submission and administrative simplification provisions of chapter 62J;

(4) the integrated service network and the employer comply with the provider tax pass-through provisions of section 295.582;

(5) the integrated service network's required minimum reserves reflect the risk borne by the integrated service network under this paragraph, with an appropriate adjustment for the 110 percent limit on risk borne by the integrated service network;

(6) on or after July 1, 1994, but prior to January 1, 1995, the employer has at least 1,500 current employees, as defined in section 62L.02, or, on or after January 1, 1995, the employer has at least 750 current employees, as defined in section 62L.02;

(7) the employer does not exclude any eligible employees or their dependents, both as defined in section 62L.02, from coverage offered by the employer, under this paragraph or any other health coverage, insured or self-insured, offered by the employer, on the basis of the health status or health history of the person.

This paragraph expires December 31, 1997.

Subd. 9. **Network.** "Network" means an integrated service network as defined in this section.

Subd. 10. **Participating entity.** "Participating entity" means a health care providing entity, a risk-bearing entity, or an entity providing other services through an integrated service network.

Subd. 11. **Price.** "Price" means the actual amount of money paid, after discounts or other adjustments, by the person or organization paying money to buy health care coverage and health care services. "Price" does not mean the cost or costs incurred by a network or other entity to provide health care services to individuals.

Subd. 12. **Risk-bearing entity.** "Risk-bearing entity" means an entity that participates in an integrated service network so as to bear all or part of the risk of loss. "Risk-bearing entity" includes an entity that provides reinsurance, stop-loss, excess-of-loss, and similar coverage.

History: *1993 c 345 art 1 s 3; 1994 c 625 art 1 s 3,4; art 8 s 34*

62N.03 APPLICABILITY OF OTHER LAW.

Chapters 60A, 60B, 60G, 61A, 61B, 62A, 62C, 62D, 62E, 62H, 62L, 62M, and 64B do not, except as expressly provided in this chapter or in those other chapters, apply to integrated service networks, or to entities otherwise subject to those chapters, with respect to participation by those entities in integrated service networks. Chapters 72A and 72C apply to integrated service networks, except as otherwise expressly provided in this chapter.

Integrated service networks are in "the business of insurance" for purposes of the federal McCarran-Ferguson Act, United States Code, title 15, section 1012, are "domestic insurance companies" for purposes of the federal Bankruptcy Reform Act of 1978, United States Code, title 11, section 109, and are "insurance" for purposes of the federal Employee Retirement Income Security Act, United States Code, title 29, section 1144.

History: *1993 c 345 art 1 s 4*

62N.04 REGULATION.

Integrated service networks are under the supervision of the commissioner, who shall enforce this chapter. The commissioner has, with respect to this chapter, all

enforcement and rulemaking powers available to the commissioner under section 62D.17.

History: *1993 c 345 art 1 s 5*

62N.05 RULES GOVERNING INTEGRATED SERVICE NETWORKS.

Subdivision 1. **Rules.** The commissioner, in consultation with the commission, may adopt emergency and permanent rules to establish more detailed requirements governing integrated service networks in accordance with this chapter.

Subd. 2. **Requirements.** The commissioner shall include in the rules requirements that will ensure that the annual rate of growth of an integrated service network's aggregate total revenues received from purchasers and enrollees, after adjustments for changes in population size and risk, does not exceed the growth limit established in section 62J.04. A network's aggregate total revenues for purposes of these growth limits are net of the contributions, surcharges, taxes, and assessments listed in section 62P.04, subdivision 2, that the network pays. The commissioner may include in the rules the following:

(1) requirements for licensure, including a fee for initial application and an annual fee for renewal;

(2) quality standards;

(3) requirements for availability and comprehensiveness of services;

(4) requirements regarding the defined population to be served by an integrated service network;

(5) requirements for open enrollment;

(6) provisions for incentives for networks to accept as enrollees individuals who have high risks for needing health care services and individuals and groups with special needs;

(7) prohibitions against disenrolling individuals or groups with high risks or special needs;

(8) requirements that an integrated service network provide to its enrollees information on coverage, including any limitations on coverage, deductibles and copayments, optional services available and the price or prices of those services, any restrictions on emergency services and services provided outside of the network's service area, any responsibilities enrollees have, and describing how an enrollee can use the network's enrollee complaint resolution system;

(9) requirements for financial solvency and stability;

(10) a deposit requirement;

(11) financial reporting and examination requirements;

(12) limits on copayments and deductibles;

(13) mechanisms to prevent and remedy unfair competition;

(14) provisions to reduce or eliminate undesirable barriers to the formation of new integrated service networks;

(15) requirements for maintenance and reporting of information on costs, prices, revenues, volume of services, and outcomes and quality of services;

