CHAPTER 62J

HEALTH CARE COST CONTAINMENT

62J.017 IMPLEMENTATION TIMETABLE.

The state seeks to complete the restructuring of the health care delivery and financing system. Beginning July 1, 1994, measures will be taken to increase the public accountability of existing health plan companies, to promote the development of small, community–based integrated service networks, and to reduce administrative costs by standardizing third–party billing forms and procedures and utilization review requirements.

History: *1997 c 225 art 2 s 9*

62J.03 DEFINITIONS.

[For text of subds 1 and 2, see M.S.1996]

Subd. 3. [Repealed, 1997 c 225 art 2 s 63]

[For text of subds 4 and 5, see M.S.1996]

Subd. 6. **Group purchaser.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self–insured employers; trusts established in a collective bargaining agreement under the federal Labor–Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

[For text of subds 7 to 10, see M.S.1996]

History: *1997 c 225 art 2 s 62*

62J.04 MONITORING THE RATE OF GROWTH OF HEALTH CARE SPENDING.

Subdivision 1. **Cost containment goals.** (a) The commissioner of health shall set annual cost containment goals for public and private spending on health care services for Minnesota residents, as provided in paragraph (b). The cost containment goals must be set at levels the commissioner determines to be realistic and achievable but that will reduce the rate of growth in health care spending by at least ten percent per year for the next five years. The commissioner shall set cost containment goals based on available data on spending and growth trends, including data from group purchasers, national data on public and private sector health care spending and cost trends, and trend information from other states.

(b) The commissioner shall set the following annual cost containment goals for public and private spending on health care services for Minnesota residents:

(1) for calendar year 1994, the cost containment goal must not exceed the change in the regional consumer price index for urban consumers for calendar year 1993 plus 6.5 percentage points;

(2) for calendar year 1995, the cost containment goal must not exceed the change in the regional consumer price index for urban consumers for calendar year 1994 plus 5.3 percentage points;

(3) for calendar year 1996, the cost containment goal must not exceed the change in the regional consumer price index for urban consumers for calendar year 1995 plus 4.3 percentage points;

(4) for calendar year 1997, the cost containment goal must not exceed the change in the regional consumer price index for urban consumers for calendar year 1996 plus 3.4 percentage points; and

(5) for calendar year 1998, the cost containment goal must not exceed the change in the regional consumer price index for urban consumers for calendar year 1997 plus 2.6 percentage points.

The commissioner shall adjust the cost containment goal set for calendar year 1995 to recover savings in health care spending required for the period July 1, 1993, to December 31, 1993.

(c) The commissioner shall publish:

(1) the projected cost containment goal in the State Register by April 15 of the year immediately preceding the year in which the cost containment goal will be effective except for the year 1993, in which the cost containment goal shall be published by July 1, 1993;

(2) the quarterly change in the regional consumer price index for urban consumers; and

(3) the health care financing administration forecast for total growth in the national health care expenditures.

Subd. 1a. **Cost containment goals.** The commissioner shall publish the final adjusted cost containment goal in the State Register by January 31 of the year that the cost containment goal is to be in effect. The adjusted cost containment goal must reflect the actual regional consumer price index for urban consumers for the previous calendar year, and may deviate from the previously published projected cost containment goal to reflect differences between the actual regional consumer price index for urban consumers and the projected Consumer Price Index for urban consumers. The commissioner shall report to the legislature by February 15 of each year on the implementation of the cost containment goal. This annual report shall describe the differences between the projected increase in health care expenditures, the actual expenditures based on data collected, and the impact and validity of cost containment goals within the overall health care reform strategy.

Subd. 3. **Cost containment duties.** After obtaining the advice and recommendations of the Minnesota health care commission, the commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.37 to 62J.41 to monitor statewide achievement of the cost containment goals;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

(3) provide technical assistance to regional coordinating boards;

(4) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(5) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Health Care Financing Administration 1500 form, or other standardized forms or procedures;

(6) undertake health planning responsibilities as provided in section 62J.15;

(7) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(8) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start–up grants for worksite wellness programs;

(9) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans; and

(10) make the cost containment goal data available to the public in a consumer–oriented manner.

Subd. 4. [Repealed, 1997 c 225 art 2 s 63]

[For text of subds 5 and 6, see M.S.1996]

Subd. 7. [Repealed, 1997 c 225 art 2 s 63]

[For text of subd 9, see M.S.1996]

History: *1997 c 150 s 2,3; 1997 c 187 art 1 s 5*

NOTE: Subdivision 1, paragraph (c), clause (3), was also amended by Laws 1997, chapter 150, section 1, to read as follows:

"(3) the health care financing administration forecast for total growth in the national health care expenditures. In setting the cost containment goals, the commissioner is exempt from the rulemaking requirements of chapter 14. The commissioner's decision on the cost containment goals is not appealable."

62J.041 INTERIM HEALTH PLAN COMPANY COST CONTAINMENT GOALS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan company" has the definition provided in section 62Q.01.

(c) "Total expenditures" means incurred claims or expenditures on health care services, administrative expenses, charitable contributions, and all other payments made by health plan companies out of premium revenues.

(d) "Net expenditures" means total expenditures minus exempted taxes and assessments and payments or allocations made to establish or maintain reserves.

(e) "Exempted taxes and assessments" means direct payments for taxes to government agencies, contributions to the Minnesota comprehensive health association, the medical as-

sistance provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the health coverage reinsurance association, assessments by the Minnesota life and health insurance guaranty association, assessments by the Minnesota risk adjustment association, and any new assessments imposed by federal or state law.

(f) "Consumer cost–sharing or subscriber liability" means enrollee coinsurance, copayment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. **Establishment.** The commissioner of health shall establish cost containment goals for the increase in net expenditures by each health plan company for calendar years 1994, 1995, 1996, and 1997. The cost containment goals must be the same as the annual cost containment goals for health care spending established under section 62J.04, subdivision 1, paragraph (b). Health plan companies that are affiliates may elect to meet one combined cost containment goal.

Subd. 3. **Determination of expenditures.** Health plan companies shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993; April 1, 1995, for calendar year 1994; April 1, 1996, for calendar year 1995; April 1, 1997, for calendar year 1996; and April 1, 1998, for calendar year 1997 all information the commissioner determines to be necessary to implement this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments and the election to meet one cost containment goal for affiliated health plan companies must be submitted to the commissioner by September 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.

Subd. 4. **Monitoring of reserves.** (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to assess the degree to which savings resulting from the establishment of cost containment goals are passed on to consumers in the form of lower premium rates.

(b) Health plan companies shall fully reflect in the premium rates the savings generated by the cost containment goals. No premium rate, currently reviewed by the departments of health or commerce, may be approved for those health plan companies unless the health plan company establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year. These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as a community

integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end of the quarter and enrollment changes within each service area of the new organization. The reserve calculations shall be maintained by the commissioners as trade secret information, except to the extent that such information is also required to be filed by another provision of state law and is not treated as trade secret information under such other provisions.

