CHAPTER 62Q

REQUIREMENTS FOR HEALTH PLAN COMPANIES

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

[For text of subd 1, see M.S.1998]

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, expiration, and removal of members. 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.

(e) Before including risk adjustment in a contract for the prepaid medical assistance program, the prepaid general assistance medical care program, or the MinnesotaCare program, the commissioner of human services shall provide to the contractor an analysis of the expected impact on the contractor of the implementation of risk adjustment. This analysis may be limited by the available data and resources, as determined by the commissioner, and shall not be binding on future contract periods. This paragraph shall not apply if the contractor has not supplied information to the commissioner related to the risk adjustment analysis.

(f) The commissioner of human services shall report to the public program risk adjustment work group on the methodology the department will use for risk adjustment prior to implementation of the risk adjustment payment methodology. Upon completion of the report to the work group, the commissioner shall phase in risk adjustment according to the following schedule:

(1) for the first contract year, no more than ten percent of reimbursements shall be risk adjusted; and

(2) for the second contract year, no more than 30 percent of reimbursements shall be risk adjusted.

[For text of subds 5b to 12, see M.S.1998]

History: *1999 c 245 art 2 s 12*

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, and other community organizations providing health services within the same service area as the managed care organization. Local government units with responsibilities and authority defined under chapters 145A and 256E may designate individuals to participate in the collaborative planning with the managed care organization to provide expertise and represent community needs and goals as identified under chapters 145A and 256E.

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

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

(b) description of the process by which the managed care organization will coordinate its activities with the community health boards, 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 local community health boards, and other relevant community organizations within the managed care organization's service area. After reviewing the plan, these commu-

nity 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: *1999 c 245 art 2 s 13*

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 in its commercial health plan products 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.

[For text of subds 2 to 6, see M.S.1998]

History: *1999 c 181 s 5*

62Q.105 [Repealed, 1999 c 239 s 43]

NOTE: Subdivision 1 was also amended by Laws 1999, chapter 177, section 56, to read as follows:

"Subdivision 1. **Establishment.** Each health plan company shall establish and make available to enrollees, by July 1, 2001, 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."

62Q.106 DISPUTE RESOLUTION BY COMMISSIONER.

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

History: *1999 c 239 s 32*

NOTE: The amendment to this section by Laws 1999, chapter 239, section 32, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62Q.11 [Repealed, 1999 c 239 s 43]

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

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

(b) This section does not require renewal if:

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

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

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

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

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

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

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

(d) This section does not require renewal of the coverage of individual enrollees under the health benefit plan if the individual enrollee has performed an act or practice that constitutes fraud or misrepresentation of material fact under the terms of the health benefit plan.

History: *1999 c 177 s 57*

62Q.19 ESSENTIAL COMMUNITY PROVIDERS.

[For text of subds 1 to 5, see M.S.1998]

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.

[For text of subds 5b to 7, see M.S.1998]

History: *1999 c 239 s 33*

NOTE: The amendment to subdivision 5a by Laws 1999, chapter 239, section 33, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62Q.30 [Repealed, 1999 c 239 s 43]

NOTE: This section was also amended by Laws 1999, chapter 177, section 58, to read as follows:

"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, 2001. 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."

62Q.51 POINT-OF-SERVICE OPTION.

[For text of subds 1 to 3, see M.S.1998]

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

History: *1999 c 181 s 6*

COMPLAINT RESOLUTION

62Q.68 DEFINITIONS.

Subdivision 1. **Application.** For purposes of sections 62Q.68 to 62Q.72, the terms defined in this section have the meanings given them. For purposes of sections 62Q.69 and 62Q.70, the term "health plan company" does not include an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01 or a nonprofit health service plan corporation regulated under chapter 62C that only provides dental coverage or vision coverage.

Subd. 2. **Complaint.** "Complaint" means any grievance against a health plan company that is not the subject of litigation and that has been submitted by a complainant to a health plan company regarding the provision of health services including, but not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the period of time the individual was an enrollee. Any grievance requiring a medical determination in its resolution must have the medical determination aspect of the complaint processed under the appeal procedure described in section 62M.06.

Subd. 3. **Complainant.** "Complainant" means an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant, or former enrollee, who submits a complaint.

History: *1999 c 239 s 34*

NOTE: This section, as added by Laws 1999, chapter 239, section 34, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62Q.69 COMPLAINT RESOLUTION.

Subdivision 1. **Establishment.** Each health plan company must establish and maintain an internal complaint resolution process that meets the requirements of this section to provide for the resolution of a complaint initiated by a complainant.

Subd. 2. **Procedures for filing a complaint.** (a) A complainant may submit a complaint to a health plan company either by telephone or in writing. If a complaint is submitted orally and the resolution of the complaint, as determined by the complainant, is partially or wholly adverse to the complainant, or the oral complaint is not resolved to the satisfaction of the complainant, by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing. The health plan company must also offer to provide the complainant with any assistance needed to submit a written complaint, including an offer to complete the complaint form for a complaint that was previously submitted orally and promptly mail the completed form to the complainant for the complainant's signature. At the complainant's request, the health plan company must provide the assistance requested by the complainant. The complaint form must include the following information:

(1) the telephone number of the office of health care consumer assistance, advocacy, and information, and the health plan company member services or other departments or persons equipped to advise complainants on complaint resolution;

(2) the address to which the form must be sent;

(3) a description of the health plan company's internal complaint procedure and the applicable time limits; and

(4) the toll–free telephone number of either the commissioner of health or commerce and notification that the complainant has the right to submit the complaint at any time to the appropriate commissioner for investigation.

