CHAPTER 62Q

REQUIREMENTS FOR HEALTH PLAN COMPANIES

62Q.01 DEFINITIONS.

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

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

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

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

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

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

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

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

[For text of subd 6, see M.S.1996]

History: *1997 c 225 art 2 s 37–39,62*

62Q.021 FEDERAL ACT; COMPLIANCE REQUIRED.

Each health plan company shall comply with the federal Health Insurance Portability and Accountability Act of 1996, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this section.

History: *1997 c 175 art 4 s 2*

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

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

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

(b) The commissioners of health and human services shall jointly convene a public programs risk adjustment work group responsible for advising the commissioners in the design of the public programs risk adjustment system. The public programs risk adjustment work group is governed by section 15.059 for purposes of membership terms and removal of members and shall terminate on June 30, 1999. The work group shall meet at the discretion of the commissioners of health and human services. The commissioner of health shall work with the risk adjustment association to ensure coordination between the risk adjustment systems for the public and private sectors. The commissioner of human services shall seek any needed federal approvals necessary for the inclusion of the medical assistance program in the public programs risk adjustment system.

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

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

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

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

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

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

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

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

(d) The commissioners of health and human services, with the advice of the public programs risk adjustment work group, shall develop a work plan and time frame and shall coordinate their efforts with the private sector risk adjustment association's activities and other state initiatives related to public program managed care reimbursement.

[For text of subds 5b to 12, see M.S.1996]

History: *1997 c 192 s 18; 1997 c 225 art 2 s 40*

62Q.07 ACTION PLANS.

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

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

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

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

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

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

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

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

History: *1997 c 225 art 2 s 62*

62Q.075 LOCAL PUBLIC ACCOUNTABILITY AND COLLABORATION PLAN.

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

[For text of subds 2 to 4, see M.S.1996]

History: *1997 c 225 art 2 s 62*

62Q.105 HEALTH PLAN COMPANY COMPLAINT PROCEDURE.

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

[For text of subds 2 to 8, see M.S.1996]

History: *1997 c 237 s 9*

62Q.106 DISPUTE RESOLUTION BY COMMISSIONER.

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

History: *1997 c 225 art 2 s 41*

62Q.145 ABORTION AND SCOPE OF PRACTICE.

Health plan company policies related to scope of practice for allied independent health providers as defined in section 62Q.095, subdivision 5, midlevel practitioners as defined in section 144.1495, subdivision 1, and other nonphysician health care professionals must comply with the requirements governing the performance of abortions in section 145.412, subdivision 1.

History: *1997 c 183 art 2 s 20*

62Q.165 UNIVERSAL COVERAGE.

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

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

62Q.18 PORTABILITY OF COVERAGE.

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

(1) "continuous coverage" has the meaning given in section 62L.02, subdivision 9;

(2) "guaranteed issue" means:

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

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

(3) "large employer" means an entity that would be a small employer, as defined in section 62L.02, subdivision 26, except that the entity has more than 50 current employees, based upon the method provided in that subdivision for determining the number of current employees;

(4) "preexisting condition" has the meaning given in section 62L.02, subdivision 23; and

(5) "qualifying coverage" has the meaning given in section 62L.02, subdivision 24.

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

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

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

(3) with respect to a group health plan offered, sold, issued, or renewed to a large employer, impose preexisting condition limitations or preexisting condition exclusions except to the extent that would be permitted under chapter 62L if the group sponsor were a small employer as defined in section 62L.02, subdivision 26.

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

History: *1997 c 175 art 3 s 1,2*

62Q.181 WRITTEN CERTIFICATION OF COVERAGE.

A health plan company shall provide the written certifications of coverage required under United States Code, title 42, sections 300gg(e) and 300gg–43. This section applies only to coverage that is subject to regulation under state law and only to the extent that the certification of coverage is required under federal law. The commissioner shall enforce this section.

History: *1997 c 175 art 4 s 3*

62Q.185 GUARANTEED RENEWABILITY; LARGE EMPLOYER GROUP HEALTH COVERAGE.

(a) No health plan company, as defined in section 62Q.01, subdivision 4, shall refuse to renew a health benefit plan, as defined in section 62L.02, subdivision 15, but issued to a large employer, as defined in section 62Q.18, subdivision 1.

(b) This section does not require renewal if:

(1) the large employer has failed to pay premiums or contributions as required under the terms of the health benefit plan, or the health plan company has not received timely premium payments unless the late payments were received within a grace period provided under state law;

(2) the large employer has performed an act or practice that constitutes fraud or misrepresentation of material fact under the terms of the health benefit plan;

(3) the large employer has failed to comply with a material plan provision relating to employer contribution or group participation rules not prohibited by state law;

(4) the health plan company is ceasing to offer coverage in the large employer market in this state in compliance with United States Code, title 42, section 300gg–12(c), and applicable state law;

(5) in the case of a health maintenance organization, there is no longer any enrollee in the large employer's health benefit plan who lives, resides, or works in the approved service area; or

(6) in the case of a health benefit plan made available to large employers only through one or more bona fide associations, the membership of the large employer in the association ceases, but only if such coverage is terminated uniformly without regard to any health–related factor relating to any covered individual.

