CHAPTER 62Q

REQUIREMENTS FOR HEALTH PLAN COMPANIES

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62Q.01 DEFINITIONS.

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

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health for purposes of regulating health maintenance organizations, community integrated service networks, and integrated service networks, or the commissioner of commerce for purposes of regulating all other health plan companies. For all other purposes, "commissioner" means the commissioner of health.

Subd. 2a. **Enrollee.** "Enrollee" means a natural person covered by a health plan and includes an insured, policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Subd. 3. **Health plan.** "Health plan" means a health plan as defined in section 62A.011; a policy, contract, or certificate issued by a community integrated service network; or an integrated service network.

Subd. 4. **Health plan company.** "Health plan company" means:

(1) a health carrier as defined under section 62A.011, subdivision 2;

(2) an integrated service network as defined under section 62N.02, subdivision 8; or

(3) a community integrated service network as defined under section 62N.02, subdivision 4a.

Subd. 5. **Managed care organization.** "Managed care organization" means: (1) a health maintenance organization operating under chapter 62D; (2) a community integrated service network as defined under section 62N.02, subdivision 4a; (3) an integrated service network as defined under section 62N.02, subdivision 8; or (4) an insurance company licensed under chapter 60A, nonprofit health service plan corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

Subd. 6. **Medicare-related coverage.** "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts) or 1876 (known

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as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

History: *1994 c 625 art 2 s 14; 1995 c 234 art 2 s 2–6; art 3 s 5*

62Q.02 APPLICABILITY OF CHAPTER.

(a) This chapter applies only to health plans, as defined in section 62Q.01, and not to other types of insurance issued or renewed by health plan companies, unless otherwise specified.

(b) This chapter applies to a health plan company only with respect to health plans, as defined in section 62Q.01, issued or renewed by the health plan company, unless otherwise specified.

(c) If a health plan company issues or renews health plans in other states, this chapter applies only to health plans issued or renewed in this state for Minnesota residents, or to cover a resident of the state, unless otherwise specified.

History: *1995 c 234 art 2 s 7*

62Q.03 PROCESS FOR DEFINING, DEVELOPING, AND IMPLEMENTING A RISK ADJUSTMENT SYSTEM.

Subdivision 1. **Purpose.** The purpose of risk adjustment is to reduce the effects of risk selection on health insurance premiums by making monetary transfers from health plan companies that insure lower risk populations to health plan companies that insure higher risk populations. Risk adjustment is needed to: achieve a more equitable, efficient system of health care financing; remove current disincentives in the health care system to insure and provide adequate access for high risk and special needs populations; promote fair competition among health plan companies on the basis of their ability to efficiently and effectively provide services rather than on the risk status of those in a given insurance pool; and help maintain the viability of health plan companies, by protecting them from the financial effects of enrolling a disproportionate number of high risk individuals. It is the commitment of the state to develop and implement a risk adjustment system. The risk adjustment system shall:

(1) possess a reasonable level of accuracy and administrative feasibility, be adaptable to changes as methods improve, incorporate safeguards against fraud and manipulation, and shall neither reward inefficiency nor penalize for verifiable improvements in health status;

(2) require participation by all health plan companies providing coverage in the individual, small group, and Medicare supplement markets;

(3) address unequal distribution of risk between health plan companies, but shall not address the financing of public programs or subsidies for low–income people; and

(4) be developed and implemented by the risk adjustment association with joint oversight by the commissioners of health and commerce.

Subd. 2. [Repealed, 1995 c 234 art 2 s 36]

Subd. 3. [Repealed, 1995 c 234 art 2 s 36]

Subd. 4. [Repealed, 1995 c 234 art 2 s 36]

Subd. 5. [Repealed, 1995 c 234 art 2 s 36]

Subd. 5a. **Public programs.** (a) A separate risk adjustment system must be developed for state–run public programs, including medical assistance, general assistance medical care, and MinnesotaCare. The system must be developed in accordance with the general risk adjustment methodologies described in this section, must include factors in addition to age and sex adjustment, and may include additional demographic factors, different targeted conditions, and/or different payment amounts for conditions. The risk adjustment system for public programs must attempt to reflect the special needs related to poverty, cultural, or language barriers and other needs of the public program population.

(b) The commissioners of health and human services shall jointly convene a public programs risk adjustment work group responsible for advising the commissioners in the design of the public programs risk adjustment system. The commissioner of health shall work with the risk adjustment association to ensure coordination between the risk adjustment systems

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for the public and private sectors. The commissioner of human services shall seek any needed federal approvals necessary for the inclusion of the medical assistance program in the public programs risk adjustment system.

(c) The public programs risk adjustment work group must be representative of the persons served by publicly paid health programs and providers and health plans that meet their needs. To the greatest extent possible, the appointing authorities shall attempt to select representatives that have historically served a significant number of persons in publicly paid health programs or the uninsured. Membership of the work group shall be as follows:

(1) one provider member appointed by the Minnesota Medical Association;

(2) two provider members appointed by the Minnesota Hospital Association, at least one of whom must represent a major disproportionate share hospital;

(3) five members appointed by the Minnesota Council of HMOs, one of whom must represent an HMO with fewer than 50,000 enrollees located outside the metropolitan area and one of whom must represent an HMO with at least 50 percent of total membership enrolled through a public program;

(4) two representatives of counties appointed by the Association of Minnesota Counties;

(5) three representatives of organizations representing the interests of families, children, childless adults, and elderly persons served by the various publicly paid health programs appointed by the governor;

(6) two representatives of persons with mental health, developmental or physical disabilities, chemical dependency, or chronic illness appointed by the governor; and

(7) three public members appointed by the governor, at least one of whom must represent a community health board. The risk adjustment association may appoint a representative, if a representative is not otherwise appointed by an appointing authority.

(d) The commissioners of health and human services, with the advice of the public programs risk adjustment work group, shall develop a work plan and time frame and shall coordinate their efforts with the private sector risk adjustment association's activities and other state initiatives related to public program managed care reimbursement. The commissioners of health and human services shall report to the health care commission and to the appropriate legislative committees on January 15, 1996, and on January 15, 1997, on any policy or legislative changes necessary to implement the public program risk adjustment system.

Subd. 5b. **Medicare supplement market.** A risk adjustment system may be developed for the Medicare supplement market. The Medicare supplement risk adjustment system may include a demographic component and may, but is not required to, include a condition-specific risk adjustment component.

Subd. 6. **Creation of risk adjustment association.** The Minnesota risk adjustment association is created on July 1, 1994, and may operate as a nonprofit unincorporated association, but is authorized to incorporate under chapter 317A.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association may operate under the approved plan of operation and shall be governed in accordance with this chapter and may operate in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation meets the requirements of filing articles of incorporation.