(d) Health plan companies in paragraph (c) whose reserves are less than the required minimum or more than the required maximum at the end of the fiscal year shall submit a plan of corrective action to the commissioner of health or commerce under subdivision 7.

(e) The commissioner of commerce, in consultation with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements.

Subd. 5. **Notice.** The commissioner of health shall publish in the State Register and make available to the public by July 1, 1995, a list of all health plan companies that exceeded their cost containment goal for the 1994 calendar year. The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined cost containment goal for calendar years 1994 and 1995. The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its cost containment goal, at least 30 days before publishing the list, and shall provide each health plan company with ten days to provide an explanation for exceeding the cost containment goal. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. **Assistance by the commissioner of commerce.** The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health plan companies regulated by the commissioner of commerce.

Subd. 7. [Repealed by amendment, 1997 c 150 s 4]

History: *1997 c 150 s 4; 1997 c 225 art 2 s 62*

62J.042 [Repealed, 1997 c 150 s 6]

62J.05 [Repealed, 1997 c 225 art 2 s 63]

62J.051 [Repealed, 1997 c 225 art 2 s 63]

62J.06 IMMUNITY FROM LIABILITY.

No member of the regional coordinating boards established under section 62J.09, or the health technology advisory committee established under section 62J.15, shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

History: *1997 c 225 art 2 s 10*

62J.07 LEGISLATIVE OVERSIGHT COMMISSION.

Subdivision 1. **Legislative oversight.** The legislative commission on health care access reviews the activities of the commissioner of health, the regional coordinating boards, the health technology advisory committee, and all other state agencies involved in the implementation and administration of this chapter, including efforts to obtain federal approval through waivers and other means.

[For text of subd 2, see M.S.1996]

Subd. 3. **Reports to the commission.** The commissioner of health, the regional coordinating boards, and the health technology advisory committee shall report on their activities annually and at other times at the request of the legislative commission on health care access.

The commissioners of health, commerce, and human services shall provide periodic reports to the legislative commission on the progress of rulemaking that is authorized or required under this act and shall notify members of the commission when a draft of a proposed rule has been completed and scheduled for publication in the State Register. At the request of a member of the commission, a commissioner shall provide a description and a copy of a proposed rule.

History: *1997 c 225 art 2 s 11,12*

62J.09 REGIONAL COORDINATING BOARDS.

Subdivision 1. **General duties.** (a) The commissioner shall divide the state into six regions, one of these regions being the seven–county metropolitan area.

(b) Each region shall establish a locally controlled regional coordinating board consisting of providers, health plan companies, employers, consumers, and elected officials. Regional coordinating boards may:

(1) undertake voluntary activities to educate consumers, providers, and purchasers about community plans and projects promoting health care cost containment, consumer accountability, access, and quality and efforts to achieve public health goals;

(2) make recommendations to the commissioner regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state;

(3) provide technical assistance to parties interested in establishing or operating a community integrated service network within the region. This assistance must complement assistance provided by the commissioner under section 62N.23;

(4) advise the commissioner on public health goals, taking into consideration the relevant portions of the community health service plans, plans required by the Minnesota Comprehensive Adult Mental Health Act, the Minnesota Comprehensive Children's Mental Health Act, and the Community Social Service Act plans developed by county boards or community health boards in the region under chapters 145A, 245, and 256E;

(5) prepare an annual regional education plan that is consistent with and supportive of public health goals identified by community health boards in the region; and

(6) serve as advisory bodies to identify potential applicants for federal Health Professional Shortage Area and federal Medically Underserved Area designation as requested by the commissioner.

[For text of subd 2, see M.S.1996]

Subd. 3a. [Repealed, 1997 c 225 art 2 s 63]

[For text of subds 4 to 8, see M.S.1996]

History: *1997 c 225 art 2 s 13,62*

62J.15 HEALTH PLANNING.

Subdivision 1. **Health technology advisory committee.** The legislative commission on health care access may convene or authorize the commissioner of health to convene an advisory committee to conduct evaluations of existing research and technology assessments conducted by other entities of new and existing health care technologies as designated by the legislative commission on health care access, the commissioner, or the advisory committee. The advisory committee must include at least one person representing physicians, at least one person representing hospitals, and at least one person representing the health care technology industry. Health care technologies include high–cost drugs, devices, procedures, or processes applied to human health care, such as high–cost transplants and expensive scanners and imagers. The advisory committee is governed by section 15.0575, subdivision 3, except that members do not receive per diem payments.

[For text of subd 1a, see M.S.1996]

History: *1997 c 225 art 2 s 14*

62J.152 DUTIES OF HEALTH TECHNOLOGY ADVISORY COMMITTEE.

Subdivision 1. **Generally.** The health technology advisory committee established in section 62J.15 shall:

(1) develop criteria and processes for evaluating health care technology assessments made by other entities;

(2) conduct evaluations of specific technologies and their specific use and application;

(3) provide the legislature with scientific evaluations of proposed benefit mandates that utilize health care technologies for a specific use and application;

(4) report the results of the evaluations to the commissioner and the legislative commission on health care access; and

(5) carry out other duties relating to health technology assigned by the legislature or the legislative commission on health care access.

Subd. 1a. **Legislative action.** Nothing in subdivision 1 shall be construed to:

(1) require the legislature to postpone hearings or legislative action on a proposed benefit mandate; or

(2) require the legislature to act in accordance with any recommendations of the health technology advisory committee.

Subd. 2. **Criteria for evaluation.** The health technology advisory committee shall consider the following criteria in assessing or evaluating technologies:

(1) the level of controversy within the medical or scientific community, including questionable or undetermined efficacy;

(2) the cost implications;

(3) the potential for rapid diffusion;

(4) the impact on a substantial patient population;

(5) the existence of alternative technologies;

(6) the impact on patient safety and health outcome;

(7) the public health importance;

(8) the level of public and professional demand;

(9) the social, ethical, and legal concerns; and

(10) the prevalence of the disease or condition.

The committee may give different weights or attach different importance to each of the criteria, depending on the technology being considered. The committee shall consider any additional criteria approved by the commissioner and the legislative commission on health care access. The committee shall present its list of technologies for evaluation to the legislative commission on health care access for review.

[For text of subd 3, see M.S.1996]

Subd. 4. **Technology evaluation process.** (a) The health technology advisory committee shall collect and evaluate studies and research findings on the technologies selected for evaluation from as wide of a range of sources as needed, including, but not limited to: federal agencies or other units of government, international organizations conducting health care technology assessments, health carriers, insurers, manufacturers, professional and trade associations, nonprofit organizations, and academic institutions. The health technology advisory committee may use consultants or experts and solicit testimony or other input as needed to evaluate a specific technology.

