CHAPTER 62Q

REQUIREMENTS FOR HEALTH PLAN COMPANIES

62Q.01 DEFINITIONS.

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

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health for purposes of regulating health maintenance organizations, 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.

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

Subd. 3. **Health plan.** "Health plan" means a health plan as defined in section 62A.011 or 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.

Subd. 6. **Medicare-related coverage.** "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that sup-

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plement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts) or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

History: *1994 c 625 art 2 s 14; 1995 c 234 art 2 s 2–6; art 3 s 5; 1997 c 225 art 2 s 37–39,62; 1998 c 254 art 1 s 15*

62Q.02 APPLICABILITY OF CHAPTER.

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

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

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

History: *1995 c 234 art 2 s 7*

62Q.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.

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

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

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

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

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

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

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

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

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

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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.

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

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

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

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

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

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

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

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

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

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

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

(6) recommend market conduct guidelines; and

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

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

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

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

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

Subd. 10. **State oversight of risk adjustment activities.** The association's activities shall be supervised by the commissioners of health and commerce. The commissioners shall

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provide specific oversight functions during the development and implementation phases of the risk adjustment system as follows:

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

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

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

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

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

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

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

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

History: *1994 c 625 art 2 s 15; 1995 c 234 art 2 s 8–17; 1996 c 440 art 1 s 33; 1996 c 451 art 4 s 2; 1997 c 192 s 18; 1997 c 225 art 2 s 40; 1998 c 254 art 1 s 16*

62Q.07 ACTION PLANS.

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

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

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

(b) An action plan must include the number of full-time equivalent physicians, by specialty, nonphysician providers, and allied health providers used to provide services. The action plan must also describe how the health plan company intends to encourage the use of nonphysician providers, midlevel practitioners, and allied health professionals, through at least consumer education, physician education, and referral and advisement systems. The annual action plan must also include data that is broken down by type of provider, reflecting

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

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

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

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

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

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

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

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

History: *1994 c 625 art 7 s 1; 1995 c 234 art 8 s 17; 1996 c 451 art 4 s 3; 1997 c 225 art 2 s 62*

62Q.09 [EXPIRED]

62Q.095 EXPANDED PROVIDER NETWORKS.

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

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

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view by the health plan company of the care provided by an allied independent health provider in the expanded network after a referral is made.

Subd. 3. **Mandatory offering to enrollees.** (a) Each health plan company shall offer to enrollees the option of receiving covered services through the expanded network of allied independent health providers established under subdivisions 1 and 2. This expanded network option may be offered as a separate health plan. The network may establish separate premium rates and cost-sharing requirements for this expanded network plan, as long as these premium rates and cost-sharing requirements are actuarially justified and approved by the commissioner. This subdivision does not apply to Medicare, medical assistance, general assistance medical care, and MinnesotaCare.

(b) Information on this expanded provider network option must be provided by each health plan company during open enrollment and upon enrollment.

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

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

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

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

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

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

History: *1994 c 625 art 1 s 6,18; 1998 c 407 art 2 s 19*

62Q.096 CREDENTIALING OF PROVIDERS.

If a health plan company has initially credentialed, as providers in its provider network, individual providers employed by or under contract with an entity that:

(1) is authorized to bill under section 256B.0625, subdivision 5;

(2) meets the requirements of Minnesota Rules, parts 9520.0750 to 9520.0870;

(3) is designated an essential community provider under section 62Q.19; and

(4) is under contract with the health plan company to provide mental health services, the health plan company must continue to credential at least the same number of providers from that entity, as long as those providers meet the health plan company's credentialing standards.

A health plan company shall not refuse to credential these providers on the grounds that their provider network has a sufficient number of providers of that type.

History: *1998 c 407 art 8 s 4*

62Q.10 NONDISCRIMINATION.

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

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

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62Q.105 HEALTH PLAN COMPANY COMPLAINT PROCEDURE.

Subdivision 1. **Establishment.** Each health plan company shall establish and make available to enrollees, by July 1, 1999, an informal complaint resolution process that meets the requirements of this section. A health plan company must make reasonable efforts to resolve enrollee complaints, and must inform complainants in writing of the company's decision within 30 days of receiving the complaint. The complaint resolution process must treat the complaint and information related to it as required under sections 72A.49 to 72A.505.

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

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

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

Subd. 5. **Requirements for managed care organizations.** Each managed care organization shall submit all health care quality related complaints to its quality review board or quality review organization for evaluation and possible action. The complaint resolution process for managed care organizations must clearly indicate the entity responsible for resolving complaints made by enrollees against hospitals, other health care facilities, and health care providers, that are owned by or under contract with the managed care organization.

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

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

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

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

(2) how to request an impartial appeal;

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

(4) that they have the right to litigate.