(16) a provision allowing an integrated service network to set credentialing standards for practitioners employed by or under contract with the network;

(17) a requirement that an integrated service network employ or contract with practitioners and other health care providers, and minimum requirements for those contracts if the commissioner deems requirements to be necessary to ensure that each network will be able to control expenditures and revenues or to protect enrollees and potential enrollees;

(18) provisions regarding liability for medical malpractice;

(19) provisions regarding permissible and impermissible underwriting criteria applicable to the standard set of benefits;

(20) a method or methods to facilitate and encourage appropriate provision of services by midlevel practitioners and pharmacists;

(21) a method or methods to assure that all integrated service networks are subject to the same regulatory requirements. All health carriers, including health maintenance organizations, insurers, and nonprofit health service plan corporations shall be regulated under the same rules, to the extent that the health carrier is operating an integrated service network or is a participating entity in an integrated service network;

(22) provisions for appropriate risk adjusters or other methods to prevent or compensate for adverse selection of enrollees into or out of an integrated service network; and

(23) rules prescribing standard measures and methods by which integrated service networks shall determine and disclose their prices, copayments, deductibles, out-of-pocket limits, enrollee satisfaction levels, and anticipated loss ratios.

Subd. 3. **Criteria for rulemaking.** (a) **Applicability.** The commissioner shall adopt rules governing integrated service networks based on the criteria and objectives specified in this subdivision.

(b) **Competition.** The rules must encourage and facilitate competition through the collection and distribution of reliable information on the cost, prices, and quality of each integrated service network in a manner that allows comparisons between networks.

(c) **Flexibility.** The rules must allow significant flexibility in the structure and organization of integrated service networks. The rules must allow and facilitate the formation of networks by providers, employers, and other organizations, in addition to health carriers.

(d) **Expanding access and coverage.** The rules must be designed to expand access to health care services and coverage for all Minnesotans, including individuals and groups who have preexisting health conditions, who represent a higher risk of requiring treatment, who require translation or other special services to facilitate treatment, who face social or cultural barriers to obtaining health care, or who for other reasons face barriers to access to health care and coverage. Enrollment standards must ensure that high risk and special needs populations will be included and growth limits and payment systems must be designed to provide incentives for networks to enroll even the most challenging and costly groups and populations. The rules must be consistent with the principles of health insurance reform that are reflected in Laws 1992, chapter 549.

(e) **Ability to bear financial risk.** The rules must allow a variety of options for integrated service networks to demonstrate their ability to bear the financial risk of serving their enrollees, to facilitate diversity and innovation and the entry into the market of new networks. The rules must allow the phasing in of reserve requirements and other requirements relating to financial solvency.

(f) **Participation of providers.** The rules must not require providers to participate in an integrated service network and must allow providers to participate in more than one network and to serve both patients who are covered by an integrated service network and patients who are not. The rules must allow significant flexibility for an integrated service network and providers to define and negotiate the terms and conditions of provider participation. The rules must encourage and facilitate the participation of midlevel practitioners, allied health care practitioners, and pharmacists, and eliminate inappropriate barriers to their participation. The rules must encourage and facilitate the participation of disproportionate share providers in integrated service networks and eliminate inappropriate barriers to this participation.

(g) **Rural communities.** The rules must permit a variety of forms of integrated service networks to be developed in rural areas in response to the needs, preferences, and conditions of rural communities, utilizing to the greatest extent possible current existing health care providers and hospitals.

(h) **Limits on growth.** The rules must include provisions to enable the commissioner to enforce the limits on growth in health care total revenues for each integrated service network and for the entire system of integrated service networks.

(i) **Standard benefit set.** The commission shall make recommendations to the commissioner regarding a standard benefit set.

(j) **Conflict of interest.** The rules shall include provisions the commissioner deems necessary and appropriate to address integrated service networks' and participating providers' relationship to section 62J.23 or other laws relating to provider conflicts of interest.

History: *1993 c 345 art 1 s 6*

62N.06 AUTHORIZED ENTITIES.

Subdivision 1. **Authorized entities.** (a) An integrated service network may be organized as a separate nonprofit corporation under chapter 317A or as a cooperative under chapter 308A.

(b) A nonprofit health carrier, as defined in section 62A.011, may establish and operate one or more integrated service networks without forming a separate corporation or cooperative, but only if all of the following conditions are met:

(i) an existing contract between the health carrier and a health care provider, for a term of less than seven years, that does not explicitly mention the provider's relationship within an integrated service network, or a future integrated service network, does not bind the health carrier or provider as applied to integrated service network services, except with the mutual consent of the health carrier and provider. This clause does not apply to contracts between a health carrier and its salaried employees;

(ii) the health carrier shall not apply toward the net worth, working capital, or deposit requirements of this chapter any assets used to satisfy net worth, working capital, deposit, or other financial requirements under any other chapter of Minnesota law;

(iii) the health carrier shall not include in its premiums for health coverage provided under any other chapter of Minnesota law, an assessment or surcharge relating to net worth, working capital, or deposit requirements imposed upon the integrated service network under this chapter; and

(iv) the health carrier shall not include in its premiums for integrated service network coverage under this chapter an assessment or surcharge relating to net worth working capital or deposit requirements imposed upon health coverage offered under any other chapter of Minnesota law.