(b) When the evaluation process on a specific technology has been completed, the health technology advisory committee shall submit a preliminary report to the commissioner and the legislative commission on health care access and publish a summary of the preliminary report in the State Register with a notice that written comments may be submitted. The preliminary report must include the results of the technology assessment evaluation, studies and research findings considered in conducting the evaluation, and the health technology advisory committee's summary statement about the evaluation. Any interested persons or organizations may submit to the health technology advisory committee written comments re-

garding the technology evaluation within 30 days from the date the preliminary report was published in the State Register. The health technology advisory committee's final report on its technology evaluation must be submitted to the commissioner, to the legislature, and to the information clearinghouse. A summary of written comments received by the health technology advisory committee within the 30–day period must be included in the final report.

(c) The reports of the health technology advisory committee should not eliminate or bar new technology.

Subd. 5. **Use of technology evaluation.** (a) The final report on the technology evaluation may be used:

(1) by the commissioner in retrospective and prospective review of major expenditures;

(2) by group purchasers and by employers, in making coverage, contracting, purchasing, and reimbursement decisions;

(3) by organizations in the development of practice parameters;

(4) by health care providers in making decisions about adding or replacing technology and the appropriate use of technology;

(5) by consumers in making decisions about treatment;

(6) by medical device manufacturers in developing and marketing new technologies; and

(7) as otherwise needed by health care providers, health care plans, consumers, and purchasers.

(b) At the request of the commissioner, the health technology advisory committee shall submit specific recommendations relating to technologies that have been evaluated under this section for purposes of retrospective and prospective review of major expenditures and coverage, contracting, purchasing, and reimbursement decisions affecting state programs.

[For text of subd 7, see M.S.1996]

Subd. 8. **Repealer.** This section and sections 62J.15 and 62J.156 are repealed effective July 1, 2001.

History: *1997 c 187 art 3 s 16; 1997 c 225 art 2 s 15–20*

62J.17 EXPENDITURE REPORTING.

[For text of subds 1 to 5a, see M.S.1996]

Subd. 6a. **Prospective review and approval.** (a) **Requirement.** No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) **Application.** A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The application must address each item listed in subdivision 4a, paragraph (a), and must also include documentation to support the response to each item. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under subdivision 7. The submission may be made either in addition to or instead of the submission of information relating to the items listed in subdivision 4a, paragraph (a).

(c) **Review.** The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under subdivision 7. In

making this determination, the commissioner may also consider relevant information from other sources. At the request of the commissioner, the health technology advisory committee shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner. The commissioner shall make a decision on the application within 60 days after an application is received.

(d) **Penalties and remedies.** The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

[For text of subd 7, see M.S.1996]

History: *1997 c 225 art 2 s 21*

62J.22 PARTICIPATION OF FEDERAL PROGRAMS.

The commissioner of health shall seek the full participation of federal health care programs under this chapter, including Medicare, medical assistance, veterans administration programs, and other federal programs. The commissioner of human services shall submit waiver requests and take other action necessary to obtain federal approval to allow participation of the medical assistance program. If federal approval is not given for one or more federal programs, data on the amount of health care spending that is collected under section 62J.04 shall be adjusted so that state and regional spending limits take into account the failure of the federal program to participate.

History: *1997 c 225 art 2 s 22*

62J.23 PROVIDER CONFLICTS OF INTEREST.

[For text of subds 1 to 3, see M.S.1996]

Subd. 4. **Chapter 62N networks.** (a) The legislature finds that the formation and operation of community integrated service networks will accomplish the purpose of the federal Medicare antikickback statute, which is to reduce the overutilization and overcharging that may result from inappropriate provider incentives. Accordingly, it is the public policy of the state of Minnesota to support the development of community integrated service networks. The legislature finds that the federal Medicare antikickback laws should not be interpreted to interfere with the development of community integrated service networks or to impose liability for arrangements between an integrated service network or a community integrated service network and its participating entities.

(b) An arrangement between a community integrated service network and any or all of its participating entities is not subject to liability under subdivisions 1 and 2.

History: *1997 c 225 art 2 s 62*

62J.25 MANDATORY MEDICARE ASSIGNMENT.

(a) Effective January 1, 1993, a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 115 percent of the Medicare–approved amount for any Medicare–covered service provided.

(b) Effective January 1, 1994, a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 110 percent of the Medicare–approved amount for any Medicare–covered service provided.

(c) Effective January 1, 1995, a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 105 percent of the Medicare–approved amount for any Medicare–covered service provided.

(d) Effective January 1, 1996, a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of the Medicare–approved amount for any Medicare–covered service provided.

(e) This section does not apply to ambulance services as defined in section 144E.001, subdivision 3, or medical supplies and equipment.

History: *1997 c 199 s 14; 1997 c 225 art 2 s 23*

62J.2911 [Repealed, 1997 c 237 s 22]

62J.2912 [Repealed, 1997 c 237 s 22]

62J.2913 [Repealed, 1997 c 237 s 22]

62J.2914 [Repealed, 1997 c 237 s 22]

NOTE: Subdivision 1 was also amended by Laws 1997, chapter 225, article 2, section 24, to read as follows:

"Subdivision 1. **Disclosure.** An application for approval must include, to the extent applicable, disclosure of the following:

(1) a descriptive title;

(2) a table of contents;

(3) exact names of each party to the application and the address of the principal business office of each party;

(4) the name, address, and telephone number of the persons authorized to receive notices and communications with respect to the application;

(5) a verified statement by a responsible officer of each party to the application attesting to the accuracy and completeness of the enclosed information;

(6) background information relating to the proposed arrangement, including:

(i) a description of the proposed arrangement, including a list of any services or products that are the subject of the proposed arrangement;

(ii) an identification of any tangential services or products associated with the services or products that are the subject of the proposed arrangement;

(iii) a description of the geographic territory involved in the proposed arrangement;

(iv) if the geographic territory described in item (iii), is different from the territory in which the applicants have engaged in the type of business at issue over the last five years, a description of how and why the geographic territory differs;

(v) identification of all products or services that a substantial share of consumers would consider substitutes for any service or product that is the subject of the proposed arrangement;

(vi) identification of whether any services or products of the proposed arrangement are currently being offered, capable of being offered, utilized, or capable of being utilized by other providers or purchasers in the geographic territory described in item (iii);

(vii) identification of the steps necessary, under current market and regulatory conditions, for other parties to enter the territory described in item (iii) and compete with the applicant;

(viii) a description of the previous history of dealings between the parties to the application;

(ix) a detailed explanation of the projected effects, including expected volume, change in price, and increased revenue, of the arrangement on each party's current businesses, both generally as well as the aspects of the business directly involved in the proposed arrangement;

(x) the present market share of the parties to the application and of others affected by the proposed arrangement, and projected market shares after implementation of the proposed arrangement;

(xi) a statement of why the projected levels of cost, access, or quality could not be achieved in the existing market without the proposed arrangement; and

(xii) an explanation of how the arrangement relates to any applicable regional coordinating board plans for delivery of health care; and

(7) a detailed explanation of how the transaction will affect cost, access, and quality. The explanation must address the factors in section 62J.2917, subdivision 2, paragraphs (b) to (d), to the extent applicable."