History: *1995 c 234 art 2 s 21, 1997 c 237 s 9; 1998 c 407 art 2 s 20*

62Q.1055 CHEMICAL DEPENDENCY.

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

History: *1995 c 234 art 2 s 22*

62Q.106 DISPUTE RESOLUTION BY COMMISSIONER.

A complainant may at any time submit a complaint to the appropriate commissioner to investigate. After investigating a complaint, or reviewing a company's decision, the ap-

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propriate commissioner may order a remedy as authorized under section 62Q.30 or chapter 45, 60A, or 62D.

History: *1995 c 234 art 2 s 23; 1997 c 225 art 2 s 41*

62Q.107 PROHIBITED PROVISION; JUDICIAL REVIEW.

Beginning January 1, 1999, no health plan, including the coverages described in section 62A.011, subdivision 3, clauses (7) and (10), may specify a standard of review upon which a court may review denial of a claim or of any other decision made by a health plan company with respect to an enrollee. This section prohibits limiting court review to a determination of whether the health plan company's decision is arbitrary and capricious, an abuse of discretion, or any other standard less favorable to the enrollee than a preponderance of the evidence.

History: *1998 c 407 art 2 s 21*

62Q.11 DISPUTE RESOLUTION.

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

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

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

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

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

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

62Q.12 DENIAL OF ACCESS.

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

History: *1994 c 625 art 2 s 20*

62Q.135 CONTRACTING FOR CHEMICAL DEPENDENCY SERVICES.

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

History: *1994 c 625 art 2 s 21*

62Q.14 RESTRICTIONS ON ENROLLEE SERVICES.

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

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

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(2) the diagnosis of infertility;

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

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

History: *1994 c 625 art 2 s 22*

62Q.145 ABORTION AND SCOPE OF PRACTICE.

Health plan company policies related to scope of practice for allied independent health providers as defined in section 62Q.095, subdivision 5, midlevel practitioners as defined in section 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: *1995 c 234 art 2 s 25; 1997 c 183 art 2 s 20*

62Q.16 MIDMONTH TERMINATION PROHIBITED.

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

History: *1994 c 625 art 2 s 23*

62Q.165 UNIVERSAL COVERAGE.

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

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

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

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

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

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

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

62Q.17 VOLUNTARY PURCHASING POOLS.

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

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

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

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

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

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

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

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

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

(1) the number of lives in the pool;

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

(3) the number of health plans offered;

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

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

(6) evidence of compliance with chapter 62L;

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

(8) a list of all administrative fees charged.

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

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

62Q.18 PORTABILITY OF COVERAGE.

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

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

(2) "guaranteed issue" means:

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

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

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

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

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

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

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

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

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

(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 preexistmg 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 m section 62L.02, except that for group health plans issued to groups that are not small employers, this subdivision's requirement that the individual have maintained continuous coverage applies. An individual who has maintained continuous coverage, but would be considered a late entrant under chapter 62L, may be treated as a late entrant in the same manner under this subdivision as permitted under chapter 62L.

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

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

History: *1994 c 625 art 6 s 3; art 8 s 72; 1995 c 96 s 2; 1995 c 234 art 4 s 2; 1997 c 175 art 3 s 1,2; 1997 c 225 art 2 s 63*

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 defmed in section 62L 02, subdivision 15, but issued to a large employer, as defined in section 62Q 18, subdivision 1.

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(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.

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

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

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

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

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

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

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

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

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

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

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

Subd. 7. **Rulemaking.** By January 1, 1996, the commissioner shall adopt rules for establishing essential community providers and for governing their relationship with health plan companies. The commissioner shall also identify and address any conflict of interest issues regarding essential community provider designation for local governments. The rules

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shall require health plan companies to comply with all provisions of section 62Q.14 with respect to enrollee use of essential community providers.

History: *1994 c 625 art 4 s 6, 1995 c 234 art 2 s 26; 1996 c 451 art 2 s 1,2; 1997 c 225 art 2 s 42*

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

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 estab-

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lishing 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.23 GENERAL SERVICES.

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

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

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

History: *1994 c 625 art 4 s 8*

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

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

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, 1999. If the disputed issue relates to whether a service is appropriate and necessary, the commissioner shall issue an order only after consulting with appropriate experts knowledgeable, trained, and practicing in the area in dispute, reviewing pertinent literature, and considering the availability of satisfactory alternatives. The commissioner shall take steps including but not limited to fining, suspending, or revoking the license of a health plan company that is the subject of repeated orders by the commissioner that suggests a pattern of inappropriate underutilization.

History: *1994 c 625 art 4 s 12; 1995 c 234 art 3 s 6; 1997 c 237 s 10; 1998 c 407 art 2 s 22*

62Q.32 LOCAL OMBUDSPERSON.