Subd. 2. **Separate accounting required.** Any entity operating one or more integrated service networks shall maintain separate accounting and record keeping procedures, acceptable to the commissioner, for each integrated service network.

Subd. 3. **Governmental subdivision.** A political subdivision may establish and operate an integrated service network directly, without forming a separate entity. Unless otherwise specified, a network authorized under this subdivision must comply with all other provisions governing networks.

History: *1993 c 345 art 1 s 7; 1994 c 625 art 4 s 2*

62N.065 ADMINISTRATIVE COST CONTAINMENT.

Subdivision 1. **Unreasonable expenses.** No integrated service network shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of this chapter; in order to safeguard the underlying nonprofit status of integrated service networks; and to ensure that payment of integrated service network money to any person or organization results in a corresponding benefit to the integrated service network and its enrollees; when determining whether an integrated service network has incurred an unreasonable expense in relation to payments made to a person or organization, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the integrated service network have acted with good faith and in the best interests of the inte-

grated service network in entering into, and performing under, a contract under which the integrated service network has incurred an expense. In addition to the compliance powers under subdivision 3, the commissioner has standing to sue, on behalf of an integrated service network, officers or trustees of the integrated service network who have breached their fiduciary duty in entering into and performing such contracts.

Subd. 2. **Data on contracts.** Integrated service networks shall keep on file in the offices of the integrated service network copies of all contracts regulated under subdivision 1, and data on the payments, salaries, and other remuneration paid to for-profit firms, affiliates, or to persons for administrative expenses, service contracts, and management of the integrated service network, and shall make these records available to the commissioner upon request.

Subd. 3. **Compliance authority.** The commissioner may review any contract, arrangement, or agreement to determine whether it complies with the provisions contained in subdivision 1. The commissioner may suspend any provision that does not comply with subdivision 1 and may require the integrated service network to replace those provisions with provisions that do comply.

History: *1993 c 345 art 1 s 8; 1Sp1993 c 6 s 37; 1994 c 625 art 8 s 35*

62N.07 [Repealed, 1994 c 625 art 8 s 74]
62N.075 [Repealed, 1994 c 625 art 8 s 74]
62N.08 [Repealed, 1994 c 625 art 8 s 74]
62N.085 [Repealed, 1994 c 625 art 8 s 74]

62N.10 LICENSING.

Subdivision 1. **Requirements.** All integrated service networks must be licensed by the commissioner. Licensure requirements are:

(1) the ability to be responsible for the full continuum of required health care and related costs for the defined population that the integrated service network will serve;

(2) the ability to satisfy standards for quality of care;

(3) financial solvency;

(4) the ability to develop and complete the action plans required by law; and

(5) the ability to fully comply with this chapter and all other applicable law.

The commissioner may adopt rules to specify licensure requirements for integrated service networks in greater detail, consistent with this subdivision.

Subd. 2. **Fees.** Licensees shall pay an initial fee and a renewal fee each following year to be established by the commissioner of health. The fee must be imposed at a rate sufficient to cover the cost of regulation.

Subd. 3. **Loss of license.** The commissioner may fine a licensee or suspend or revoke a license for violations of rules or statutes pertaining to integrated service networks.

Subd. 4. **Participation; government programs.** Integrated service networks shall, as a condition of licensure, participate in the medical assistance, general assistance medical care, and MinnesotaCare programs. The commissioner shall adopt rules specifying the participation required of the networks. The rules must be consistent with Minnesota Rules, parts 9505.5200 to 9505.5260, governing participation by health maintenance organizations in public health care programs.

Subd. 5. **Application.** Each application for an integrated service network license must be in a form prescribed by the commissioner.

Subd. 6. **Documents on file.** A network shall agree to retain in its files any documents specified by the commissioner. A network shall permit the commissioner to examine those documents at any time and shall promptly provide copies of any of them to the commissioner upon request.

History: *1993 c 345 art 1 s 13; 1994 c 625 art 8 s 36,37*

62N.11 EVIDENCE OF COVERAGE.

Subdivision 1. **Applicability.** Every integrated service network enrollee residing in this state is entitled to evidence of coverage or contract. The integrated service network or its designated representative shall issue the evidence of coverage or contract. The commissioner shall adopt rules specifying the requirements for contracts and evidence of coverage. "Evidence of coverage" means evidence that an enrollee is covered by a group contract issued to the group.