62J.2915 [Repealed, 1997 c 237 s 22]

NOTE: This section was also amended by Laws 1997, chapter 225, article 2, section 25, to read as follows:

"69J.2915 **Notice and comment.**

Subdivision 1. **Notice.** The commissioner shall cause the notice described in section 62J.2914, subdivision 2, to be published in the State Register and sent to the regional coordinating boards for any regions that include all or part of the territory covered by the proposed arrangement, and any person who has requested to be placed on a list to receive notice of applications. The commissioner may maintain separate notice lists for different regions of the state. The commissioner may also send a copy of the notice to any person together with a request that the person comment as provided under subdivision 2. Copies of the request must be provided to the applicant.

Subd. 2. **Comments.** Within 20 days after the notice is published, any person may mail to the commissioner written comments with respect to the application. Within 30 days after the notice is published, any regional coordinating board may mail to the commissioner comments with respect to the application. Persons submitting comments shall provide a copy of the comments to the applicant. The applicant may mail to the commissioner written responses to any comments within ten days after the deadline for mailing such comments. The applicant shall send a copy of the response to the person submitting the comment."

62J.2916 [Repealed, 1997 c 237 s 22]

NOTE: Subdivision 1 was also amended by Laws 1997, chapter 225, article 2, section 26, to read as follows:

"Subdivision 1. **Choice of procedures.** After the conclusion of the period provided in section 62J.2915, subdivision 2, for the applicant to respond to comments, the commissioner shall select one of the three procedures provided in subdivision 2. In determining which procedure to use, the commissioner shall consider the following criteria:

(1) the size of the proposed arrangement, in terms of number of parties and amount of money involved;

(2) the complexity of the proposed arrangement;

(3) the novelty of the proposed arrangement;

(4) the substance and quantity of the comments received;

(5) any comments received from the regional coordinating boards; and

(6) the presence or absence of any significant gaps in the factual record.

If the applicant demands a contested case hearing no later than the conclusion of the period provided in section 62J.2915, subdivision 2, for the applicant to respond to comments, the commissioner shall not select a procedure. Instead, the applicant shall be given a contested case proceeding as a matter of right."

62J.2917 [Repealed, 1997 c 237 s 22]

NOTE: Subdivision 2 was also amended by Laws 1997, chapter 225, article 2, section 27, to read as follows:

"Subd. 2. **Factors.** (a) **Generally applicable factors.** In making a determination about cost, access, and quality, the commissioner may consider the following factors, to the extent relevant:

(1) whether the proposal is compatible with the applicable regional plans of the regional coordinating boards;

(2) market structure:

(i) actual and potential sellers and buyers, or providers and purchasers;

(ii) actual and potential consumers;

(iii) geographic market area; and

(iv) entry conditions;

(3) current market conditions;

(4) the historical behavior of the market;

(5) performance of other, similar arrangements;

(6) whether the proposal unnecessarily restrains competition or restrains competition in ways not reasonably related to the purposes of this chapter; and

(7) the financial condition of the applicant.

(b) **Cost.** The commissioner's analysis of cost must focus on the individual consumer of health care. Cost savings to be realized by providers, health carriers, group purchasers, or other participants in the health care system are relevant only to the extent that the savings are likely to be passed on to the consumer. However, where an application is submitted by providers or purchasers who are paid primarily by third party payers unaffiliated with the applicant, it is sufficient for the applicant to show that cost savings are likely to be passed on to the unaffiliated third party payers; the applicants do not have the burden of proving that third party payers with whom the applicants are not affiliated will pass on cost savings to individuals receiving coverage through the third party payers. In making determinations as to costs, the commissioner may consider:

(1) the cost savings likely to result to the applicant;

(2) the extent to which the cost savings are likely to be passed on to the consumer and in what form;

(3) the extent to which the proposed arrangement is likely to result in cost shifting by the applicant onto other payers or purchasers of other products or services;

(4) the extent to which the cost shifting by the applicant is likely to be followed by other persons in the market;

(5) the current and anticipated supply and demand for any products or services at issue;

(6) the representations and guarantees of the applicant and their enforceability;

(7) likely effectiveness of regulation by the commissioner;

(8) inferences to be drawn from market structure;

(9) the cost of regulation, both for the state and for the applicant; and

(10) any other factors tending to show that the proposed arrangement is or is not likely to reduce cost.

(c) **Access.** In making determinations as to access, the commissioner may consider:

(1) the extent to which the utilization of needed health care services or products by the intended targeted population is likely to increase or decrease. When a proposed arrangement is likely to increase access in one geographic area, by lowering prices or otherwise expanding supply, but limits access in another geographic area by removing service capabilities from that second area, the commissioner shall articulate the criteria employed to balance these effects;

(2) the extent to which the proposed arrangement is likely to make available a new and needed service or product to a certain geographic area; and

(3) the extent to which the proposed arrangement is likely to otherwise make health care services or products more financially or geographically available to persons who need them.

If the commissioner determines that the proposed arrangement is likely to increase access and bases that determination on a projected increase in utilization, the commissioner shall also determine and make a specific finding that the increased utilization does not reflect overutilization.

(d) **Quality.** In making determinations as to quality, the commissioner may consider the extent to which the proposed arrangement is likely to:

(1) decrease morbidity and mortality;

(2) result in faster convalescence;

(3) result in fewer hospital days;

(4) permit providers to attain needed experience or frequency of treatment, likely to lead to better outcomes;

(5) increase patient satisfaction; and

(6) have any other features likely to improve or reduce the quality of health care."

62J.2918 [Repealed, 1997 c 237 s 22]

62J.2919 [Repealed, 1997 c 237 s 22]

62J.2920 [Repealed, 1997 c 237 s 22]

62J.2921 [Repealed, 1997 c 237 s 22]

NOTE: Subdivision 2 was also amended by Laws 1997, chapter 225, article 2, section 28, to read as follows:

"Subd. 2. **Notice.** The commissioner shall begin a proceeding to revoke approval by providing written notice to the applicant describing in detail the basis for the proposed revocation. Notice of the proceeding must be published in the State Register and submitted to the applicable regional coordinating boards. The notice must invite the submission of comments to the commissioner."

62J.2930 INFORMATION CLEARINGHOUSE.

Subdivision 1. **Establishment.** The commissioner of health shall establish an information clearinghouse within the department of health to facilitate the ability of consumers, employers, providers, health plan companies, and others to obtain information on health reform activities in Minnesota. The commissioner shall make available through the clearinghouse updates on federal and state health reform activities, including information developed or collected by the department of health on cost containment or other research initiatives, the development of voluntary purchasing pools, action plans submitted by health plan companies, reports or recommendations of the health technology advisory committee and other entities on technology assessments, and reports or recommendations from other formal committees applicable to health reform activities. The clearinghouse shall also refer requestors to sources of further information or assistance. The clearinghouse is subject to chapter 13.

