CHAPTER 62N

MINNESOTA INTEGRATED SERVICE NETWORK ACT

62N.02 DEFINITIONS.

[For text of subds 1 to 4a, see M.S.1994]

Subd. 4b. **Credentialing.** "Credentialing" means the process of collecting, verifying, and reviewing evidence that relates to a health care professional's qualifications to practice the health care profession as a provider within a specific integrated service network.

Subd. 4c. **Credentialing standards.** An integrated service network may set credentialing standards for providers. A network may recredential providers on a recurring basis. If a network sets credentialing standards, the network must provide a written description of those standards upon request. An integrated service network may participate in a centralized credentialing program and must provide a written description of that program upon request.

[For text of subds 5 to 12, see M.S.1994]

History: *1995 c 234 art 1 s 10,11*

62N.04 REGULATION.

Integrated service networks are under the supervision of the commissioner, who shall enforce this chapter, and the requirements of chapter 62Q as they apply to these networks. The commissioner has, with respect to this chapter and chapter 62Q, all enforcement and rulemaking powers available to the commissioner under section 62D.17.

History: *1995 c 234 art 1 s 12*

62N.05 RULES GOVERNING INTEGRATED SERVICE NETWORKS.

[For text of subd 1, see M.S.1994]

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 62J.041, 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;

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(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.

[For text of subd 3, see M.S.1994]

Subd. 4. **Recovery of costs.** The provisions of section 16A.1285, subdivision 2, limiting recovery of costs to the two fiscal years immediately preceding the setting, adjustment, or authorization of fees do not apply to fees charged to entities licensed under this chapter. This subdivision expires June 30, 1999.

History: *1995 c 233 art 2 s 38; 1995 c 234 art 3 s 9*

62N.071 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 62N.071 to 62N.078. Unless otherwise specified, terms used in those sections have the meanings required to be used in preparation of the National Association of Insurance Commissioners (NAIC) annual statement blanks for health maintenance organizations.

Subd. 2. **Admitted assets.** "Admitted assets" means admitted assets as defined under section 62D.044, including the deposit required under section 62N.073.

Subd. 3. **Net worth.** "Net worth" means admitted assets minus liabilities.

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Subd. 4. **Liabilities.** "Liabilities" means a network's debts and other obligations, including estimates of the network's reported and unreported claims incurred for covered services and supplies provided to enrollees. Liabilities do not include those obligations that are subordinated in the same manner as preferred ownership claims under section 60B.44, subdivision 10, including promissory notes subordinated to all other liabilities of the integrated service network.

Subd. 5. **Uncovered expenditures.** "Uncovered expenditures" means the charges for health care services and supplies that are covered by an integrated service network for which an enrollee would also be liable if the network becomes insolvent. Uncovered expenditures includes charges for covered health care services and supplies received by enrollees from providers that are not employed by, under contract with, or otherwise affiliated with the network. Uncovered expenditures does not include amounts that enrollees would not have to pay due to the obligations being guaranteed, insured, or assumed by a person other than the network.

Subd. 6. **Working capital.** "Working capital" means current assets minus current liabilities.

History: *1995 c 234 art 1 s 13*

62N.072 NET WORTH REQUIREMENT.

Subdivision 1. **Initial requirement.** An integrated service network must, at time of licensure, have a minimum net worth of the greater of:

(1) $1,500,000; or

(2) 8–1/3 percent of the sum of all expenses expected to be incurred in the first full year of operation, less 90 percent of the expected reinsurance premiums for that period.

Subd. 2. **Ongoing requirement.** After a network's initial year of operation, the network must maintain net worth of no less than $1,000,000 or 8–1/3 percent of the previous years' expenditures, whichever is greater.

History: *1995 c 234 art 1 s 14*

62N.073 DEPOSIT REQUIREMENT.

Subdivision 1. **Initial deposit.** An integrated service network shall deposit, at time of licensure, a deposit consisting of cash and direct United States Treasury obligations in the total amount of not less than $300,000.

Subd. 2. **Custodial account.** The deposit must be held in a custodial or other controlled account under a written account agreement acceptable to the commissioner.

Subd. 3. **Ongoing deposit.** After the initial year of operation, the required amount of the deposit is the greater of

(1) $300,000; or

(2) 33–1/3 percent of the network's uncovered expenditures incurred in the previous calendar year.

Subd. 4. **Use of deposit.** (a) In the event of any delinquency proceeding as defined in section 60B.03, the required minimum deposit shall be applied first to pay for or reimburse the commissioner for expenses incurred by the commissioner in performing the commissioner's duties in connection with the insolvency, including any legal, actuarial or accounting fees. The balance of the required minimum deposit, if any, shall be used to reimburse enrollees for uncovered expenditures, on a pro rata basis.