Subd. 2. **Filing.** No evidence of coverage or contract or amendment of coverage or contract shall be issued or delivered to any individual in this state until a copy of the form of the evidence of coverage or contract or amendment of coverage or contract has been filed with and approved by the commissioner.

History: *1993 c 345 art 1 s 14*

62N.12 ENROLLEE RIGHTS.

The cover page of the evidence of coverage and contract must contain a clear and complete statement of an enrollee's rights as a consumer. The commissioner shall adopt rules specifying enrollee rights and required disclosures to enrollees.

History: *1993 c 345 art 1 s 15*

62N.13 ENROLLEE COMPLAINT SYSTEM.

Every integrated service network must establish and maintain an enrollee complaint system, including an impartial arbitration provision, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services. The commissioner shall adopt rules specifying requirements relating to enrollee complaints.

History: *1993 c 345 art 1 s 16*

62N.14 OFFICE OF CONSUMER SERVICES.

Subdivision 1. **Duties.** Every integrated service network must have an office of consumer services which will be responsible for dealing with all enrollee complaints and inquiries. The integrated service network, through its office of consumer services, will be responsible for:

(1) soliciting consumer comment on the quality and accessibility of services available;

(2) disseminating information to consumers on the integrated service network's enrollee complaint resolutions system;

(3) receiving unsolicited comments on and complaints about services;

(4) taking prompt action upon consumer complaints; and

(5) providing for and participating in alternative dispute resolution processes including the fact-finding and dispute resolution process established under section 62Q.30.

Subd. 2. **Contact with commissioner.** Each integrated service network shall designate a contact person for direct communication with the commissioner. Integrated service network complaint files must be maintained by the integrated service network for seven years and must be made available upon the request of the commissioner. The commissioner shall periodically summarize the number, type, and resolution of complaints received by the health department from integrated service network enrollees, and shall make that information available through the office of consumer information. The commissioner may at any time inspect the integrated service network's office of consumer services complaint files.

Subd. 3. **Enrollee membership cards.** Integrated service networks shall issue enrollee membership cards to each enrollee of the integrated service network. The enrollee card shall contain, at minimum, the following information:

(1) the telephone number of the integrated service network's office of consumer services;

(2) the telephone number of the state's office of consumer information; and

(3) the telephone number of the department of health or local ombudsperson.

The membership cards shall also conform to the requirements set forth in section 62J.60.

Subd. 4. **Enrollee documents.** Each integrated service network, through its office of consumer services, is responsible for providing enrollees, upon request, with any reasonable information desired by an enrollee. This information may include duplicate copies of the evidence of coverage form required under section 62N.11; an annually updated list of addresses and telephone numbers of available integrated service network providers, including midlevel practitioners and allied professionals; and information on the enrollee complaint system of the integrated service network.

History: *1994 c 625 art 4 s 3*

62N.16 [Repealed, 1994 c 625 art 8 s 74]

62N.22 DISCLOSURE OF COMMISSIONS.

Before selling any coverage or enrollment in a community integrated service network or an integrated service network, a person selling the coverage or enrollment shall disclose in writing to the prospective purchaser the amount of any commission or other compensation the person will receive as a direct result of the sale. The disclosure may be expressed in dollars or as a percentage of the premium. The amount disclosed need not include any anticipated renewal commissions.

History: *1993 c 345 art 1 s 18; 1994 c 625 art 8 s 38*

62N.23 TECHNICAL ASSISTANCE; LOANS.

(a) The commissioner shall provide technical assistance to parties interested in establishing or operating a community integrated service network or an integrated service network. This shall be known as the integrated service network technical assistance program (ISNTAP).

The technical assistance program shall offer seminars on the establishment and operation of community integrated service networks or integrated service networks in all regions of Minnesota. The commissioner shall advertise these seminars in local and regional newspapers, and attendance at these seminars shall be free.

The commissioner shall write a guide to establishing and operating a community integrated service network or an integrated service network. The guide must provide basic instructions for parties wishing to establish a community integrated service network or an integrated service network. The guide must be provided free of charge to interested parties. The commissioner shall update this guide when appropriate.

The commissioner shall establish a toll-free telephone line that interested parties may call to obtain assistance in establishing or operating a community integrated service network or an integrated service network.

(b) The commissioner shall grant loans for organizational and start-up expenses to entities forming community integrated service networks or integrated service networks, or to networks less than one year old, to the extent of any appropriation for that purpose. The commissioner shall allocate the available funds among applicants based upon the following criteria, as evaluated by the commissioner within the commissioner's discretion:

(1) the applicant's need for the loan;

(2) the likelihood that the loan will foster the formation or growth of a network; and

(3) the likelihood of repayment.