[For text of subd 2, see M.S.1996]

Subd. 3. **Consumer information.** The information clearinghouse or another entity designated by the commissioner shall provide consumer information to health plan company enrollees to:

(1) assist enrollees in understanding their rights;

(2) explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, and the departments of health and commerce;

(3) provide information on coverage options in each regional coordinating board region of the state;

(4) provide information on the availability of purchasing pools and enrollee subsidies; and

(5) help consumers use the health care system to obtain coverage.

The information clearinghouse or other entity designated by the commissioner for the purposes of this subdivision shall not:

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

(3) serve as an advocate for consumers in disputes with health plan companies.

Nothing in this subdivision shall interfere with the ombudsman program established under section 256B.031, subdivision 6, or other existing ombudsman programs.

[For text of subd 4, see M.S.1996]

History: *1997 c 225 art 2 s 62*

62J.301 RESEARCH AND DATA INITIATIVES.

[For text of subds 1 and 2, see M.S.1996]

Subd. 3. **General duties.** The commissioner shall:

(1) collect and maintain data which enable population–based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;

(2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;

(3) collect and maintain data for the purposes of setting cost containment goals under section 62J.04, and measuring cost containment goal compliance;

(4) conduct applied research using existing and new data and promote applications based on existing research;

(5) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plan companies, as defined in section 62Q.01, subdivision 4;

(6) work closely with health plan companies and health care providers to promote improvements in health care efficiency and effectiveness; and

(7) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management.

[For text of subds 4 and 5, see M.S.1996]

History: *1997 c 150 s 5*

62J.321 DATA COLLECTION AND PROCESSING PROCEDURES.

[For text of subds 1 to 4, see M.S.1996]

Subd. 5. **Data classification.** (a) Data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 that identify individual patients or providers are private data on individuals. Data not on individuals are nonpublic data. The commissioner shall establish procedures and safeguards to ensure that data released by the commissioner is in a form that does not identify specific patients, providers, employers, individual or group purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter.

(b) Raw unaggregated data collected from household and employer surveys used by the commissioner to monitor the number of uninsured individuals, reasons for lack of insurance coverage, and to evaluate the effectiveness of health care reform, are subject to the same data classifications as data collected pursuant to sections 62J.301 to 62J.42.

(c) Notwithstanding sections 13.03, subdivisions 6 to 8; 13.10, subdivisions 1 to 4; and 138.17, data received by the commissioner pursuant to sections 62J.301 to 62J.42, shall retain the classification designated under this section and shall not be disclosed other than pursuant to this section.

(d) Summary data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 may be disseminated under section 13.05, subdivision 7. For the purposes of this section, summary data includes nonpublic data not on individuals.

(e) Notwithstanding paragraph (a), the commissioner may publish nonpublic or private data collected pursuant to sections 62J.301 to 62J.42 on health care costs and spending, quality and outcomes, and utilization for health care institutions, individual health care professionals and groups of health care professionals, and group purchasers, with a description of the methodology used for analysis. The commissioner may not make public any patient identifying information except as specified in law. The commissioner shall not reveal the name of an institution, group of professionals, individual health care professional, or group purchaser until after the institution, group of professionals, individual health care professional, or group purchaser has had 21 days to review the data and comment. The commissioner shall include comments received in the release of the data.

(f) A provider or group purchaser may contest whether the data meets the criteria of section 62J.311, subdivision 2, paragraph (a), clause (2), in accordance with a contested case

proceeding as set forth in sections 14.57 to 14.62, subject to appeal in accordance with sections 14.63 to 14.68. To obtain a contested case hearing, the provider or group purchaser must make a written request to the commissioner before the end of the time period for review and comment. Within ten days of the assignment of an administrative law judge, the provider or group purchaser shall make a clear showing to the administrative law judge of probable success in a hearing on the issue of whether the data are accurate and valid and were collected based on the criteria of section 62J.311, subdivision 2, paragraph (a), clause (2). If the administrative law judge determines that the provider or group purchaser has made such a showing, the data shall remain private or nonpublic during the contested case proceeding and appeal. If the administrative law judge determines that the provider or group purchaser has not made such a showing, the commissioner may publish the data immediately, with comments received in the release of the data. The contested case proceeding and subsequent appeal is not an exclusive remedy and any person may seek a remedy pursuant to section 13.08, subdivisions 1 to 4, or as otherwise authorized by law.

[For text of subds 6 to 8, see M.S.1996]

History: *1997 c 225 art 2 s 62*

62J.322 PROVIDER INFORMATION PILOT STUDY.

The commissioner shall develop a pilot study to collect comparative data from health care providers on opportunities and barriers to the provision of quality, cost–effective health care. The provider information pilot study shall include providers in community integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. Health plan companies and group purchasers shall provide to the commissioner providers' names, health plan assignment, and other appropriate data necessary for the commissioner to conduct the study. The provider information pilot study shall examine factors that increase and hinder access to the provision of quality, cost–effective health care. The study may examine:

(1) administrative barriers and facilitators;

(2) time spent obtaining permission for appropriate and necessary treatments;

(3) latitude to order appropriate and necessary tests, pharmaceuticals, and referrals to specialty providers;

(4) assistance available for decreasing administrative and other routine paperwork activities;

(5) continuing education opportunities provided;

(6) access to readily available information on diagnoses, diseases, outcomes, and new technologies;

(7) continuous quality improvement activities;

(8) inclusion in administrative decision making;

(9) access to social services and other services that facilitate continuity of care;

(10) economic incentives and disincentives;

(11) peer review procedures; and

(12) the prerogative to address public health needs.

In selecting additional data for collection, the commissioner shall consider the: (i) statistical validity of the data; (ii) public need for the data; (iii) estimated expense of collecting and reporting the data; and (iv) usefulness of the data to identify barriers and opportunities to improve quality care provision within health plan companies.

History: *1997 c 225 art 2 s 62*

62J.37 [Repealed, 1997 c 225 art 2 s 63]

62J.41 DATA FROM PROVIDERS.

Subdivision 1. **Cost containment data to be collected from providers.** The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on:

(1) the total number of patients served;

(2) the total number of patients served by state of residence and Minnesota county;

(3) the site or sites where the health care provider provides services;

(4) the number of individuals employed, by type of employee, by the health care provider;

(5) the services and their costs for which no payment was received;

(6) total revenue by type of payer or by groups of payers, including but not limited to, revenue from Medicare, medical assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, health maintenance organizations, and individual patients;

(7) revenue from research activities;

(8) revenue from educational activities;

(9) revenue from out–of–pocket payments by patients;

(10) revenue from donations; and

(11) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs.