(b) If a deposit exceeds the required minimum deposit, the excess shall be applied first to uncovered expenditures and the balance, if any, to the commissioner's expenses.

(c) The deposit is not subject to garnishment or levy under any circumstances.

Subd. 5. **Actual deposit required.** The deposit must be in the form specified in subdivision 1; a guarantee or letter of credit are not acceptable, in whole or in part, as substitutes.

History: *1995 c 234 art 1 s 15*

62N.074 WORKING CAPITAL.

Subdivision 1. **Requirement.** An integrated service network must maintain a positive working capital at all times.

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Subd. 2. **Notice required.** If an integrated service network's working capital is no longer positive, or is likely to soon become no longer positive, the network shall immediately notify the commissioner.

Subd. 3. **Plan of correction.** If at any time an integrated service network's net worth, working capital, investments, deposits, or guarantees do not conform with the provisions of this chapter, the network shall promptly submit to the commissioner a written proposed plan of correction. The commissioner shall promptly approve, approve as modified, or reject the proposed plan. If a plan of correction has been approved by the commissioner, the network shall comply with it and shall cooperate fully with any activities the commissioner undertakes to monitor the network's compliance.

Subd. 4. **Action by commissioner.** The commissioner may take any action permitted to the commissioner that the commissioner deems necessary or appropriate to protect the network or its enrollees if:

(1) the network fails to propose an approved plan of correction promptly;

(2) the network fails to comply with an approved plan of correction; or

(3) the commissioner determines that a deficiency in working capital cannot be corrected within a reasonable time.

Subd. 5. **Other remedies.** This section does not limit the commissioner's power to use at any time other remedies available to the commissioner.

History: *1995 c 234 art 1 s 16*

62N.076 INVESTMENT RESTRICTIONS.

Subdivision 1. **Investment policy.** An integrated service network shall have a written investment policy to govern investment of the network's assets. The written policy must be reviewed and approved annually by the network's board of directors.

Subd. 2. **Approval; investments.** A network shall not make loans or investments, unless authorized by its board of directors, or ratified by the board no later than the next regular board meeting.

Subd. 3. **Permitted investment.** An integrated service network shall make investments only in securities or property designated by law as permitted for domestic life insurance companies; this restriction includes compliance with percentage limitations that apply to domestic life insurance companies. A network may, however, invest in real estate, including leasehold improvements, for the convenience and accommodation of its operations, including the home office, branch offices, medical facilities, and field operations, in excess of the percentage permitted for a domestic life insurance company, but not to exceed 25 percent of its total admitted assets.

Subd. 4. **Conflicts of interest.** An integrated service network shall not make loans to any of its directors or principal officers or make loans to or investments in any organization in which a director or principal officer has an interest.

Subd. 5. **Proof of compliance.** An integrated service network shall annually file with the commissioner proof of compliance with this section in a form and on a date prescribed by the commissioner.

History: *1995 c 234 art 1 s 17*

62N.077 USE OF GUARANTEES.

Subdivision 1. **Guarantee permitted.** An integrated service network may, with the consent of the commissioner, satisfy up to 50 percent of its minimum net worth requirement by means of a guarantee provided by another organization.

Subd. 2. **Security for guarantee.** (a) If the guaranteeing organization is regulated for solvency by the commissioner of commerce or health, the guarantee must be treated as a liability for purposes of solvency regulation of the guaranteeing organization. If the guaranteeing organization becomes insolvent, a claim by the network on the guarantee must be at least of equal priority with claims of enrollees or other policy holders of the insolvent guaranteeing organization.

(b) If the guaranteeing organization is not regulated for solvency by the commissioner of commerce or health, the organization must maintain assets, except if, when calculated in

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combination with the assets described in section 62D.044, clause (17), the total of those assets and the real estate assets described in this subdivision do not exceed the total combined percent limitations allowable under this section and section 62D.044, clause (17), or except if permitted by the commissioner upon a finding that the percentage of the integrated service network's admitted assets is insufficient to provide convenient accommodation of the network's business acceptable to the commissioner, with a market value at least equal to the amount of the guarantee, in a custodial or other controlled account on terms acceptable to the commissioner of health.

Subd. 3. **Governmental entities.** When a guaranteeing organization is a governmental entity, sections 62N.073 and 62N.076 do not apply. The commissioner may consider factors which provide evidence that the governmental entity is a financially reliable guaranteeing organization.

History: *1995 c 234 art 1 s 18*

62N.078 FINANCIAL REPORTING AND EXAMINATION.