The commissioner shall determine any necessary application deadlines and forms and is exempt from rulemaking in doing so.

History: *1993 c 345 art 1 s 19; 1994 c 625 art 12 s 1*

62N.24 REVIEW OF RULES.

The commissioner of health shall mail copies of all proposed emergency and permanent rules that are being promulgated under this chapter to each member of the legislative commission on health care access prior to final adoption by the commissioner.

History: *1993 c 345 art 1 s 20*

62N.25 COMMUNITY INTEGRATED SERVICE NETWORKS.

Subdivision 1. **Scope of licensure.** Beginning July 1, 1994, the commissioner shall accept applications for licensure as a community integrated service network under this section. Licensed community integrated service networks may begin providing health coverage to enrollees no earlier than January 1, 1995, and may begin marketing coverage to prospective enrollees upon licensure.

Subd. 2. **Licensure requirements generally.** To be licensed and to operate as a community integrated service network, an applicant must satisfy the requirements of chapter 62D, and all other legal requirements that apply to entities licensed under chapter 62D, except as exempted or modified in this section. Community networks must, as a condition of licensure, comply with rules adopted under section 256B.0644 that apply to entities governed by chapter 62D.

Subd. 3. **Regulation; applicable law.** Community integrated service networks are regulated and licensed by the commissioner under the same authority that applies to entities licensed under chapter 62D, except as exempted or modified under this section. All statutes or rules that apply to health maintenance organizations apply to community networks, unless otherwise specified. A cooperative organized under chapter 308A may establish a community integrated service network.

Subd. 4. **Governing body.** In addition to the requirements of section 62D.06, at least 51 percent of the members of the governing body of the community integrated service network must be residents of the community integrated service network's service area. Service area, for purposes of this subdivision, may include contiguous geographic areas outside the state of Minnesota.

Subd. 5. **Benefits.** Community integrated service networks must offer the health maintenance organization benefit set, as defined in chapter 62D, and other laws applicable to entities regulated under chapter 62D, except that the community integrated service network may impose a deductible, not to exceed $1,000 per person per year, provided that out-of-pocket expenses on covered services do not exceed $3,000 per person or $5,000 per family per year. The deductible must not apply to preventive health services as described in Minnesota Rules, part 4685.0801, subpart 8. Community networks and chemical dependency facilities under contract with a community network shall use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660, when assessing enrollees for chemical dependency treatment.

Subd. 6. **Solvency.** A community integrated service network is exempt from the deposit, reserve, and solvency requirements specified in sections 62D.041, 62D.042, 62D.043, and 62D.044 and shall comply instead with sections 62N.27 to 62N.32. In applying sections 62N.27 to 62N.32, the commissioner is exempt from the rulemaking requirements of chapter 14. However, to the extent that there are analogous definitions or procedures in chapter 62D or in rules promulgated thereunder, the commissioner shall follow those existing provisions rather than adopting a contrary approach or interpretation. This rulemaking exemption shall expire on June 1, 1995.

Subd. 7. **Exemptions from existing requirements.** Community integrated service networks are exempt from the following requirements applicable to health maintenance organizations:

(1) conducting focused studies under Minnesota Rules, part 4685.1125;

(2) preparing and filing, as a condition of licensure, a written quality assurance plan, and annually filing such a plan and a work plan, under Minnesota Rules, parts 4685.1110 and 4685.1130;

(3) maintaining statistics under Minnesota Rules, part 4685.1200;

(4) filing provider contract forms under sections 62D.03, subdivision 4, and 62D.08, subdivision 1;

(5) reporting any changes in the address of a network provider or length of a provider contract or additions to the provider network to the commissioner within ten days under section 62D.08, subdivision 5. Community networks must report such information to the commissioner on a quarterly basis. Community networks that fail to make the required quarterly filing are subject to the penalties set forth in section 62D.08, subdivision 5; and

(6) preparing and filing, as a condition of licensure, a marketing plan, and annually filing a marketing plan, under sections 62D.03, subdivision 4, paragraph (l), and 62D.08, subdivision 1.

Subd. 8. **Provider contracts.** The provisions of section 62D.123 are implied in every provider contract or agreement between a community integrated service network and a provider, regardless of whether those provisions are expressly included in the contract. No participating provider, agent, trustee, or assignee of a participating provider has or may maintain any cause of action against a subscriber or enrollee to collect sums owed by the community network.

Subd. 9. **Exceptions to enrollment limit.** A community integrated service network may enroll enrollees in excess of 50,000 if necessary to comply with guaranteed issue or guaranteed renewal requirements of chapter 62L or section 62A.65.

History: *1994 c 625 art 1 s 5*

62N.255 [Renumbered 62Q.095]

62N.26 SHARED SERVICES COOPERATIVE.