The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 14, 60A, 62A, and 62P. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. The board of directors and health carriers who are members of the association are exempt from sections 325D.49 to 325D.66 in the performance of their duties as directors and members of the association. The risk adjustment association is subject to the open meeting law.

Subd. 7. **Purpose of association.** The association is established to develop and implement a private sector risk adjustment system.

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Subject to state oversight set forth in subdivision 10, the association shall:

(1) develop and implement comprehensive risk adjustment systems for individual, small group, and Medicare supplement markets consistent with the provisions of this chapter;

(2) submit a plan for the development of the risk adjustment system which identifies appropriate implementation dates consistent with the rating and underwriting restrictions of each market, recommends whether transfers attributable to risk adjustment should be required between the individual and small group markets, and makes other appropriate recommendations to the commissioners of health and commerce by November 5, 1995;

(3) develop a combination of a demographic risk adjustment system and payments for targeted conditions;

(4) test an ambulatory care groups (ACGs) and diagnostic cost groups (DCGs) system, and recommend whether such a methodology should be adopted;

(5) fund the development and testing of the risk adjustment system;

(6) recommend market conduct guidelines; and

(7) develop a plan for assessing members for the costs of administering the risk adjustment system.

Subd. 8. **Governance.** The association shall be governed according to the plan of operation as established in subdivision 8a.

Subd. 8a. **Plan of operation.** The board shall submit a proposed plan of operation by August 15, 1995, to the commissioners of health and commerce for review. The commissioners of health and commerce shall have the authority to approve or reject the plan of operation.

Amendments to the plan of operation may be made by the commissioners or by the directors of the association, subject to the approval of the commissioners.

Subd. 9. **Data collection and data privacy.** The association members shall not have access to unaggregated data on individuals or health plan companies. The association shall develop, as a part of the plan of operation, procedures for ensuring that data is collected by an appropriate entity. The commissioners of health and commerce shall have the authority to audit and examine data collected by the association for the purposes of the development and implementation of the risk adjustment system. Data on individuals obtained for the purposes of risk adjustment development, testing, and operation are designated as private data. Data not on individuals which is obtained for the purposes of development, testing, and operation of risk adjustment are designated as nonpublic data, except that the proposed and approved plan of operation, the risk adjustment methodologies examined, the plan for testing, the plan of the risk adjustment system, minutes of meetings, and other general operating information are classified as public data. Nothing in this section is intended to prohibit the preparation of summary data under section 13.05, subdivision 7. The association, state agencies, and any contractors having access to this data shall maintain it in accordance with this classification. The commissioners of health and human services have the authority to collect data from health plan companies as needed for the purpose of developing a risk adjustment mechanism for public programs.

Subd. 10. **State oversight of risk adjustment activities.** The association's activities shall be supervised by the commissioners of health and commerce. The commissioners shall provide specific oversight functions during the development and implementation phases of the risk adjustment system as follows:

(1) the commissioners shall approve or reject the association's plan for testing risk adjustment methods, the methods to be used, and any changes to those methods;

(2) the commissioners must have the right to attend and participate in all meetings of the association and its work groups or committees, except for meetings involving privileged communication between the association and its counsel as permitted under section 471.705, subdivision 1d, paragraph (e);

(3) the commissioners shall approve any consultants or administrators used by the association;

(4) the commissioners shall approve or reject the association's plan of operation; and

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(5) the commissioners shall approve or reject the plan for the risk adjustment system described in subdivision 7, clause (2).

If the commissioners reject any of the plans identified in clauses (1), (4), and (5), the directors shall submit for review an appropriate revised plan within 30 days.

Subd. 11. [Repealed, 1995 c 234 art 2 s 36]

Subd. 12. **Participation by all health plan companies.** Upon its implementation, all health plan companies, as a condition of licensure, must participate in the risk adjustment system to be implemented under this section.

History: *1994 c 625 art 2 s 15; 1995 c 234 art 2 s 8–17; 1996 c 440 art 1 s 33; 1996 c 451 art 4 s 2*

62Q.07 ACTION PLANS.

Subdivision 1. **Action plans required.** (a) To increase public awareness and accountability of health plan companies, all health plan companies that issue or renew a health plan, as defined in section 62Q.01, must annually file with the applicable commissioner an action plan that satisfies the requirements of this section beginning July 1, 1994, as a condition of doing business in Minnesota. For purposes of this subdivision, "health plan" includes the coverages described in section 62A.011, subdivision 3, clause (10). Each health plan company must also file its action plan with the information clearinghouse. Action plans are required solely to provide information to consumers, purchasers, and the larger community as a first step toward greater accountability of health plan companies. The sole function of the commissioner in relation to the action plans is to ensure that each health plan company files a complete action plan, that the action plan is truthful and not misleading, and that the action plan is reviewed by appropriate community agencies.

(b) If a commissioner responsible for regulating a health plan company required to file an action plan under this section has reason to believe an action plan is false or misleading, the commissioner may conduct an investigation to determine whether the action plan is truthful and not misleading, and may require the health plan company to submit any information that the commissioner reasonably deems necessary to complete the investigation. If the commissioner determines that an action plan is false or misleading, the commissioner may require the health plan company to file an amended plan or may take any action authorized under chapter 72A.

Subd. 2. **Contents of action plans.** (a) An action plan must include a detailed description of all of the health plan company's methods and procedures, standards, qualifications, criteria, and credentialing requirements for designating the providers who are eligible to participate in the health plan company's provider network, including any limitations on the numbers of providers to be included in the network. This description must be updated by the health plan company and filed with the applicable agency on a quarterly basis.

(b) An action plan must include the number of full–time equivalent physicians, by specialty, nonphysician providers, and allied health providers used to provide services. The action plan must also describe how the health plan company intends to encourage the use of nonphysician providers, midlevel practitioners, and allied health professionals, through at least consumer education, physician education, and referral and advisement systems. The annual action plan must also include data that is broken down by type of provider, reflecting actual utilization of midlevel practitioners and allied professionals by enrollees of the health plan company during the previous year. Until July 1, 1995, a health plan company may use estimates if actual data is not available. For purposes of this paragraph, "provider" has the meaning given in section 62J.03, subdivision 8.

(c) An action plan must include a description of the health plan company's policy on determining the number and the type of providers that are necessary to deliver cost–effective health care to its enrollees. The action plan must also include the health plan company's strategy, including provider recruitment and retention activities, for ensuring that sufficient providers are available to its enrollees.