Subdivision 1. **Financial statements.** An integrated service network shall file with the commissioner, annually on April 1, an audited financial statement. The financial statement must include the National Association of Insurance Commissioners (NAIC) annual statement blanks for health maintenance organizations, prepared in accordance with the NAIC annual statement instructions, and using the methods prescribed in the NAIC's accounting practices and procedures manual for health maintenance organizations. The financial statement must also include any other form or information prescribed by the commissioner.

Subd. 2. **Quarterly statements.** An integrated service network shall file with the commissioner quarterly financial statements for the first three quarters of each year, on a date and form and in a manner prescribed by the commissioner.

Subd. 3. **Other information.** An integrated service network shall comply promptly and fully with requests by the commissioner for other information that the commissioner deems necessary to monitor or assess the network's financial solvency.

Subd. 4. **Financial examination.** The commissioner shall conduct a complete financial examination of each integrated service network at least once every three years, and more frequently if the commissioner deems it necessary. The examinations must be conducted according to the standards provided in the NAIC examiners handbook.

History: *1995 c 234 art 1 s 19*

62N.10 LICENSING.

[For text of subds 1 to 6, see M.S.1994]

Subd. 7. **Data submission.** As a condition of licensure, an integrated service network shall comply fully with section 62J.38.

History: *1995 c 234 art 1 s 20*

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. The evidence of coverage must contain a description of provider locations, a list of the types of providers available, and information about the types of allied and midlevel practitioners and pharmacists that are available.

[For text of subd 2, see M.S.1994]

History: *1995 c 234 art 1 s 21*

62N.13 ENROLLEE COMPLAINT SYSTEM.

Every integrated service network must establish and maintain an enrollee complaint system, as required under section 62Q.105, to provide reasonable procedures for the resolu-

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tion of written complaints initiated by enrollees concerning the provision of health care services. The integrated service network must inform enrollees that they may choose to use an alternative dispute resolution process. If an enrollee chooses to use an alternative dispute resolution process, the network must participate. The commissioner shall adopt rules specifying requirements relating to enrollee complaints.

History: *1995 c 234 art 1 s 22*

62N.14 OFFICE OF CONSUMER SERVICES.

[For text of subds 1 and 2, see M.S.1994]

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 address, telephone number, and a brief description of the information clearinghouse; and

(3) the telephone number of the department of health.

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

[For text of subd 4, see M.S.1994]

History: *1995 c 234 art 1 s 23*

62N.15 PROVIDER REQUIREMENTS.

Subdivision 1. **Services.** An integrated service network may operate as a staff model as defined in section 295.50, subdivision 12b, or may contract with providers or provider organizations for the provision of services.

Subd. 2. **Location.** (a) An integrated service network must ensure that primary care providers, including allied independent health providers as defined in section 62Q.095, subdivision 5, midlevel practitioners as defined in section 136A.1356, subdivision 1, are located at adequate locations within the service area of the network. In determining whether locations are adequate, the integrated service network may consider the practice and referral patterns in each community served throughout the service area.

(b) Urgent and emergency care providers must be located within a distance of 30 miles or a travel time of 30 minutes from every enrollee.

Subd. 3. **Numbers.** An integrated service network must provide a sufficient number of providers to meet the projected needs of its enrollees, including special needs and high–risk enrollees, for all covered health care services.

Subd. 4. **Types.** An integrated service network must determine what types of providers are needed to deliver all appropriate and necessary health services to its enrollees. In determining which types of providers are necessary, networks shall use allied and midlevel practitioners and pharmacists within their respective scopes of practice.

Subd. 5. **Capacity.** An integrated service network shall monitor the capacity of the network to provide services to enrollees and take steps to increase capacity when parts of the network are not able to meet enrollee needs.

Subd. 6. **Access.** (a) An integrated service network shall make available and accessible all covered health care services on a 24–hour per day, seven days per week basis. This requirement may be fulfilled through the use of:

(1) regularly scheduled appointments;

(2) after–hour clinics;

(3) use of a 24–hour answering service;

(4) backup coverage by another participating physician; or

(5) referrals to urgent care centers and to hospital emergency care.

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(b) An integrated service network shall arrange for covered health care services, including referrals to specialty physicians, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines. An integrated service network shall have appointment scheduling guidelines based on the type of health care service.

(c) Nothing in Laws 1995, chapter 234, shall be construed to require the creation or maintenance of abortion clinics or other abortion providers within any integrated service network; nor shall anything in Laws 1995, chapter 234, be construed to authorize any agency to require the creation or maintenance of abortion clinics or abortion providers or to deny certification or any other benefit granted by Laws 1995, chapter 234, to a health plan company based on the number of or the presence or absence of abortion clinics or other abortion providers in or affiliated with the health plan company.