The commissioner of health shall establish, or assist in establishing, a shared services cooperative organized under chapter 308A to make available administrative and legal services, technical assistance, provider contracting and billing services, and other services to those community integrated service networks and integrated service networks that choose to participate in the cooperative. The commissioner shall provide, to the extent funds are appropriated, start-up loans sufficient to maintain the shared services cooperative until its operations can be maintained by fees and contributions. The cooperative must not be staffed, administered, or supervised by the commissioner of health. The cooperative shall make use of existing resources that are already available in the community, to the extent possible.

History: *1994 c 625 art 1 s 7*

62N.27 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62N.27 to 62N.32, the terms defined in this section have the meanings given. Other terms used in those sections have the meanings given in sections 62D.041, 62D.042, 62D.043, and 62D.044.

Subd. 2. **Net worth.** "Net worth" means admitted assets as defined in subdivision 3, minus liabilities. Liabilities do not include those obligations that are subordinated in the same manner as preferred ownership claims under section 60B.44, subdivision 10. For purposes of this subdivision, preferred ownership claims under section 60B.44, subdivision 10, include promissory notes subordinated to all other liabilities of the community integrated service network.

Subd. 3. **Admitted assets.** "Admitted assets" means admitted assets as defined in section 62D.044, except that real estate investments allowed by section 62D.045 are not admitted assets. Admitted assets include the deposit required under section 62N.32.

Subd. 4. **Accredited capitated provider.** "Accredited capitated provider" means a health care providing entity that:

(1) receives capitated payments from a community network under a contract to provide health services to the network's enrollees. For purposes of this section, a health

care providing entity is "capitated" when its compensation arrangement with a network involves the provider's acceptance of material financial risk for the delivery of a predetermined set of services for a specified period of time;

(2) is licensed to provide and provides the contracted services, either directly or through an affiliate. For purposes of this section, an "affiliate" is any person that directly or indirectly controls, is controlled by, or is under common control with the health care providing entity, and "control" exists when any person, directly or indirectly, owns, controls, or holds the power to vote or holds proxies representing no less than 80 percent of the voting securities or governance rights of any other person;

(3) agrees to serve as an accredited capitated provider of a community network or for the purpose of reducing the network's net worth and deposit requirements under section 62N.28; and

(4) is approved by the commissioner as an accredited capitated provider for a community network in accordance with section 62N.31.

Subd. 5. **Percentage of risk ceded.** "Percentage of risk ceded" means the ratio, expressed as a percentage, between capitated payments made or, in the case of a new entity, expected to be made by a community network to all accredited capitated providers during any contract year and the total premium revenue, adjusted to eliminate expected administrative costs, received for the same time period by the community network.

Subd. 6. **Provider amount at risk.** "Provider amount at risk" means a dollar amount certified by a qualified actuary to represent the expected direct costs to an accredited capitated provider for providing the contracted, covered health care services to the enrollees of the network to which it is accredited for a period of 120 days.

History: *1994 c 625 art 1 s 8*

62N.28 NET WORTH REQUIREMENT.

Subdivision 1. **Requirement.** Except as otherwise permitted by this chapter, each community network must maintain a minimum net worth equal to the greater of:

(1) $1,000,000;

(2) two percent of the first $150,000,000 of annual premium revenue plus one percent of annual premium revenue in excess of $150,000,000;

(3) eight percent of the annual health services costs, except those paid on a capitated or managed hospital payment basis, plus four percent of the annual capitation and managed hospital payment costs; or

(4) four months uncovered health services costs.

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

(1) "capitated basis" means fixed per member per month payment or percentage of premium paid to a provider that assumes the full risk of the cost of contracted services without regard to the type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities;

(2) "managed hospital payment basis" means agreements in which the financial risk is primarily related to the degree of utilization rather than to the cost of services; and

(3) "uncovered health services costs" means the cost to the community network of health services covered by the community network for which the enrollee would also be liable in the event of the community network's insolvency, and that are not guaranteed, insured, or assumed by a person other than the community network.

Subd. 3. **Reinsurance credit.** A community network may use the subtraction for premiums paid for insurance permitted under section 62D.042, subdivision 4.

Subd. 4. **Phase-in for net worth requirement.** A community network may choose to comply with the net worth requirement on a phase-in basis according to the following schedule:

(1) 50 percent of the amount required under subdivisions 1 to 3 at the time that the community network begins enrolling enrollees;

(2) 75 percent of the amount required under subdivisions 1 to 3 at the end of the first full calendar year of operation;

(3) 87.5 percent of the amount required under subdivisions 1 to 3 at the end of the second full calendar year of operation; and

(4) 100 percent of the amount required under subdivisions 1 to 3 at the end of the third full calendar year of operation.