(b) Upon receipt of a written complaint, the health plan company must notify the complainant within ten business days that the complaint was received, unless the complaint is resolved to the satisfaction of the complainant within the ten business days.

(c) Each health plan company must provide, in the member handbook, subscriber contract, or certification of coverage, a clear and concise description of how to submit a complaint and a statement that, upon request, assistance in submitting a written complaint is available from the health plan company.

Subd. 3. **Notification of complaint decisions.** (a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint. If the health plan company cannot make a decision within 30 days due to circumstances outside the control of the health plan company, the health plan company may take up to 14 additional days to notify the complainant of its decision. If the health plan company takes any additional days beyond the initial 30–day period to make its decision, it must inform the complainant, in advance, of the extension and the reasons for the extension.

(b) If the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.

(c) The notification must also inform the complainant of the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll–free telephone number of the appropriate commissioner.

History: *1999 c 239 s 35*

NOTE: This section, as added by Laws 1999, chapter 239, section 35, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62Q.70 APPEAL OF THE COMPLAINT DECISION.

Subdivision 1. **Establishment.** (a) Each health plan company shall establish an internal appeal process for reviewing a health plan company's decision regarding a complaint filed in accordance with section 62Q.69. The appeal process must meet the requirements of this section.

(b) The person or persons with authority to resolve or recommend the resolution of the internal appeal must not be solely the same person or persons who made the complaint decision under section 62Q.69.

(c) The internal appeal process must permit the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigating or presiding over the appeal.

Subd. 2. **Procedures for filing an appeal.** If a complainant notifies the health plan company of the complainant's desire to appeal the health plan company's decision regarding the complaint through the internal appeal process, the health plan company must provide the complainant the option for the appeal to occur either in writing or by hearing.

Subd. 3. **Notification of appeal decisions.** (a) If a complainant appeals in writing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 30 days of the health plan company's receipt of the complainant's written notice of appeal. If a complainant appeals by hearing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 45 days of the health plan company's receipt of the complainant's written notice of appeal.

(b) If the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the appeal decision to the external review process described in section 62Q.73 and the procedure for initiating the external process.

(c) Upon the request of the complainant, the health plan company must provide the complainant with a complete summary of the appeal decision.

History: *1999 c 239 s 36*

NOTE: This section, as added by Laws 1999, chapter 239, section 36, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62Q.71 NOTICE TO ENROLLEES.

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

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

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services;

(3) how to request an appeal either through the procedures described in sections 62Q.69 and 62Q.70 or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) of the toll–free telephone number of the appropriate commissioner;

(6) of the telephone number of the office of consumer assistance, advocacy, and information; and

(7) of the right to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised.

History: *1999 c 239 s 37*

NOTE: This section, as added by Laws 1999, chapter 239, section 37, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62Q.72 RECORDKEEPING; REPORTING.

Subdivision 1. **Recordkeeping.** Each health plan company shall maintain records of all enrollee complaints and their resolutions. These records shall be retained for five years and shall be made available to the appropriate commissioner upon request. An insurance company licensed under chapter 60A may instead comply with section 72A.20, subdivision 30.

Subd. 2. **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, or 30 business days as provided under section 72A.201, subdivision 4, clause (3), for insurance companies licensed under chapter 60A. The commissioner shall also make this information available to the public upon request.

History: *1999 c 239 s 38*

NOTE: This section, as added by Laws 1999, chapter 239, section 38, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62Q.73 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.

Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

(1) a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant;

(2) any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination not to certify; or

(3) a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary.

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Subd. 2. **Exception.** (a) This section does not apply to governmental programs except as permitted under paragraph (b). For purposes of this subdivision, "governmental programs" means the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance medical care program, and the federal Medicare program.

(b) In the course of a recipient's appeal of a medical determination to the commissioner of human services under section 256.045, the recipient may request an expert medical opinion be arranged by the external review entity under contract to provide independent external reviews under this section. If such a request is made, the cost of the review shall be paid by the commissioner of human services. Any medical opinion obtained under this paragraph shall only be used by a state human services referee as evidence in the recipient's appeal to the commissioner of human services under section 256.045.

(c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights provided in section 256.045 for governmental program recipients.

Subd. 3. **Right to external review.** (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination, if applicable under section 62Q.68, subdivision 1, or 62M.06, to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. The written request must be accompanied by a filing fee of $25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship.

(b) Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review.

(c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company.

Subd. 4. **Contract.** Pursuant to a request for proposal, the commissioner of administration, in consultation with the commissioners of health and commerce, shall contract with an organization or business entity to provide independent external reviews of all adverse determinations submitted for external review. The contract shall ensure that the fees for services rendered in connection with the reviews be reasonable.