(d) An action plan must include a description of actions taken or planned by the health plan company to ensure that information from report cards, outcome studies, and complaints is used internally to improve quality of the services provided by the health plan company.

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(e) An action plan must include a detailed description of the health plan company's policies and procedures for enrolling and serving high risk and special needs populations. This description must also include the barriers that are present for the high risk and special needs population and how the health plan company is addressing these barriers in order to provide greater access to these populations. "High risk and special needs populations" includes, but is not limited to, recipients of medical assistance, general assistance medical care, and MinnesotaCare; persons with chronic conditions or disabilities; individuals within certain racial, cultural, and ethnic communities; individuals and families with low income; adolescents; the elderly; individuals with limited or no English language proficiency; persons with high-cost preexisting conditions; homeless persons; chemically dependent persons; persons with serious and persistent mental illness; children with severe emotional disturbance; and persons who are at high risk of requiring treatment. For purposes of this paragraph, "provider" has the meaning given in section 62J.03, subdivision 8.

(f) An action plan must include a general description of any action the health plan company has taken and those it intends to take to offer health coverage options to rural communities and other communities not currently served by the health plan company.

(g) A health plan company other than a large managed care plan company may satisfy any of the requirements of the action plan in paragraphs (a) to (f) by stating that it has no policies, procedures, practices, or requirements, either written or unwritten, or formal or informal, and has undertaken no activities or plans on the issues required to be addressed in the action plan, provided that the statement is truthful and not misleading. For purposes of this paragraph, "large managed care plan company" means a health maintenance organization, integrated service network, or other health plan company that employs or contracts with health care providers, that has more than 50,000 enrollees in this state. If a health plan company employs or contracts with providers for some of its health plans and does not do so for other health plans that it offers, the health plan company is a large managed care plan company if it has more than 50,000 enrollees in this state in health plans for which it does employ or contract with providers.

History: *1994 c 625 art 2 s 16; 1995 c 234 art 2 s 18,19*

62Q.075 LOCAL PUBLIC ACCOUNTABILITY AND COLLABORATION PLAN.

Subdivision 1. **Definition.** For purposes of this section, "managed care organization" means a health maintenance organization, community integrated service network, or integrated service network.

Subd. 2. **Requirement.** Beginning October 31, 1997, all managed care organizations shall file biennially with the action plans required under section 62Q.07 a plan describing the actions the managed care organization has taken and those it intends to take to contribute to achieving public health goals for each service area in which an enrollee of the managed care organization resides. This plan must be jointly developed in collaboration with the local public health units, appropriate regional coordinating boards, and other community organizations providing health services within the same service area as the managed care organization. Local government units with responsibilities and authority defined under chapters 145A and 256E may designate individuals to participate in the collaborative planning with the managed care organization to provide expertise and represent community needs and goals as identified under chapters 145A and 256E.

Subd. 3. **Contents.** The plan must address the following:

(a) specific measurement strategies and a description of any activities which contribute to public health goals and needs of high risk and special needs populations as defined and developed under chapters 145A and 256E;

(b) description of the process by which the managed care organization will coordinate its activities with the community health boards, regional coordinating boards, and other relevant community organizations servicing the same area;

(c) documentation indicating that local public health units and local government unit designees were involved in the development of the plan;

(d) documentation of compliance with the plan filed the previous year, including data on the previously identified progress measures.

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Subd. 4. **Review.** Upon receipt of the plan, the appropriate commissioner shall provide a copy to the regional coordinating boards, local community health boards, and other relevant community organizations within the managed care organization's service area. After reviewing the plan, these community groups may submit written comments on the plan to either the commissioner of health or commerce, as applicable, and may advise the commissioner of the managed care organization's effectiveness in assisting to achieve regional public health goals. The plan may be reviewed by the county boards, or city councils acting as a local board of health in accordance with chapter 145A, within the managed care organization's service area to determine whether the plan is consistent with the goals and objectives of the plans required under chapters 145A and 256E and whether the plan meets the needs of the community. The county board, or applicable city council, may also review and make recommendations on the availability and accessibility of services provided by the managed care organization. The county board, or applicable city council, may submit written comments to the appropriate commissioner, and may advise the commissioner of the managed care organization's effectiveness in assisting to meet the needs and goals as defined under the responsibilities of chapters 145A and 256E. The commissioner of health shall develop recommendations to utilize the written comments submitted as part of the licensure process to ensure local public accountability. These recommendations shall be reported to the legislative commission on health care access by January 15, 1996. Copies of these written comments must be provided to the managed care organization. The plan and any comments submitted must be filed with the information clearinghouse to be distributed to the public.

History: *1994 c 625 art 7 s 1; 1995 c 234 art 8 s 17; 1996 c 451 art 4 s 3*

62Q.09 [EXPIRED]

62Q.095 EXPANDED PROVIDER NETWORKS.

Subdivision 1. **Provider acceptance required.** Each health plan company, with the exception of any health plan company with 50,000 or fewer enrollees and health plan companies that are exempt under subdivision 6, shall establish an expanded network of allied independent health providers, in addition to a preferred network. A health plan company shall accept as a provider in the expanded network any allied independent health provider who: (1) meets the health plan company's credentialing standards; (2) agrees to the terms of the health plan company's provider contract; and (3) agrees to comply with all managed care protocols of the health plan company. A preferred network shall be considered an expanded network if all allied independent health providers who meet the requirements of clauses (1), (2), and (3) are accepted into the preferred network. A community integrated service network may offer to its enrollees an expanded network of allied independent health providers as described under this section.

Subd. 2. **Managed care.** The managed care protocols used by the health plan company may include: (1) a requirement that an enrollee obtain a referral from the health plan company before obtaining services from an allied independent health provider in the expanded network; (2) limits on the number and length of visits to allied independent health providers in the expanded network allowed by each referral, as long as the number and length of visits allowed is not less than the number and length allowed for comparable referrals to allied independent health providers in the preferred network; and (3) ongoing management and review by the health plan company of the care provided by an allied independent health provider in the expanded network after a referral is made.

Subd. 3. **Mandatory offering to enrollees.** Each health plan company shall offer to enrollees the option of receiving covered services through the expanded network of allied independent health providers established under subdivisions 1 and 2. This expanded network option may be offered as a separate health plan. The network may establish separate premium rates and cost–sharing requirements for this expanded network plan, as long as these premium rates and cost–sharing requirements are actuarially justified and approved by the commissioner. This subdivision does not apply to Medicare, medical assistance, general assistance medical care, and MinnesotaCare. This subdivision is effective January 1, 1995, and applies to health plans issued or renewed, or offers of health plans to be issued or renewed, on or after January 1, 1995, except that this subdivision is effective January 1, 1996, for collec-

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tive bargaining agreements of the department of employee relations and the University of Minnesota.