The commissioner may, by rule, modify the data submission categories listed above if the commissioner determines that this will reduce the reporting burden on providers without having a significant negative effect on necessary data collection efforts.

[For text of subd 2, see M.S.1996]

History: *1997 c 225 art 2 s 62*

62J.451 MINNESOTA HEALTH DATA INSTITUTE.

[For text of subds 1 to 6a, see M.S.1996]

Subd. 6b. **Consumer surveys.** (a) The health data institute shall develop and implement a mechanism for collecting comparative data on consumer perceptions of the health care system, including consumer satisfaction, through adoption of a standard consumer survey. This survey shall include enrollees in community integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. The health data institute shall determine a mechanism for the inclusion of the uninsured. This consumer survey may be conducted every two years. A focused survey may be conducted on the off years. Health plan companies and group purchasers shall provide to the health data institute roster data as defined in subdivision 2, including the names, addresses, and telephone numbers of enrollees and former enrollees and other data necessary for the completion of this survey. This roster data provided by the health plan companies and group purchasers is classified as provided under section 62J.452. The health data institute may analyze and prepare findings from the raw, unaggregated data, and the findings from this survey may be included in the health plan company performance reports specified in subdivision 6a, and in other reports developed and disseminated by the health data institute and the commissioner. The raw, unaggregated data is classified as provided under section 62J.452, and may be made available by the health data institute to the extent permitted under section 62J.452. The health data institute shall provide raw, unaggregated data to the commissioner. The survey may include information on the following subjects:

(1) enrollees' overall satisfaction with their health care plan;

(2) consumers' perception of access to emergency, urgent, routine, and preventive care, including locations, hours, waiting times, and access to care when needed;

(3) premiums and costs;

(4) technical competence of providers;

(5) communication, courtesy, respect, reassurance, and support;

(6) choice and continuity of providers;

(7) continuity of care;

(8) outcomes of care;

(9) services offered by the plan, including range of services, coverage for preventive and routine services, and coverage for illness and hospitalization;

(10) availability of information; and

(11) paperwork.

(b) The health data institute shall appoint a consumer advisory group which shall consist of 13 individuals, representing enrollees from public and private health plan companies and programs and two uninsured consumers, to advise the health data institute on issues of concern to consumers. The advisory group must have at least one member from each regional coordinating board region of the state. The advisory group expires June 30, 1996.

Subd. 6c. **Provider organization performance measurement.** (a) As part of the performance measurement plan specified in subdivision 6, the health data institute shall develop a mechanism to assess the performance of hospitals and other provider organizations, and to disseminate this information to consumers, purchasers, policymakers, and other interested parties, consistent with the data policies specified in section 62J.452. Data to be collected may include structural characteristics including staff–mix and nurse–patient ratios. In selecting additional data for collection, the health data institute may consider:

(1) feasibility and statistical validity of the indicator;

(2) purchaser and public demand for the indicator;

(3) estimated expense of collecting and reporting the indicator; and

(4) usefulness of the indicator for internal improvement purposes.

(b) The health data institute may conduct consumer surveys that focus on health care provider organizations. Health care provider organizations may provide roster data, as defined in subdivision 2, including names, addresses, and telephone numbers of their patients, to the health data institute for purposes of conducting the surveys. Roster data provided by health care provider organizations under this paragraph are private data on individuals as defined in section 13.02, subdivision 12. Providing data under this paragraph does not constitute a release of health records for purposes of section 144.335, subdivision 3a.

[For text of subds 7 to 16, see M.S.1996]

History: *1997 c 225 art 2 s 29,62; 1997 c 228 s 1*

62J.48 CRITERIA FOR REIMBURSEMENT.

All ambulance services licensed under section 144E.10 are eligible for reimbursement under health plan companies. The commissioner shall require health plan companies to adopt the following reimbursement policies.

(1) All scheduled or prearranged air and ground ambulance transports must be reimbursed if requested by an attending physician or nurse, and, if the person is an enrollee in a health plan company, if approved by a designated representative of a health plan company who is immediately available on a 24–hour basis. The designated representative must be a registered nurse or a physician assistant with at least three years of critical care or trauma experience, or a licensed physician.

(2) Reimbursement must be provided for all emergency ambulance calls in which a patient is transported or medical treatment rendered.

(3) Special transportation services must not be billed or reimbursed if the patient needs medical attention immediately before transportation.

History: *1997 c 199 s 14*

62J.49 AMBULANCE SERVICES FINANCIAL DATA.

Subdivision 1. **Establishment.** The emergency medical services regulatory board established under chapter 144 shall establish a financial data collection system for all ambulance services licensed in this state. To establish the financial database, the emergency medi-

cal services regulatory board may contract with an entity that has experience in ambulance service financial data collection.

Subd. 2. **Data classification.** All financial data collected by the emergency medical services regulatory board shall be classified as nonpublic data under section 13.02, subdivision 9.

History: *1997 c 203 art 2 s 1*

62J.54 IDENTIFICATION AND IMPLEMENTATION OF UNIQUE IDENTIFIERS.

Subdivision 1. **Unique identification number for health care provider organizations.** (a) Not later than 24 months after the date on which a unique health identifier for health care providers is adopted or established under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify health care provider organizations, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d–4 (1996 and subsequent amendments), shall use a unique identification number to identify health provider organizations no later than 36 months after the date on which a unique health identifier for health care providers is adopted or established under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments).

(c) The unique health identifier for health care providers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments), shall be used as the unique identification number for health care provider organizations.

(d) Provider organizations required to have a unique health identifier are:

(1) hospitals licensed under chapter 144;

(2) nursing homes and hospices licensed under chapter 144A;

(3) subacute care facilities;

(4) individual providers organized as a clinic or group practice;

(5) independent laboratory, pharmacy, surgery, radiology, or outpatient facilities;

(6) ambulance services licensed under chapter 144;

(7) special transportation services certified under chapter 174; and

(8) other provider organizations as required by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments).

Provider organizations shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the unique health care provider organization identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 2. **Unique identification number for individual health care providers.** (a) Not later than 24 months after the date on which a unique health identifier for health care providers is adopted or established under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify an individual health care provider, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d–4 (1996 and subsequent amendments), shall use a unique identification number to identify an individual health care provider no later than 36 months after the date on which a unique health identifier for health care providers is adopted or established under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments).

(c) The unique health identifier for health care providers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments), shall be used as the unique identification number for individual health care providers.

(d) Individual providers required to have a unique health identifier are:

(1) physicians licensed under chapter 147;

(2) dentists licensed under chapter 150A;

(3) chiropractors licensed under chapter 148;

(4) podiatrists licensed under chapter 153;

(5) physician assistants as defined under section 147A.01;

(6) advanced practice nurses as defined under section 62A.15;

(7) doctors of optometry licensed under section 148.57;

(8) pharmacists licensed under chapter 151;

(9) individual providers who may bill Medicare for medical and other health services as defined in United States Code, title 42, section 1395x(s);

(10) individual providers who are providers for state and federal health care programs administered by the commissioner of human services; and

(11) other individual providers as required by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments).