Subd. 5. **Criteria.** (a) The request for proposal must require that the entity demonstrate:

(1) no conflicts of interest in that it is not owned, a subsidiary of, or affiliated with a health plan company or utilization review organization;

(2) an expertise in dispute resolution;

(3) an expertise in health–related law;

(4) an ability to conduct reviews using a variety of alternative dispute resolution procedures depending upon the nature of the dispute;

(5) an ability to provide data to the commissioners of health and commerce on reviews conducted; and

(6) an ability to ensure confidentiality of medical records and other enrollee information.

(b) The commissioner of administration shall take into consideration, in awarding the contract according to subdivision 4, any national accreditation standards that pertain to an external review entity.

Subd. 6. **Process.** (a) Upon receiving a request for an external review, the external review entity must provide immediate notice of the review to the enrollee and to the health plan company. Within ten business days of receiving notice of the review, the health plan company and the enrollee must provide the external review entity with any information that they wish to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. An enrollee may be assisted or represented by a person of the enrollee's choice.

(b) As part of the external review process, any aspect of an external review involving a medical determination must be performed by a health care professional with expertise in the medical issue being reviewed.

(c) An external review shall be made as soon as practical but in no case later than 40 days after receiving the request for an external review and must promptly send written notice of the decision and the reasons for it to the enrollee, the health plan company, and the commissioner who is responsible for regulating the health plan company.

Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan.

(b) For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

(c) For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.

Subd. 8. **Effects of external review.** A decision rendered under this section shall be nonbinding on the enrollee and binding on the health plan company. The health plan company may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 9. **Immunity from civil liability.** A person who participates in an external review by investigating, reviewing materials, providing technical expertise, or rendering a decision shall not be civilly liable for any action that is taken in good faith, that is within the scope of the person's duties, and that does not constitute willful or reckless misconduct.

Subd. 10. **Data reporting.** The commissioners shall make available to the public, upon request, summary data on the decisions rendered under this section, including the number of reviews heard and decided and the final outcomes. Any data released to the public must not individually identify the enrollee initiating the request for external review.

History: *1999 c 239 s 39*

NOTE: This section, as added by Laws 1999, chapter 239, section 39, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

NETWORK SHADOW CONTRACTING

62Q.74 NETWORK SHADOW CONTRACTING.

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Category of coverage" means one of the following types of health-related coverage:

(1) health;

(2) no-fault automobile medical benefits; or

(3) workers' compensation medical benefits.

(c) "Health care provider" or "provider" has the meaning given in section 148.01.

(d) "Network organization" means a preferred provider organization as defined in section 145.61, subdivision 4c; a managed care organization as defined in section 62Q.01, subdivision 5; or other entity that uses or consists of a network of health care providers; but does not include a nonprofit health service plan corporation operating under chapter 62C or its affiliates.

Subd. 2. **Provider consent required.** (a) No network organization shall require a health care provider to participate in a network under a category of coverage that differs from the category or categories of coverage to which the existing contract between the network organization and the provider applies, without the consent of the provider obtained under subdivision 3.

(b) This section does not apply to situations in which the network organization wishes the provider to participate in a new or different plan or other arrangement within a category of coverage that is already provided for in an existing contract between the network organization and the provider.

(c) Compliance with this section may not be waived in a contract or otherwise.

Subd. 3. **Consent procedure.** (a) The network organization, if it wishes to apply an existing contract with a provider to a different category of coverage, shall first notify the provider in writing. The written notice must include at least the following:

(1) the network organization's name, address, and telephone number, and the name of the specific network, if it differs from that of the network organization;

(2) a description of the proposed new category of coverage;

(3) the names of all payers expected by the network organization to use the network for the new category of coverage;

(4) the approximate number of current enrollees of the network organization in that category of coverage within the provider's geographical area;

(5) a disclosure of all contract terms of the proposed new category of coverage, including the discount or reduced fees, care guidelines, utilization review criteria, prior authorization process, and dispute resolution process;

(6) a form for the provider's convenience in accepting or declining participation in the proposed new category of coverage, provided that the provider need not use that form in responding; and

(7) a statement informing the provider of the provisions of paragraph (b).

(b) If the provider does not decline participation within 30 days after the postmark date of the notice, the provider is deemed to have accepted the proposed new category of coverage.

Subd. 4. **Contract termination restricted.** A network organization must not terminate an existing contract with a provider, or fail to honor the contract in good faith, based solely on the provider's decision not to accept a proposed new category of coverage. The most recent agreed–upon contractual obligations remain in force until the existing contract's renewal or termination date.

Subd. 5. **Remedy.** If a network organization violates this section by reimbursing a provider as if the provider had agreed under this section to participate in the network under a category of coverage to which the provider has not agreed, the provider has a cause of action against the network organization to recover two times the difference between the reasonable charges for claims affected by the violation and the amounts actually paid to the provider. The provider is also entitled to recover costs, disbursements, and reasonable attorney fees.

History: *1999 c 94 s 1*