Subd. 4. **Provider reimbursement.** A health plan company shall pay each allied independent health provider in the expanded network the same rate per unit of service as paid to allied independent health providers in the preferred network.

Subd. 5. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Allied independent health provider" means an independently enrolled audiologist, chiropractor, dietitian, home health care provider, licensed marriage and family therapist, nurse practitioner or advanced practice nurse, occupational therapist, optometrist, optician, outpatient chemical dependency counselor, pharmacist who is not employed by and based on the premises of a health plan company, physical therapist, podiatrist, licensed psychologist, psychological practitioner, licensed social worker, or speech therapist.

(c) "Home health care provider" means a provider of personal care assistance, home health aide, homemaker, respite care, adult day care, or home therapies and home health nursing services.

(d) "Independently enrolled" means that a provider can bill, and receive direct payment for services from, a third–party payer or patient.

Subd. 6. **Exemption.** A health plan company, to the extent that it operates as a staff model health plan company as defined in section 295.50, subdivision 12b, by employing allied independent health care providers to deliver health care services to enrollees, is exempt from this section.

History: *1994 c 625 art 1 s 6,18*

62Q.10 NONDISCRIMINATION.

If a health plan company, with the exception of a community integrated service network or an indemnity insurer licensed under chapter 60A who does not offer a product through a preferred provider network, offers coverage of a health care service as part of its plan, it may not deny provider network status to a qualified health care provider type who meets the credentialing requirements of the health plan company solely because the provider is an allied independent health care provider as defined in section 62Q.095.

History: *1994 c 625 art 1 s 18; art 2 s 18*

62Q.105 HEALTH PLAN COMPANY COMPLAINT PROCEDURE.

Subdivision 1. **Establishment.** Each health plan company shall establish and make available to enrollees, by July 1, 1997, 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.

Subd. 2. **Medically urgent complaints.** Health plan companies shall make reasonable efforts to resolve medically urgent enrollee complaints within 72 hours of receiving the complaint.

Subd. 3. **Appeals process.** Health plan companies shall establish and make available to enrollees an impartial appeals process. If a decision by a health plan company regarding a complaint is partially or wholly adverse to the complainant, the health plan company shall advise the complainant of the right to appeal through the impartial appeals process or to the commissioner.

Subd. 4. **Alternative dispute resolution.** Health plan companies shall make available to enrollees an alternative dispute resolution process, and shall participate in alternative dispute resolution at the request of an enrollee, as required under section 62Q.11. A health plan company may meet the requirements of subdivision 3 by providing an alternative dispute resolution process. If the health plan company chooses to provide alternative dispute resolution to meet the requirements of subdivision 3, the process shall be provided at no cost to the enrollee.

Subd. 5. **Requirements for managed care organizations.** Each managed care organization shall submit all health care quality related complaints to its quality review board or

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quality review organization for evaluation and possible action. The complaint resolution process for managed care organizations must clearly indicate the entity responsible for resolving complaints made by enrollees against hospitals, other health care facilities, and health care providers, that are owned by or under contract with the managed care organization.

Subd. 6. **Recordkeeping.** Health plan companies shall maintain records of all enrollee complaints and their resolutions. These records must be retained for five years, and must be made available to the appropriate commissioner upon request.

Subd. 7. **Reporting.** Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that are not resolved within 30 days. A health plan company shall also make this information available to the public upon request.

Subd. 8. **Notice to enrollees.** Health plan companies shall provide a clear and complete description of their complaint resolution procedures to enrollees as part of their evidence of coverage or contract. The description must specifically inform enrollees:

(1) how to file a complaint with the health plan company;

(2) how to request an impartial appeal;

(3) that they have the right to request the use of alternative methods of dispute resolution; and

(4) that they have the right to litigate.

History: *1995 c 234 art 2 s 21*

62Q.1055 CHEMICAL DEPENDENCY.

All health plan companies shall use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660, when assessing and placing enrollees for chemical dependency treatment.

History: *1995 c 234 art 2 s 22*

62Q.106 DISPUTE RESOLUTION BY COMMISSIONER.

A complainant may at any time submit a complaint to the appropriate commissioner to investigate. After investigating a complaint, or reviewing a company's decision, the appropriate commissioner may order a remedy as authorized under section 62N.04, 62Q.30, chapter 45, 60A, or 62D.

History: *1995 c 234 art 2 s 23*

62Q.11 DISPUTE RESOLUTION.

Subdivision 1. **Established.** The commissioners of health and commerce shall make dispute resolution processes available to encourage early settlement of disputes in order to avoid the time and cost associated with litigation and other formal adversarial hearings. For purposes of this section, "dispute resolution" means the use of negotiation, mediation, arbitration, mediation–arbitration, neutral fact finding, and minitrials. These processes shall be nonbinding unless otherwise agreed to by all parties to the dispute.

Subd. 2. **Requirements.** (a) If an enrollee, health care provider, or applicant for network provider status chooses to use a dispute resolution process prior to the filing of a formal claim or of a lawsuit, the health plan company must participate.

(b) If an enrollee, health care provider, or applicant for network provider status chooses to use a dispute resolution process after the filing of a lawsuit, the health plan company must participate in dispute resolution, including, but not limited to, alternative dispute resolution under rule 114 of the Minnesota general rules of practice.

(c) The commissioners of health and commerce shall inform and educate health plan companies' enrollees about dispute resolution and its benefits, and shall establish appropriate cost–sharing requirements for parties taking part in alternative dispute resolution.

(d) A health plan company may encourage but not require an enrollee to submit a complaint to alternative dispute resolution.

History: *1994 c 625 art 2 s 19; 1995 c 234 art 2 s 24*

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62Q.12 DENIAL OF ACCESS.

No health plan company may deny access to a covered health care service unless the denial is made by, or under the direction of, or subject to the review of a health care professional licensed to provide the service in question.

History: *1994 c 625 art 2 s 20*

62Q.135 CONTRACTING FOR CHEMICAL DEPENDENCY SERVICES.

No health plan company shall contract with a chemical dependency treatment program, unless the program participates in the chemical dependency treatment accountability plan established by the commissioner of human services. The commissioner of human services shall make data on chemical dependency services and outcomes collected through this program available to health plan companies.

History: *1994 c 625 art 2 s 21*

62Q.14 RESTRICTIONS ON ENROLLEE SERVICES.