Providers shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the unique individual health care provider identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 3. **Unique identification number for group purchasers.** (a) Not later than 24 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d–4 (1996 and subsequent amendments), shall use a unique identification number to identify group purchasers no later than 36 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments).

(c) The unique health identifier for health plans and employers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments), shall be used as the unique identification number for group purchasers.

(d) Group purchasers shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) The unique group purchaser identifier, as described in this section, shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 4. **Unique patient identification number.** (a) Not later than 24 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments),

all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d–4 (1996 and subsequent amendments), shall use a unique identification number to identify each patient who receives health care services in Minnesota no later than 36 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments).

(c) The unique health identifier for individuals adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments), shall be used as the unique patient identification number, except as provided in paragraphs (e) and (f).

(d) The unique patient identification number shall be used by group purchasers and health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(e) Within the limits of available appropriations, the commissioner shall develop a proposal for an alternate numbering system for patients who do not have or refuse to provide their social security numbers, if:

(1) a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d–8 (1996 and subsequent amendments);

(2) the unique health identifier is the social security number of the patient;

(3) there is no federal alternate numbering system for patients who do not have or refuse to provide their social security numbers; and

(4) federal law or the federal Secretary of Health and Human Services explicitly allows a state to develop an alternate numbering system for patients who do not have or refuse to provide their social security numbers.

(f) If an alternate numbering system is developed under paragraph (e), patients who use numbers issued by the alternate numbering system are not required to provide their social security numbers and group purchasers or providers may not demand the social security numbers of patients who provide numbers issued by the alternate numbering system. If an alternate numbering system is developed under paragraph (e), group purchasers and health care providers shall establish procedures to notify patients that they can elect not to have their social security number used as the unique patient identifier.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

History: *1997 c 228 s 2; 1Sp1997 c 5 s 16*

62J.60 STANDARDS FOR THE MINNESOTA UNIFORM HEALTH CARE IDENTIFICATION CARD.

[For text of subds 1 and 2, see M.S.1996]

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be the card's front background. No standard label is required for this data element;

(2) claim submission number. The standardized label for this element is "Clm Subm #";

(3) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

(4) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last

name, optional space and name suffix. The standardized label for this data element is "Name";

(5) account number(s), which is any other number, such as a group number, if required for part of the identification or claims process. The standardized label for this data element is "Account";

(6) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

(7) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health. The standard label for this data element is "Svc Type"; and

(8) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the Minnesota health identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission name(s) and address(es), which are the name(s) and address(es) of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled; and

(2) telephone number(s) and name(s); which are the telephone number(s) and name(s) of the following contact(s) with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the card for health maintenance organizations:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

[For text of subd 4, see M.S.1996]

History: *1997 c 205 s 17; 1997 c 225 art 2 s 62*

62J.61 RULEMAKING; IMPLEMENTATION.

Subdivision 1. **Exemption.** The commissioner of health is exempt from chapter 14, including section 14.386, in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.59.

Subd. 2. **Procedure.** (a) The commissioner shall publish proposed rules in the State Register or, if the commissioner determines that publishing the text of the proposed rules

would be unduly cumbersome, shall publish notice of the proposed rules that contains a detailed description of the rules along with a statement that a free copy of the entire set of rules is available upon request to the agency.

(b) Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish notice in the State Register that the rules have been adopted 30 days before they are to take effect.

(c) If the adopted rules are the same as the proposed rules, the notice shall state that the rules have been adopted as proposed and shall cite the prior publication. If the adopted rules differ from the proposed rules, the portions of the adopted rules which differ from the proposed rules shall be included in the notice of adoption together with a citation to the prior State Register that contained the notice of the proposed rules.

(d) The commissioner may use rulemaking to implement the remainder of this article.

Subd. 3. **Restrictions.** The commissioner shall not adopt any rules requiring patients to provide their social security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter.

Subd. 4. **Patient privacy.** The commissioner shall seek comments from the ethics and confidentiality committee of the Minnesota health data institute and the department of administration, public information policy analysis division, before adopting or publishing final rules relating to issues of patient privacy and medical records.

Subd. 5. **Biennial review of rulemaking procedures and rules.** The commissioner shall biennially seek comments from affected parties about the effectiveness of and continued need for the rulemaking procedures set out in subdivision 2 and about the quality and effectiveness of rules adopted using these procedures. The commissioner shall seek comments by holding a meeting and by publishing a notice in the State Register that contains the date, time, and location of the meeting and a statement that invites oral or written comments. The notice must be published at least 30 days before the meeting date. The commissioner shall write a report summarizing the comments and shall submit the report to the Minnesota health data institute and to the Minnesota administrative uniformity committee by January 15 of every even–numbered year.

History: *1997 c 187 art 4 s 3*

62J.68 SENIOR DRUG DISCOUNT PROGRAM.

[For text of subds 1 to 4, see M.S.1996]

Subd. 5. **Eligibility.** (a) Senior citizens are eligible for the program if:

(1) their household income does not exceed 200 percent of the federal poverty guidelines;

(2) they are enrolled in Medicare Part A and Part B;

(3) they do not have coverage for prescription drugs under a health plan, as defined in section 62Q.01, subdivision 3;

(4) they do not have coverage for prescription drugs under a Medicare supplement plan, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1976 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended, or coverage for prescription drugs under medical assistance under chapter 256B, general assistance medical care under chapter 256D, MinnesotaCare, or the qualified medical beneficiaries program;

(5) they meet the residency requirements established under section 256L.09; and

(6) they do not have coverage for prescription drugs under medical assistance, general assistance medical care, MinnesotaCare, or the qualified Medicare beneficiary program.

(b) The commissioner of human services shall provide each eligible senior with a Minnesota health care programs card indicating enrollment in the senior drug discount program.

Eligible seniors must present this card to the participating pharmacy in order to receive the discounted price.

[For text of subds 6 to 9, see M.S.1996]

62J.685 PRESCRIPTION DRUG PRICE DISCLOSURE.

By January 1, 1998, and annually thereafter, a health plan company or hospital licensed under chapter 144 must submit to the attorney general the total amount of: (1) aggregate purchases of prescription drugs, and (2) discount, rebate, or other payment received during the previous calendar year for aggregate purchases of prescription drugs, including any fee associated with education, data collection, research, training or market share movement received from a manufacturer as defined under section 151.44, paragraph (c), or wholesale drug distributor as defined under section 151.44, paragraph (d). The identification of individual manufacturers or wholesalers or specific drugs is not required. The attorney general shall make this information available to the public through the information clearinghouse under section 62J.2930.