Subd. 5. **Net worth corridor.** A community network shall not maintain net worth that exceeds 2-1/2 times the amount required of the community network under subdivision 1. Subdivision 4 is not relevant for purposes of this subdivision.

Subd. 6. **Net worth reduction.** If a community network has contracts with accredited capitated providers, and only for so long as those contracts or successor contracts remain in force, the net worth requirement of subdivision 1 shall be reduced by the percentage of risk ceded, but in no event shall the net worth requirements be reduced by this subdivision to less than $1,000,000. The phase-in requirements of subdivision 4 shall not be affected by this reduction.

History: *1994 c 625 art 1 s 9*

62N.29 GUARANTEEING ORGANIZATION.

A community network may satisfy its net worth and deposit requirements, in whole or in part, through the use of one or more guaranteeing organizations, with the approval of the commissioner, under the conditions permitted in chapter 62D. Governmental entities, such as counties, may serve as guaranteeing organizations subject to the requirements of chapter 62D.

History: *1994 c 625 art 1 s 10*

62N.31 STANDARDS FOR ACCREDITED CAPITATED PROVIDER ACCREDITATION.

Subdivision 1. **General.** Each health care providing entity seeking initial accreditation as an accredited capitated provider shall submit to the commissioner of health sufficient information to establish that the applicant has operational capacity, facilities, personnel, and financial capability to provide the contracted covered services to the enrollees of the network for which it seeks accreditation (1) on an ongoing basis; and (2) for a period of 120 days following the insolvency of the network without receiving payment from the network. Accreditation shall continue until abandoned by the accredited capitated provider or revoked by the commissioner in accordance with subdivision 4. The applicant may establish financial capability by demonstrating that the provider amount at risk can be covered by or through any of allocated or restricted funds, a letter of credit, the taxing authority of the applicant or governmental sponsor of the applicant, an unrestricted fund balance at least two times the provider amount at risk, reinsurance, either purchased directly by the applicant or by the community network to which it will be accredited, or any other method accepted by the commissioner. Accreditation of a health care providing entity shall not in itself limit the right of the accredited capitated provider to seek payment of unpaid capitated amounts from a community network, whether the community network is solvent or insolvent; provided that, if the community network is subject to any liquidation, rehabilitation, or conservation proceedings, the accredited capitated provider shall have the status accorded creditors under section 60B.44, subdivision 10.

Subd. 2. **Annual reporting period.** Each accredited capitated provider shall submit to the commissioner annually, no later than April 15, the following information for each network to which it is accredited: the provider amount at risk for that year, the number of enrollees for the network, both for the prior year and estimated for the current year, any material change in the provider's operational or financial capacity since its last report, and any other information reasonably requested by the commissioner.

Subd. 3. **Additional reporting.** Each accredited capitated provider shall provide the commissioner with 60 days' advance written notice of termination of the accredited capitated provider relationship with a network.

Subd. 4. **Revocation of accreditation.** The commissioner may revoke the accreditation of an accredited capitated provider if the accredited capitated provider's ongoing operational or financial capabilities fail to meet the requirements of this section. The revocation shall be handled in the same fashion as placing a health maintenance organization under administrative supervision.

History: *1994 c 625 art 1 s 11*

62N.32 DEPOSIT REQUIREMENT.

A community network must satisfy the deposit requirement provided in section 62D.041. The deposit counts as an admitted asset and as part of the required net worth. The deposit requirement cannot be reduced by the alternative means that may be used to reduce the net worth requirement, other than through the use of a guaranteeing organization.

History: *1994 c 625 art 1 s 12*

62N.33 COVERAGE FOR ENROLLEES OF INSOLVENT NETWORKS.

In the event of a community network insolvency, the commissioner shall determine whether one or more community networks or health plan companies are willing and able to provide replacement coverage to all of the failed community network's enrollees, and if so, the commissioner shall facilitate the provision of the replacement coverage. If such replacement coverage is not available, the commissioner shall randomly assign enrollees of the insolvent community network to other community networks and health plan companies in the service area, in proportion to their market share, for the remaining terms of the enrollees' contracts with the insolvent network. The other community networks and health plan companies must accept the allocated enrollees under their policy or contract most similar to the enrollees' contracts with the insolvent community network. The allocation must keep groups together. Enrollees with special continuity of care needs may, in the commissioner's discretion, be given a choice of replacement coverage rather than random assignment. Individuals and groups that are assigned randomly may choose a different community network or health plan company when their contracts expire, on the same basis as any other individual or group. The replacement health plan company must comply with any guaranteed renewal or other renewal provisions of the prior coverage, including but not limited to, provisions regarding preexisting conditions and health conditions that developed during prior coverage.