No health plan company may restrict the choice of an enrollee as to where the enrollee receives services related to:

(1) the voluntary planning of the conception and bearing of children, provided that this clause does not refer to abortion services;

(2) the diagnosis of infertility;

(3) the testing and treatment of a sexually transmitted disease; and

(4) the testing for AIDS or other HIV–related conditions.

History: *1994 c 625 art 2 s 22*

62Q.145 ABORTION AND SCOPE OF PRACTICE.

Health plan company policies related to scope of practice for allied independent health providers as defined in section 62Q.095, subdivision 5, midlevel practitioners as defined in section 136A.1356, subdivision 1, and other nonphysician health care professionals must comply with the requirements governing the performance of abortions in section 145.412, subdivision 1.

History: *1995 c 234 art 2 s 25*

62Q.16 MIDMONTH TERMINATION PROHIBITED.

The termination of a person's coverage under any health plan as defined in section 62A.011, subdivision 3, with the exception of individual health plans, issued or renewed on or after January 1, 1995, must provide coverage until the end of the month in which coverage was terminated.

History: *1994 c 625 art 2 s 23*

62Q.165 UNIVERSAL COVERAGE.

Subdivision 1. **Definition.** It is the commitment of the state to achieve universal health coverage for all Minnesotans. Universal coverage is achieved when:

(1) every Minnesotan has access to a full range of quality health care services;

(2) every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care; and

(3) every Minnesotan pays into the health care system according to that person's ability.

Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward reducing the number of Minnesotans who do not have health coverage so that by January 1, 2000, fewer than four percent of the state's population will be without health coverage. The goal will be achieved by improving access to private health coverage through insurance reforms and market reforms, by making health coverage more affordable for low–income Minnesotans through purchasing pools and state subsidies, and by reducing the cost of health coverage through cost containment programs and methods of ensuring that all Minnesotans are paying into the system according to their ability.

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Subd. 3. **Report on health care access.** (a) The health care commission shall annually report to the legislature regarding the extent to which the state is making progress toward the goal of universal coverage described in this section. As part of this report, the commission shall monitor the number of uninsured in the state. The annual report must be submitted no later than January 15 of each year in compliance with section 3.195.

(b) The annual report required under paragraph (a), due January 15, 1996, shall advise the legislature regarding possible additional steps in insurance reform that would be helpful in progressing toward universal coverage. The commission shall consider further initiatives involving group purchasing pools, narrowing premium variations, guaranteed issue and portability requirements, preexisting condition limitations, and other provisions that provide greater opportunities to obtain affordable health coverage. The commission shall consider the small employer reforms contained in the model laws recommended by the National Association of Insurance Commissioners and shall recommend whether these reforms should be adopted.

(c) The annual report due required under paragraph (a), required on January 15, 1996, shall advise the legislature regarding possible changes in the individual insurance market. The report shall consider initiatives regarding purchasing pools, including specific design details of a state–run or state–initiated purchasing pool for individuals, specific legislative reforms needed to encourage the formation of purchasing pools, and point–by–point consideration of the obstacles to enactment of these purchasing pools, including adverse selection. The report shall consider the creation of a standard and objective definition of eligibility for the comprehensive health association, and whether the enactment of such a definition could be coupled with guaranteed issuance for the remainder of the individual market. The report should include all other considerations of the commission as to the optimal reforms of the individual market.

(d) The health care commission shall in its annual report make recommendations regarding any steps toward achieving universal coverage that became feasible as a result of changes in federal law that remove barriers to state efforts to expand health care access.

(e) To the extent possible, the health care commission shall utilize existing information, including information collected by other state or federal agencies and organizations, to complete the studies and reports in this subdivision. State agencies and organizations shall provide information, technical and analytic support, and other assistance to the commission as possible, to ensure the timely and efficient completion of the studies and reports in this subdivision. Staff from the appropriate state agencies shall participate with the commission executive director no later than June 15 each year in initial planning and coordination for the annual reports and studies of this subdivision. Following this initial planning, the executive director shall report to the legislative oversight commission on health care access by July 1 each year on the initial study plan, and on any commission tasks or studies which may not be completed as scheduled due to such constraints as lack of sufficient available information or resources.

History: *1994 c 625 art 6 s 1; 1995 c 234 art 4 s 1*

62Q.17 VOLUNTARY PURCHASING POOLS.

Subdivision 1. **Permission to form.** Notwithstanding section 62A.10, employers, groups, and individuals may voluntarily form purchasing pools, solely for the purpose of negotiating and purchasing health plan coverage from health plan companies for members of the pool.

Subd. 2. **Common factors.** All participants in a purchasing pool must live within a common geographic region, be employed in a similar occupation, or share some other common factor as approved by the commissioner of commerce. The membership criteria must not be designed to include disproportionately employers, groups, or individuals likely to have low costs of health coverage, or to exclude disproportionately employers, groups, or individuals likely to have high costs of health coverage.

Subd. 3. **Governing structure.** Each pool must have a governing structure controlled by its members. The governing structure of the pool is responsible for administration of the pool. The governing structure shall review and evaluate all bids for coverage from health plan companies, shall determine criteria for joining and leaving the pool, and may design

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incentives for healthy lifestyles and health promotion programs. The governing structure may design uniform entrance standards for all employers, except small employers as defined under section 62L.02. Small employers must be permitted to enter any pool if the small employer meets the pool's membership requirements. Pools must provide as much choice in health plans to members as is financially possible. The governing structure may charge all members a fee for administrative purposes.

Subd. 4. **Enrollment.** Pools must have an annual open enrollment period of not less than 15 days, during which all individuals or groups that qualify for membership may enter the pool without any preexisting condition limitations or exclusions or exclusionary riders, except those permitted under chapter 62L for groups or section 62A.65 for individuals. Pools must reach and maintain an enrolled population of at least 1,000 members within six months of formation. If a pool fails to reach or maintain the minimum enrollment, all coverage subsequently purchased through the purchasing pool must be regulated through existing applicable laws and forego all advantages under this section.

Subd. 5. **Members.** The governing structure of the pool shall set a minimum time period for membership. Members must stay in the purchasing pool for the entire minimum period to avoid paying a penalty. Penalties for early withdrawal from the purchasing pool shall be established by the governing structure.

Subd. 6. **Employer–based purchasing pools.** Employer–based purchasing pools must, with respect to small employers as defined in section 62L.02, meet all the requirements of chapter 62L. The experience of the pool must be pooled and the rates blended across all groups. Pools may decide to create tiers within the pool, based on experience of group members. These tiers must be designed within the requirements of section 62L.08. The governing structure may establish criteria limiting movement between tiers. Tiers must be phased out within two years of the pool's creation.