Subd. 7. **Continuity.** (a) An integrated service network shall provide continuing care for enrollees in the event of contract termination between the integrated service network and any of its contracted providers or in the event of site closings involving a provider with more than one location of service.

(b) An integrated service network shall provide to its enrollees a written disclosure of the process by which continuity of care will be provided to all enrollees.

Subd. 8. **Review.** The commissioner shall review each network's compliance with subdivisions 1 to 7. If the commissioner determines that a network is not meeting the requirements of this section, the commissioner may order the network to submit a plan of corrective action, and may order the network to comply with the provisions of that plan, as amended by the commissioner.

History: *1995 c 234 art 1 s 24*

62N.17 OUT-OF-NETWORK SERVICES.

(a) An integrated service network shall provide coverage for all emergency services provided outside the network, when the care is immediately necessary or believed to be necessary to preserve life, prevent impairment of bodily functions, or to prevent placing the physical or mental health of the enrollee in jeopardy.

(b) An integrated service network shall include in its marketing materials a description of all limitations of coverage for out-of-network services, including when enrollees reside or travel outside the network's service area.

History: *1995 c 234 art 1 s 25*

62N.18 QUALITY IMPROVEMENT.

Subdivision 1. **Internal measures.** Every integrated service network shall establish and maintain an internal quality improvement process. A network shall disclose these processes to enrollees, and to the commissioner upon request.

Subd. 2. **Enrollee surveys.** (a) Every integrated service network shall, on at least a biennial basis, survey enrollee satisfaction with network performance and quality of care, and shall make survey results available to enrollees and potential enrollees. Integrated service networks shall also submit survey results to the information clearinghouse.

(b) Every integrated service network shall participate in the consumer survey efforts established under section 62J.451, subdivision 6b, to evaluate enrollee satisfaction, network performance, and quality of care. Participation in the consumer survey efforts of section 62J.451, subdivision 6b, shall satisfy paragraph (a) of this subdivision.

Subd. 3. **Quality improvement workplans.** (a) An integrated service network shall submit annual quality improvement workplans to the commissioner. A workplan must:

(1) identify the four most common enrollee complaints related to service delivery and the four most common enrollee complaints related to administration;

(2) identify the specific measures that the network plans to take to address each of these complaint areas;

(3) provide an assessment of how these complaints affect health care outcomes; and

(4) identify the mechanisms that the network will use to communicate and implement the changes needed to address each of these complaints identified in clause (1).

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(b) An integrated service network shall disclose in marketing materials the complaints identified in paragraph (a), and measures that will be taken by the network to address these complaints.

History: *1995 c 234 art 1 s 26*

62N.25 COMMUNITY INTEGRATED SERVICE NETWORKS.

[For text of subd 1, see M.S.1994]

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. A community integrated service network that phases in its net worth over a three–year period is not required to respond to requests for proposals under section 256B.0644 during the first 12 months of licensure. These community networks are not prohibited from responding to requests for proposals, however, if they choose to do so during that time period. After the initial 12 months of licensure, these community networks are required to respond to the requests for proposals as required under section 256B.0644.

[For text of subds 3 to 9, see M.S.1994]

History: *1995 c 234 art 1 s 27*

62N.34 [Repealed, 1995 c 234 art 1 s 29]

62N.381 AMBULANCE SERVICE RATE NEGOTIATION.

[For text of subd 1, see M.S.1994]

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 emergency medical services regulatory board.

Subd. 3. **Development of criteria.** The emergency medical services regulatory board, 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 emergency medical services regulatory board, 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 board shall require the network and ambulance service to adhere to this reimbursement rate for the contract period.

[For text of subd 5, see M.S.1994]

History: *1995 c 207 art 9 s 1–3*

NOTE: The amendments to subdivisions 2, 3, and 4 by Laws 1995, chapter 207, article 9, sections 1 to 3, are effective July 1, 1996. See Laws 1995, chapter 207, article 9, section 62, subdivision 1.

62N.40 CHEMICAL DEPENDENCY SERVICES.

Each community integrated service network and integrated service network regulated under this chapter must ensure that chemically dependent individuals have access to cost–effective treatment options that address the specific needs of individuals. These include, but are not limited to, the need for: treatment that takes into account severity of illness and com-

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orbidities; provision of a continuum of care, including treatment and rehabilitation programs licensed under Minnesota Rules, parts 9530.4100 to 9530.4410 and 9530.5000 to 9530.6500; the safety of the individual's domestic and community environment; gender appropriate and culturally appropriate programs; and access to appropriate social services.

History: *1995 c 234 art 1 s 28*

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