History: *1994 c 625 art 1 s 13*

62N.34 INSOLVENCY FUNDING.

(a) In the event of an insolvency of a community network, all other community networks and health plan companies shall be assessed a surcharge, if necessary, to pay expenses and claims set forth in paragraph (b), based on average annual premiums on health plans as defined in section 62A.011. For purposes of this section, "average annual premiums" means annual premiums averaged over the three most recent calendar years for which information is available preceding the calendar year in which the community network became insolvent. The total of all such surcharges upon a community network or health plan company shall not, in any one calendar year, exceed two percent of the community network's or health plan company's average annual premium in this state on health plans as defined in section 62A.011.

(b) Money raised by the assessment shall be used to pay for the following, to the extent that they exceed the community network's deposit and other remaining assets:

(1) expenses in connection with the insolvency and transfer of enrollees;

(2) outstanding fee-for-service claims from nonparticipating providers, dis-

counted by 25 percent of the claim amount. Claims incurred after the implementation of the fee schedules provided under chapter 62P will be reimbursed at the fee schedule amount discounted by 25 percent. Providers may not seek to recover the unpaid portion of their claim from enrollees; and

(3) premiums to community networks and health plan companies that take enrollees of the insolvent community network, prorated to account for premiums already paid to the insolvent community network on behalf of those enrollees, to purchase coverage for time periods for which the insolvent community network can no longer provide coverage.

(c) In any year in which an assessment is made, the commissioner, in consultation with community networks and other health carriers, shall report to the legislature and governor on the continuing viability of the assessment approach and on the merits of potential alternative funding sources.

History: *1994 c 625 art 1 s 14*

62N.35 BORDER ISSUES.

To the extent feasible and appropriate, community networks that also operate under the health maintenance organization or similar prepaid health care law of another state must be licensed and regulated by this state in a manner that avoids unnecessary duplication and expense for the community network. The commissioner shall communicate with regulatory authorities in neighboring states to explore the feasibility of cooperative approaches to streamline regulation of border community networks, such as joint financial audits, and shall report to the legislature on any changes to Minnesota law that may be needed to implement appropriate collaborative approaches to regulation.

History: *1994 c 625 art 1 s 15*

62N.38 FEDERAL AGENCY PARTICIPATION.

Subdivision 1. **Participation.** An integrated service network may be organized by a department, agency, or instrumentality of the United States government.

Subd. 2. **Enrollees.** An integrated service network organized under subdivision 1 may limit its enrollment to those persons entitled to care under the federal program responsible for the integrated service network.

Subd. 3. **Participation in state programs.** An integrated service network organized under subdivision 1 may request that the commissioner of health waive the requirement of section 62N.10, subdivision 4, with regard to some or all of the programs listed in that provision. The commissioner shall grant the waiver unless the commissioner determines that the applicant does not plan to provide care to low-income persons who are otherwise eligible for enrollment in the integrated service network. The integrated service network may withdraw its waiver with respect to some or all of the programs listed in section 62N.10, subdivision 4, at any time, as long as it is willing and able to enroll in the programs previously waived on the same basis as other integrated service networks.

Subd. 4. **Solvency.** The commissioner shall consult with federal officials to develop procedures to allow integrated service networks organized under subdivision 1 to use the United States government as a guaranteeing organization.

Subd. 5. **Veterans.** In developing and implementing initiatives to expand access to health care, the commissioner shall recognize the unique problems of veterans and consider methods to reach underserved portions of the veteran population.

History: *1994 c 625 art 4 s 4*

62N.381 AMBULANCE SERVICE RATE NEGOTIATION.

Subdivision 1. **Applicability.** This section applies to all reimbursement rate negotiations between ambulance services and community integrated service networks or integrated service networks.

Subd. 2. **Range of rates.** The reimbursement rate negotiated for a contract period must not be more than 20 percent above or below the individual ambulance service's current customary charges, plus the rate of growth allowed under section 62J.04, subdivision 1. If the network and ambulance service cannot agree on a reimbursement rate, each party shall submit their rate proposal along with supportive data to the commissioner.

Subd. 3. **Development of criteria.** The commissioner, in consultation with representatives of the Minnesota Ambulance Association, regional emergency medical services programs, community integrated service networks, and integrated service networks, shall develop guidelines to use in reviewing rate proposals and making a final reimbursement rate determination.

Subd. 4. **Review of rate proposals.** The commissioner, using the guidelines developed under subdivision 3, shall review the rate proposals of the ambulance service and community integrated service network or integrated service network and shall adopt either the network's or the ambulance service's proposal. The commissioner shall require the network and ambulance service to adhere to this reimbursement rate for the contract period.

Subd. 5. **Expiration.** This section expires July 1, 1996.

History: *1994 c 625 art 4 s 5*