Subd. 7. **Individual members.** Purchasing pools that contain individual members must meet all of the underwriting and rate restrictions found in the individual health plan market.

Subd. 8. **Reports.** Prior to the initial effective date of coverage, and annually on July 1 thereafter, each pool shall file a report with the information clearinghouse and the commissioner of commerce. The information clearinghouse must use the report to promote the purchasing pools. The annual report must contain the following information:

(1) the number of lives in the pool;

(2) the geographic area the pool intends to cover;

(3) the number of health plans offered;

(4) a description of the benefits under each plan;

(5) a description of the premium structure, including any copayments or deductibles, of each plan offered;

(6) evidence of compliance with chapter 62L;

(7) a sample of marketing information, including a phone number where the pool may be contacted; and

(8) a list of all administrative fees charged.

Subd. 9. **Enforcement.** Purchasing pools must register prior to offering coverage, and annually on July 1 thereafter, with the commissioner of commerce on a form prescribed by the commissioner. The commissioner of commerce shall enforce this section and all other state laws with respect to purchasing pools, and has for that purpose all general rulemaking and enforcement powers otherwise available to the commissioner of commerce. The commissioner may charge an annual registration fee sufficient to meet the costs of the commissioner's duties under this section.

History: *1994 c 625 art 6 s 2; 1995 c 234 art 7 s 24–26*

62Q.18 PORTABILITY OF COVERAGE.

Subdivision 1. **Definition.** For purposes of this section,

(1) "continuous coverage" has the meaning given in section 62L.02;

(2) "guaranteed issue" means:

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(i) for individual health plans, that a health plan company shall not decline an application by an individual for any individual health plan offered by that health plan company, including coverage for a dependent of the individual to whom the health plan has been or would be issued; and

(ii) for group health plans, that a health plan company shall not decline an application by a group for any group health plan offered by that health plan company and shall not decline to cover under the group health plan any person eligible for coverage under the group's eligibility requirements, including persons who become eligible after initial issuance of the group health plan; and

(3) "qualifying coverage" has the meaning given in section 62L.02.

Subd. 2. [Repealed, 1995 c 234 art 4 s 4]

Subd. 3. [Repealed, 1995 c 234 art 4 s 4]

Subd. 4. [Repealed, 1995 c 234 art 4 s 4]

Subd. 5. [Repealed, 1995 c 234 art 4 s 4]

Subd. 6. [Repealed, 1995 c 234 art 4 s 4]

Subd. 7. **Portability of coverage.** Effective July 1, 1994, no health plan company shall offer, sell, issue, or renew any group health plan that does not, with respect to individuals who maintain continuous coverage and who qualify under the group's eligibility requirements:

(1) make coverage available on a guaranteed issue basis; and

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or preexisting condition exclusion.

To the extent that this subdivision conflicts with chapter 62L, chapter 62L governs, regardless of whether the group sponsor is a small employer as defined in section 62L.02, except that for group health plans issued to groups that are not small employers, this subdivision's requirement that the individual have maintained continuous coverage applies. An individual who has maintained continuous coverage, but would be considered a late entrant under chapter 62L, may be treated as a late entrant in the same manner under this subdivision as permitted under chapter 62L.

Subd. 8. [Repealed, 1995 c 234 art 4 s 4]

Subd. 9. [Repealed, 1995 c 234 art 4 s 4]

History: *1994 c 625 art 6 s 3; art 8 s 72; 1995 c 234 art 4 s 2*

NOTE: Subdivision 8 was also amended by Laws 1995, chapter 96, section 2, to read as follows:

"Subd. 8. **Comprehensive health association.** Effective on the date specified by law enacted after January 1, 1995, pursuant to subdivision 9, the comprehensive health association created in section 62E.10 shall not accept new applicants for enrollment, except for Medicare–related coverage described in section 62E.12 and for coverage described in section 62E.18."

62Q.19 ESSENTIAL COMMUNITY PROVIDERS.

Subdivision 1. **Designation.** The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high–risk and special needs populations as defined in section 62Q.07, subdivision 2, paragraph (e), underserved, and other special needs populations; and

(2) a commitment to serve low–income and underserved populations by meeting the following requirements:

(i) has nonprofit status in accordance with chapter 317A;

(ii) has tax exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);

(iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and

(iv) does not restrict access or services because of a client's financial limitation;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, an Indian tribal government, an Indian health service unit, or community health board as defined in chapter 145A; or

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(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions.

Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

Subd. 2. **Application.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner. Applications must be accepted within two years after the effective date of the rules adopted by the commissioner to implement this section.

(b) Each application submitted must be accompanied by an application fee in an amount determined by the commissioner. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

Subd. 2a. **Definition of health plan company.** For purposes of this section, "health plan company" does not include a health plan company as defined in section 62Q.01 with fewer than 50,000 enrollees, all of whose enrollees are covered under medical assistance, general assistance medical care, or MinnesotaCare.

Subd. 3. **Health plan company affiliation.** A health plan company must offer a provider contract to any designated essential community provider located within the area served by the health plan company. A health plan company shall not restrict enrollee access to services designated to be provided by the essential community provider for the population that the essential community provider is certified to serve. A health plan company may also make other providers available for these services. A health plan company may require an essential community provider to meet all data requirements, utilization review, and quality assurance requirements on the same basis as other health plan providers.

Subd. 4. **Essential community provider responsibilities.** Essential community providers must agree to serve enrollees of all health plan companies operating in the area in which the essential community provider is located.

Subd. 5. **Contract payment rates.** An essential community provider and a health plan company may negotiate the payment rate for covered services provided by the essential community provider. This rate must be at least the same rate per unit of service as is paid to other health plan providers for the same or similar services.

Subd. 5a. **Cooperation.** Each health plan company and essential community provider shall cooperate to facilitate the use of the essential community provider by the high risk and special needs populations. This includes cooperation on the submission and processing of claims, sharing of all pertinent records and data, including performance indicators and specific outcomes data, and the use of all dispute resolution methods as defined in section 62Q.11, subdivision 1.

Subd. 5b. **Enforcement.** For any violation of this section or any rule applicable to an essential community provider, the commissioner may suspend, modify, or revoke an essential community provider designation. The commissioner may also use the enforcement authority specified in section 62D.17.

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Subd. 6. **Termination.** The designation as an essential community provider terminates five years after it is granted, or when universal coverage as defined under section 62Q.165 is achieved, whichever is later. Once the designation terminates, the former essential community provider has no rights or privileges beyond those of any other health care provider. The commissioner shall make a recommendation to the legislature on whether an essential community provider designation should be longer than five years.