(c) This section does not prohibit a health plan company from modifying the premium rate or from modifying the coverage for purposes of renewal.

History: *1997 c 175 art 3 s 3*

62Q.19 ESSENTIAL COMMUNITY PROVIDERS.

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

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

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

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

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

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

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

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal government, an Indian health service unit, or a community health board as defined in chapter 145A;

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

(5) a rural hospital that has qualified for a sole community hospital financial assistance grant in the past three years under section 144.1484, subdivision 1. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services.

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

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

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

[For text of subds 2 to 7, see M.S.1996]

History: *1997 c 225 art 2 s 42*

62Q.22 HEALTH CARE SERVICES PREPAID OPTION.

Subdivision 1. **Scope.** A community health clinic that is designated as an essential community provider under section 62Q.19 and is associated with a hospital, a governmental unit, or the University of Minnesota may offer to individuals and families the option of purchasing basic health care services on a fixed prepaid basis without satisfying the requirements of chapter 60A, 62A, 62C, or 62D, or any other law or rule that applies to entities licensed under those chapters.

Subd. 2. **Registration.** A community health clinic that offers a prepaid option under this section must register on an annual basis with the commissioner of health.

Subd. 3. **Premiums.** The premiums for a prepaid option offered under this section must be based on a sliding fee schedule based on current poverty income guidelines.

Subd. 4. **Health care services.** (a) A prepaid option offered under this section must provide basic health care services including:

(1) services for the diagnosis and treatment of injuries, illnesses, or conditions;

(2) child health supervision services up to age 18, as defined under section 62A.047; and

(3) preventive health services, including:

(i) health education;

(ii) health supervision, evaluation, and follow–up;

(iii) immunization; and

(iv) early disease detection.

(b) Inpatient hospital services shall not be offered as a part of a community health clinic's prepaid option. A clinic may associate with a hospital to provide hospital services to an individual or family who is enrolled in the prepaid option so long as these services are not offered as part of the prepaid option.

(c) All health care services included by the community health clinic in a prepaid option must be services that are offered within the scope of practice of the clinic by the clinic's professional staff.

Subd. 5. **Guaranteed renewability.** A community health clinic shall not refuse to renew a prepaid option, except for nonpayment of premiums, fraud, or misrepresentation, or as permitted under subdivisions 8 and 9, paragraph (b).

Subd. 6. **Information to be provided.** (a) A community health clinic must provide an individual or family who purchases a prepaid option a clear and concise written statement that includes the following information:

(1) the health care services that the prepaid option covers;

(2) any exclusions or limitations on the health care services offered, including any preexisting condition limitations, cost–sharing arrangements, or prior authorization requirements;

(3) where the health care services may be obtained;

(4) a description of the clinic's method for resolving patient complaints, including a description of how a patient can file a complaint with the department of health; and

(5) a description of the conditions under which the prepaid option may be canceled or terminated.

(b) The commissioner of health must approve a copy of the written statement before the community health clinic may offer the prepaid option described in this section.

Subd. 7. **Complaint process.** (a) A community health clinic that offers a prepaid option under this section must establish a complaint resolution process. As an alternative to establishing its own process, a community health clinic may use the complaint process of another organization.

(b) A community health clinic must make reasonable efforts to resolve complaints and to inform complainants in writing of the clinic's decision within 60 days of receiving the complaint.

(c) A community health clinic that offers a prepaid option under this section must report all complaints that are not resolved within 60 days to the commissioner of health.

Subd. 8. **Public assistance program eligibility.** A community health clinic may require an individual or family enrolled in the clinic's prepaid option to apply for medical assistance, general assistance medical care, or the MinnesotaCare program. The clinic must assist the individual or family in filing the application for the appropriate public program. If, upon the request of the clinic, an individual or family refuses to apply for these programs, the clinic may disenroll the individual or family from the prepaid option at any time.

Subd. 9. **Limitations on enrollment.** (a) A community health clinic may limit enrollment in its prepaid option. If enrollment is limited, a waiting list must be established.

(b) A community health clinic may deny enrollment in its prepaid option to an individual or family whose gross family income is greater than 275 percent of the federal poverty guidelines.

(c) No community health clinic may restrict or deny enrollment in its prepaid option because of an individual's or a family's financial limitations, except as permitted under this subdivision.

History: *1997 c 194 s 1*

62Q.25 [Repealed, 1997 c 225 art 2 s 63]

62Q.29 [Repealed, 1997 c 225 art 2 s 63]

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

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

History: *1997 c 237 s 10*

62Q.33 LOCAL GOVERNMENT PUBLIC HEALTH FUNCTIONS.