History: *1997 c 202 art 2 s 35*

62J.69 MEDICAL EDUCATION AND RESEARCH TRUST FUND.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Medical education" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, dentists, advanced practice nurses (clinical nurse specialist, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(b) "Clinical training" means accredited training that is funded and was historically funded in part by inpatient care revenues and that occurs in both inpatient and ambulatory care settings.

(c) "Trainee" means students involved in an accredited clinical training program for medical education as defined in paragraph (a).

(d) "Health care research" means approved clinical, outcomes, and health services investigations that are funded by patient out–of–pocket expenses or a third–party payer.

(e) "Commissioner" means the commissioner of health.

(f) "Teaching institutions" means any hospital, medical center, clinic, or other organization that currently sponsors or conducts accredited medical education programs or clinical research in Minnesota.

Subd. 2. **Allocation and funding for medical education and research.** (a) The commissioner may establish a trust fund for the purposes of funding medical education and research activities in the state of Minnesota.

(b) By January 1, 1997, the commissioner may appoint an advisory committee to provide advice and oversight on the distribution of funds from the medical education and research trust fund. If a committee is appointed, the commissioner shall: (1) consider the interest of all stakeholders when selecting committee members; (2) select members that represent both urban and rural interest; and (3) select members that include ambulatory care as well as inpatient perspectives. The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers, public and private academic medical centers, managed care organizations, Blue Cross and Blue Shield of Minnesota, commercial carriers, Minnesota Medical Association, Minnesota Nurses Association, medical product manufacturers, employers, and other relevant stakeholders, including consumers. The advisory committee is governed by section 15.059, for membership terms and removal of members and will sunset on June 30, 1999.

(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs operating in Minnesota. Applications must be submitted by the sponsoring institution on behalf of the teaching program, and must be received by September 30 of each year for distribution in January of the following year. An application for funds must include the following:

(1) the official name and address of the sponsoring institution and the official name and address of the facility or program on whose behalf the institution is applying for funding;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) the total number, type, and specialty orientation of eligible Minnesota–based trainees in each accredited medical education program for which funds are being sought;

(4) audited clinical training costs per trainee for each medical education program;

(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support;

(6) other revenue received for the purposes of clinical training;

(7) a statement identifying unfunded costs; and

(8) other supporting information the commissioner, with advice from the advisory committee, determines is necessary for the equitable distribution of funds.

(d) The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available; (2) total eligible trainees in each eligible education program; and (3) the statewide average cost per trainee, by type of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources. Funds shall be distributed to the sponsoring institutions indicating the amount to be paid to each of the sponsor's medical education programs based on the criteria in this paragraph. Sponsoring institutions which receive funds from the trust fund must distribute approved funds to the medical education program according to the commissioner's approval letter. Further, programs must distribute funds among the sites of training based on the percentage of total program training performed at each site.

(e) Medical education programs receiving funds from the trust fund must submit annual cost and program reports through the sponsoring institution based on criteria established by the commissioner. The reports must include:

(1) the total number of eligible trainees in the program;

(2) the programs and residencies funded, the amounts of trust fund payments to each program, and within each program, the percentage distributed to each training site;

(3) the average cost per trainee and a detailed breakdown of the components of those costs;

(4) other state or federal appropriations received for the purposes of clinical training;

(5) other revenue received for the purposes of clinical training; and

(6) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training.

The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year.

(f) The commissioner is authorized to distribute funds made available through:

(1) voluntary contributions by employers or other entities;

(2) allocations for the department of human services to support medical education and research; and

(3) other sources as identified and deemed appropriate by the legislature for inclusion in the trust fund.

(g) The advisory committee shall continue to study and make recommendations on:

(1) the funding of medical research consistent with work currently mandated by the legislature and under way at the department of health; and

(2) the costs and benefits associated with medical education and research.

Subd. 3. **Medical assistance and general assistance service.** The commissioner of health, in consultation with the medical education and research costs advisory committee, shall develop a system to recognize those teaching programs which serve higher numbers or high proportions of public program recipients and shall report to the legislative commission

on health care access by January 15, 1998, on an allocation formula to implement this system.

History: *1997 c 203 art 2 s 2,3; 1997 c 205 s 18*

PATIENT PROTECTION ACT

62J.695 CITATION.

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

History: *1997 c 237 s 1*

62J.70 DEFINITIONS.

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

Subd. 2. **Health care provider or provider.** "Health care provider" or "provider" means:

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

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

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

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

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

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

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

History: *1997 c 237 s 2*

62J.71 PROHIBITED PROVIDER CONTRACTS.

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

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

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

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

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

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

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

(1) a health plan company;

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

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

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

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

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

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

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

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

History: *1997 c 237 s 3*

62J.72 DISCLOSURE OF HEALTH CARE PROVIDER INFORMATION.

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

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

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

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

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

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

(d) A disclosure statement that has voluntarily been filed with the commissioner for approval under chapter 72C or voluntarily filed with the commissioner for approval for purposes other than pursuant to chapter 72C is deemed approved 30 days after the date of filing,

unless approved or disapproved by the commissioner on or before the end of that 30–day period.

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

(f) Health plan companies and providers may enter into agreements to determine how to respond to enrollee requests received by either the provider or the health plan company. This subdivision does not require disclosure of specific amounts paid to a provider, provider fee schedules, provider salaries, or other proprietary information of a specific health plan company or health insurer or health coverage plan or provider.

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

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

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

History: *1997 c 237 s 4*

62J.73 PROHIBITION ON EXCLUSIVE ARRANGEMENTS.

Subdivision 1. **Prohibition on exclusive relationships.** No provider, group of providers, or health plan company shall restrict a person's right to provide health services or procedures to another provider, group of providers, or health plan company, unless the person is an employee.

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

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

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

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

History: *1997 c 237 s 5*

62J.74 ENFORCEMENT.

Subdivision 1. **Authority.** The commissioners of health and commerce shall each periodically review contracts and arrangements among health care providing entities and health plan companies they regulate to determine compliance with sections 62J.70 to 62J.73. Any person may submit a contract or arrangement to the relevant commissioner for review if the person believes sections 62J.70 to 62J.73 have been violated. Any provision of a contract or arrangement found by the relevant commissioner to violate this section is null and void, and the relevant commissioner may assess civil penalties against the health plan company in an

amount not to exceed $2,500 for each day the contract or arrangement is in effect, and may use the enforcement procedures otherwise available to the commissioner. All due process rights afforded under chapter 14 apply to this section.

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

History: *1997 c 237 s 6*

62J.75 CONSUMER ADVISORY BOARD.

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

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

(2) are not registered lobbyists; and

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

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

(c) The board shall advise the commissioners of health and commerce on the following:

(1) the needs of health care consumers and how to better serve and educate the consumers on health care concerns and recommend solutions to identified problems; and

(2) consumer protection issues in the self–insured market, including, but not limited to, public education needs.

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

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

History: *1997 c 237 s 7*

62J.76 NONPREEMPTION.

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

History: *1997 c 237 s 8*