Subd. 7. **Rulemaking.** By January 1, 1996, the commissioner shall adopt rules for establishing essential community providers and for governing their relationship with health plan companies. The commissioner shall also identify and address any conflict of interest issues regarding essential community provider designation for local governments. The rules shall require health plan companies to comply with all provisions of section 62Q.14 with respect to enrollee use of essential community providers.

History: *1994 c 625 art 4 s 6; 1995 c 234 art 2 s 26; 1996 c 451 art 2 s 1,2*

62Q.21 [Repealed, 1995 c 234 art 2 s 36]

62Q.23 GENERAL SERVICES.

(a) Health plan companies shall comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(b) Health plan companies shall comply with sections 62A.047, 62A.27, and any other coverage required under chapter 62A of newborn infants, dependent children who do not reside with a covered person, handicapped children and dependents, and adopted children. A health plan company providing dependent coverage shall comply with section 62A.302.

(c) Health plan companies shall comply with the equal access requirements of section 62A.15.

History: *1994 c 625 art 4 s 8*

NOTE: This section, as added by Laws 1994, chapter 625, article 4, section 8, is effective July 1, 1997. Laws 1994, chapter 625, article 4, section 14.

62Q.25 SUPPLEMENTAL COVERAGE.

Health plan companies may choose to offer separate supplemental coverage for services not covered under the universal benefits set. Health plan companies may offer any Medicare supplement, Medicare select, or other Medicare–related product otherwise permitted for any type of health plan company in this state. Each Medicare–related product may be offered only in full compliance with the requirements in chapters 62A, 62D, and 62E that apply to that category of product.

History: *1994 c 625 art 4 s 9*

NOTE: This section, as added by Laws 1994, chapter 625, article 4, section 9, is effective July 1, 1997. Laws 1994, chapter 625, article 4, section 14.

62Q.27 [Repealed, 1995 c 234 art 2 s 36]

62Q.29 STATE–ADMINISTERED PUBLIC PROGRAMS.

Public agencies, in conjunction with the department of health and the department of human services, on behalf of eligible recipients enrolled in public programs such as medical assistance, general assistance medical care, and MinnesotaCare, may contract with health plan companies to provide services included in these programs, but not included in the universal standard benefits set.

History: *1994 c 625 art 4 s 11*

NOTE: This section, as added by Laws 1994, chapter 625, article 4, section 11, is effective July 1, 1997. Laws 1994, chapter 625, article 4, section 14.

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. The commissioner may order an integrated service

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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.

History: *1994 c 625 art 4 s 12; 1995 c 234 art 3 s 6*

62Q.32 LOCAL OMBUDSPERSON.

County board or community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services through a health plan company. The ombudsperson's functions may include, but are not limited to:

(a) mediation or advocacy on behalf of a person accessing the complaint and appeal procedures to ensure that necessary medical services are provided by the health plan company; and

(b) investigation of the quality of services provided to a person and determine the extent to which quality assurance mechanisms are needed or any other system change may be needed. The commissioner of health shall make recommendations for funding these functions including the amount of funding needed and a plan for distribution. The commissioner shall submit these recommendations to the legislative commission on health care access by January 15, 1996.

History: *1994 c 625 art 7 s 2; 1995 c 234 art 8 s 18*

62Q.33 LOCAL GOVERNMENT PUBLIC HEALTH FUNCTIONS.

Subdivision 1. **Findings.** The legislature finds that the local government public health functions of community assessment, policy development, and assurance of service delivery are essential elements in consumer protection and in achieving the objectives of health care reform in Minnesota. The legislature further finds that the site–based and population–based services provided by state and local health departments are a critical strategy for the long–term containment of health care costs. The legislature further finds that without adequate resources, the local government public health system will lack the capacity to fulfill these functions in a manner consistent with the needs of a reformed health care delivery system.

Subd. 2. **Report on system development.** The commissioner of health, in consultation with the state community health services advisory committee and the commissioner of human services, and representatives of local health departments, county government, a municipal government acting as a local board of health, the Minnesota health care commission, area Indian health services, health care providers, and citizens concerned about public health, shall coordinate the process for defining implementation and financing responsibilities of the local government core public health functions. The commissioner shall submit recommendations and an initial and final report on local government core public health functions according to the timeline established in subdivision 5.

Subd. 3. **Core public health functions.** (a) The report required by subdivision 2 must describe the local government core public health functions of: assessment of community health needs; goal–determination, public policy, and program development for addressing these needs; and assurance of service availability and accessibility to meet community health goals and needs. The report must further describe activities for implementation of these functions that are the continuing responsibility of the local government public health system, taking into account the ongoing reform of the health care delivery system.

(b) The activities to be defined in terms of the local government core public health functions include, but are not limited to:

(1) consumer protection and advocacy;

(2) targeted outreach and linkage to personal services;

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(3) health status monitoring and disease surveillance;

(4) investigation and control of diseases and injuries;

(5) protection of the environment, work places, housing, food, and water;

(6) laboratory services to support disease control and environmental protection;

(7) health education and information;

(8) community mobilization for health–related issues;

(9) training and education of public health professionals;

(10) public health leadership and administration;

(11) emergency medical services;

(12) violence prevention; and

(13) other activities that have the potential to improve the health of the population or special needs populations and reduce the need for or cost of health care services.

Subd. 4. **Capacity building, accountability and funding.** The recommendations required by subdivision 2 shall include:

(1) a definition of minimum outcomes for implementing core public health functions, including a local ombudsperson under the assurance of services function;

(2) the identification of counties and applicable cities with public health programs that need additional assistance to meet the minimum outcomes;

(3) a budget for supporting all functions needed to achieve the minimum outcomes, including the local ombudsperson assurance of services function;

(4) an analysis of the costs and benefits expected from achieving the minimum outcomes;

(5) strategies for improving local government public health functions throughout the state to meet the minimum outcomes including: (i) funding distribution for local government public health functions necessary to meet the minimum outcomes; and (ii) strategies for the financing of personal health care services through the health plan companies and identifying appropriate mechanisms for the delivery of these services; and

(6) a recommended level of dedicated funding for local government public health functions in terms of a percentage of total health service expenditures by the state or in terms of a per capita basis, including methods of allocating the dedicated funds to local government. Funding recommendations must be broad–based and must consider all financial resources.

Subd. 5. **Timeline.** (a) By January 15, 1996, the commissioner shall submit a final report to the legislature, with specific recommendations for capacity building and financing to be implemented over the period from January 1, 1996, through December 31, 1997.