County board or community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services

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through a health plan company The ombudsperson's functions may include, but are not limited to:

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

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

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

62Q.33 LOCAL GOVERNMENT PUBLIC HEALTH FUNCTIONS.

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

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

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

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

(1) consumer protection and advocacy;

(2) targeted outreach and linkage to personal services;

(3) health status monitoring and disease surveillance;

(4) investigation and control of diseases and injuries;

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

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

(7) health education and information;

(8) community mobilization for health–related issues;

(9) training and education of public health professionals;

(10) public health leadership and administration;

(11) emergency medical services;

(12) violence prevention; and

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

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

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

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

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

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

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

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

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

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

History: *1994 c 625 art 7 s 3; 1995 c 234 art 8 s 19,20; 1997 c 225 art 2 s 43*

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

62Q.43 GEOGRAPHIC ACCESS.

Subdivision 1. **Closed–panel health plan.** For purposes of this section, "closed–panel health plan" means a health plan as defined in section 62Q.01 that requires an enrollee to receive all or a majority of primary care services from a specific clinic or physician designated by the enrollee that is within the health plan company's clinic or physician network.

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

History: *1995 c 234 art 2 s 27*

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

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

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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: *1995 c 234 art 2 s 28; 1997 c 225 art 2 s 44*

62Q.47 MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES.

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

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

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

History: *1995 c 234 art 2 s 29*

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

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

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

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

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

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

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

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

History: *1996 c 446 art 1 s 50*

62Q.50 PROSTATE CANCER SCREENING.

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

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

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

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

History: *1996 c 446 art 1 s 51,72,73; 1998 c 339 s 12*

62Q.51 POINT-OF-SERVICE OPTION.

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

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

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

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

History: *1996 c 446 art 1 s 52*

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.525 COVERAGE FOR OFF-LABEL DRUG USE.

Subdivision 1. **Scope of coverage.** This section applies to all health plans, including the coverages described in section 62A.011, subdivision 3, clauses (7) and (10), that are issued or renewed to a Minnesota resident.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Medical literature" means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform require-

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ments for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

(c) "Off–label use of drugs" means when drugs are prescribed for treatments other than those stated in the labeling approved by the federal Food and Drug Administration.

(d) "Standard reference compendia" means:

(1) the United States Pharmacopeia Drug Information; or

(2) the American Hospital Formulary Service Drug Information.

Subd 3. **Required coverage.** (a) Every type of coverage included in subdivision 1 that provides coverage for drugs may not exclude coverage of a drug for the treatment of cancer on the ground that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard reference compendia or in one article in the medical literature, as defined in subdivision 2.

(b) Coverage of a drug required by this subdivision includes coverage of medically necessary services directly related to and required for appropriate administration of the drug.

(c) Coverage required by this subdivision does not include coverage of a drug not listed on the formulary of the coverage included in subdivision 1.

(d) Coverage of a drug required under this subdivision must not be subject to any copayment, coinsurance, deductible, or other enrollee cost–sharing greater than the coverage included in subdivision 1 applies to other drugs.

(e) The commissioner of commerce or health, as appropriate, may direct a person that issues coverage included in subdivision 1 to make payments required by this section.

Subd. 4. **Construction.** This section must not be construed to

(1) alter existing law limiting the coverage of drugs that have not been approved by the federal Food and Drug Administration;

(2) require coverage for any drug when the federal Food and Drug Administration has determined its use to be contraindicated;

(3) require coverage for experimental drugs not otherwise approved for any indication by the federal Food and Drug Administration; or

(4) reduce or limit coverage for off–label use of drugs otherwise required by law or contract.

History: *1998 c 301 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*

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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 trans-

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fer 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:

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(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*

62Q.66 DURABLE MEDICAL EQUIPMENT COVERAGE.

No health plan company that covers durable medical equipment may utilize medical coverage criteria for durable medical equipment that limits coverage solely to equipment used in the home.

History: *1998 c 334 s 1*

62Q.67 DISCLOSURE OF COVERED DURABLE MEDICAL EQUIPMENT.

Subdivision 1. **Disclosure.** A health plan company that covers durable medical equipment shall provide enrollees, and upon request prospective enrollees, written disclosure that includes the information set forth in subdivision 2. The health plan company may include the information in the member contract, certificate of coverage, schedule of payments, member handbook, or other written enrollee communication.

Subd. 2. **Information to be disclosed.** A health plan company that covers durable medical equipment shall disclose the following information:

(a) general descriptions of the coverage for durable medical equipment, level of coverage available, and criteria and procedures for any required prior authorizations; and

(b) the address and telephone number of a health plan representative whom an enrollee may contact to obtain specific information verbally, or upon request in writing, about prior authorization including criteria used in making coverage decisions and information on limitations or exclusions for durable medical equipment

History: *1998 c 334 s 2*

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