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

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

[For text of subds 3 to 5, see M.S.1996]

History: *1997 c 225 art 2 s 43*

62Q.41 [Repealed, 1997 c 225 art 2 s 63]

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

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

Subd. 2. **Definition.** For purposes of this section, "managed care organization" means:

(1) a health maintenance organization operating under chapter 62D;

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

(3) an insurance company licensed under chapter 60A, nonprofit health service plan corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

History: *1997 c 225 art 2 s 44*

62Q.52 DIRECT ACCESS TO OBSTETRIC AND GYNECOLOGIC SERVICES.

(a) Health plan companies shall allow female enrollees direct access to obstetricians and gynecologists for the following services:

(1) annual preventive health examinations, which shall include a gynecologic examination, and any subsequent obstetric or gynecologic visits determined to be medically necessary by the examining obstetrician or gynecologist, based upon the findings of the examination;

(2) maternity care; and

(3) evaluation and necessary treatment for acute gynecologic conditions or emergencies.

(b) For purposes of this section, "direct access" means that a female enrollee may obtain the obstetric and gynecologic services specified in paragraph (a) from obstetricians and gynecologists in the enrollee's network without a referral from, or prior approval through, another physician, the health plan company, or its representatives.

(c) Health plan companies shall not require higher copayments, coinsurance, deductibles, or other enrollee cost–sharing for direct access.

(d) This section applies only to services described in paragraph (a) that are covered by the enrollee's coverage, but coverage of a preventive health examination for female enrollees must not exclude coverage of a gynecologic examination.

History: *1997 c 26 s 1*

62Q.53 MENTAL HEALTH COVERAGE; MINIMUM STANDARDS FOR MEDICALLY NECESSARY CARE.

Subdivision 1. **Requirement.** No health plan that covers mental health services may be offered, sold, issued, or renewed in this state that requires mental health services to satisfy a definition of "medically necessary care," "medical necessity," or similar term that is more restrictive with respect to mental health than the definition provided in subdivision 2.

Subd. 2. **Minimum definition.** "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the enrollee's health; or

(2) prevent deterioration of the enrollee's condition.

Subd. 3. **Health plan; definition.** For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages listed in section 62A.011, subdivision 3, clauses (7) and (10).

History: *1997 c 49 s 1*

62Q.54 REFERRALS FOR RESIDENTS OF HEALTH CARE FACILITIES.

If an enrollee is a resident of a health care facility licensed under chapter 144A or a housing with services establishment registered under chapter 144D, the enrollee's primary care physician must refer the enrollee to that facility's skilled nursing unit or that facility's appropriate care setting, provided that the health plan company and the provider can best meet the patient's needs in that setting, if the following conditions are met:

(1) the facility agrees to be reimbursed at that health plan company's contract rate negotiated with similar providers for the same services and supplies; and

(2) the facility meets all guidelines established by the health plan company related to quality of care, utilization, referral authorization, risk assumption, use of health plan company network, and other criteria applicable to providers under contract for the same services and supplies.

History: *1997 c 225 art 2 s 45*

62Q.55 EMERGENCY SERVICES.

(a) Enrollees have the right to available and accessible emergency services, 24 hours a day and seven days a week. The health plan company shall inform its enrollees how to obtain emergency care and, if prior authorization for emergency services is required, shall make available a toll–free number, which is answered 24 hours a day, to answer questions about emergency services and to receive reports and provide authorizations, where appropriate, for treatment of emergency medical conditions. Emergency services shall be covered whether

provided by participating or nonparticipating providers and whether provided within or outside the health plan company's service area. In reviewing a denial for coverage of emergency services, the health plan company shall take the following factors into consideration:

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

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

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

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

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

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

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

History: *1997 c 237 s 11*

62Q.56 CONTINUITY OF CARE.

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

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

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

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

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

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

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

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

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

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

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

History: *1997 c 237 s 12*

62Q.58 ACCESS TO SPECIALTY CARE.

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

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

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

History: *1997 c 237 s 13*

62Q.64 DISCLOSURE OF EXECUTIVE COMPENSATION.

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

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

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

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

History: *1997 c 237 s 14*

62Q.65 ACCESS TO PROVIDER DISCOUNTS.

Subdivision 1. **Requirement.** A high deductible health plan must, when used in connection with a medical savings account, provide the enrollee access to any discounted provider fees for services covered by the high deductible health plan, regardless of whether the enrollee has satisfied the deductible for the high deductible health plan.

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

(1) "high deductible health plan" has the meaning given under the Internal Revenue Code of 1986, section 220(c)(2);

(2) "medical savings account" has the meaning given under the Internal Revenue Code of 1986, section 220(d)(1); and

(3) "discounted provider fees" means fees contained in a provider agreement entered into by the issuer of the high deductible health plan, or an affiliate of the issuer, for use in connection with the high deductible health plan.

History: *1997 c 225 art 2 s 46*