(b) By January 15, 1997, and by January 15 of each odd–numbered year thereafter, the commissioner shall present to the legislature an updated report and recommendations.

History: *1994 c 625 art 7 s 3; 1995 c 234 art 8 s 19,20*

62Q.41 ANNUAL IMPLEMENTATION REPORT.

(a) The commissioner of health, in consultation with the Minnesota health care commission, shall develop an annual implementation report to be submitted to the legislature each year beginning January 1, 1995, describing the progress and status of rule development and implementation of the integrated service network system, and providing recommendations for legislative changes that the commissioner determines may be needed.

(b) As part of the report required in paragraph (a) due for 1996, the commissioner, in consultation with the health care commission, shall make recommendations on the design and development of an appropriate framework to apply regulations uniformly among all health plan companies and to ensure adequate oversight and consumer protection in the absence of a regulated all–payer system.

History: *1994 c 625 art 5 s 1; 1995 c 234 art 3 s 7*

62Q.43 GEOGRAPHIC ACCESS.

Subdivision 1. **Closed–panel health plan.** For purposes of this section, "closed–panel health plan" means a health plan as defined in section 62Q.01 that requires an enrollee to

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receive all or a majority of primary care services from a specific clinic or physician designated by the enrollee that is within the health plan company's clinic or physician network.

Subd. 2. **Access requirement.** Every closed–panel health plan must allow enrollees who are full–time students under the age of 25 years to change their designated clinic or physician at least once per month, as long as the clinic or physician is part of the health plan company's statewide clinic or physician network. A health plan company shall not charge enrollees who choose this option higher premiums or cost sharing than would otherwise apply to enrollees who do not choose this option. A health plan company may require enrollees to provide 15 days written notice of intent to change their designated clinic or physician.

History: *1995 c 234 art 2 s 27*

62Q.45 COVERAGE FOR OUT–OF–AREA PRIMARY CARE.

Subdivision 1. **Study.** The commissioner of health shall develop methods to allow enrollees of managed care organizations to obtain primary care health services outside of the service area of their managed care organization, from health care providers who are employed by or under contract with another managed care organization. The commissioner shall make recommendations on: (1) whether this out–of–area primary care coverage should be available to students and/or other enrollees without additional premium charges or cost sharing; (2) methods to coordinate the services provided by different managed care organizations; (3) methods to manage the quality of care provided by different managed care organizations and monitor health care outcomes; (4) methods to reimburse managed care organizations for care provided to enrollees of other managed care organizations; and (5) other issues relevant to the design and administration of out–of–area primary care coverage. The commissioner shall present recommendations to the legislature by January 15, 1996.

Subd. 2. **Definition.** For purposes of this section, "managed care organization" means: (1) a health maintenance organization operating under chapter 62D; (2) a community integrated service network as defined under section 62N.02, subdivision 4a; (3) an integrated service network as defined under section 62N.02, subdivision 8; or (4) an insurance company licensed under chapter 60A, nonprofit health service plan corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

History: *1995 c 234 art 2 s 28*

62Q.47 MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for mental health or chemical dependency services, must comply with the requirements of this section.

(b) Cost–sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost–sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

History: *1995 c 234 art 2 s 29*

62Q.49 ENROLLEE COST SHARING; NEGOTIATED PROVIDER PAYMENTS.

Subdivision 1. **Applicability.** This section applies to all health plans, as defined in section 62Q.01, subdivision 3, that provide coverage for health care to be provided entirely or partially:

(1) through contracts in which health care providers agree to accept discounted charges, negotiated charges, or other limits on health care provider charges;

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(2) by employees of, or facilities or entities owned by, the issuer of the health plan; or

(3) through contracts with health care providers that provide for payment to the providers on a fully or partially capitated basis or on any other non–fee–for–service basis.

Subd. 2. **Disclosure required.** (a) All health plans included in subdivision 1 must clearly specify how the cost of health care used to calculate any copayments, coinsurance, or lifetime benefits will be affected by the arrangements described in subdivision 1.

(b) Any summary or other marketing material used in connection with marketing of a health plan that is subject to this section must prominently disclose and clearly explain the provisions required under paragraph (a), if the summary or other marketing material refers to copayments, coinsurance, or maximum lifetime benefits.

(c) A health plan that is subject to paragraph (a) must not be used in this state if the commissioner of commerce or health, as appropriate, has determined that it does not comply with this section.

History: *1996 c 446 art 1 s 50*

NOTE: This section, as added by Laws 1996, chapter 446, article 1, section 50, is effective June 30, 1997, and applies to health plans issued or renewed on or after that date. Laws 1996, chapter 446, article 1, section 73.

62Q.50 PROSTATE CANCER SCREENING.

A health plan must cover prostate cancer screening for men 40 years of age or over who are symptomatic or in a high–risk category and for all men 50 years of age or older.

The screening must consist at a minimum of a prostate–specific antigen blood test and a digital rectal examination.

This coverage is subject to any deductible, coinsurance, copayment, or other limitation on coverage applicable to other coverages under the plan.

For purposes of this section, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clauses (7) and (10).

History: *1996 c 446 art 1 s 51*

NOTE: This section, as added by Laws 1996, chapter 446, article 1, section 51, applies to health plans issued or renewed to provide coverage to Minnesota residents on or after August 1, 1996, and is repealed August 1, 1998. Laws 1996, chapter 446, article 1, sections 72 and 73.

62Q.51 POINT–OF–SERVICE OPTION.

Subdivision 1. **Definition.** For purposes for this section, "point–of–service option" means a health plan under which the health plan company will reimburse an appropriately licensed or registered provider for providing covered services to an enrollee, without regard to whether the provider belongs to a particular network and without regard to whether the enrollee was referred to the provider by another provider.

Subd. 2. **Required point–of–service option.** Each health plan company operating in the small group or large group market shall offer at least one point–of–service option in each such market in which it operates.

Subd. 3. **Rate approval.** The premium rates and cost sharing requirements for each option must be submitted to the commissioner of health or the commissioner of commerce as required by law. A health plan that includes lower enrollee cost sharing for services provided by network providers than for services provided by out–of–network providers, or lower enrollee cost sharing for services provided with prior authorization or second opinion than for services provided without prior authorization or second opinion, qualifies as a point–of–service option.

Subd. 4. **Exemption.** This section does not apply to a health plan company with fewer than 50,000 enrollees.

History: *1996 c 446 art 1 s 52*

NOTE: This section, as added by Laws 1996, chapter 446, article 1, section 52, applies to health plans issued or renewed to provide coverage to Minnesota residents on or after August 1, 1996. Laws 1996, chapter 446, article 1, section 73.

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