CHAPTER 62J

HEALTH CARE COST CONTAINMENT

62J.15 HEALTH PLANNING.

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

[For text of subd 1a, see M.S.2000]

History: *2001 c 161 s 12*

62J.152 DUTIES OF HEALTH TECHNOLOGY ADVISORY COMMITTEE.

[For text of subds 1 to 7, see M.S.2000]

Subd. 8. **Repealer.** This section and sections 62J.15 and 62J.156 are repealed effective July 1, 2005.

History: *1Sp2001 c 9 art 1 s 1*

62J.38 COST CONTAINMENT DATA FROM GROUP PURCHASERS.

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for each calendar year. Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data must distinguish between costs incurred for patient care and administrative costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical

quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made during the calendar year for these purposes. The commissioner shall make public, by group purchaser data collected under this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation insurance plans and automobile insurance plans are exempt from complying with this paragraph as it relates to the submission of administrative costs.

(c) The commissioner may collect information on:

(1) premiums, benefit levels, managed care procedures, and other features of health plan companies;

(2) prices, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses; and

(3) information on health care services not provided through health plan companies, including information on prices, costs, expenditures, and utilization.

(d) All group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

History: *1Sp2001 c 9 art 16 s 4*

62J.451 MINNESOTA HEALTH DATA INSTITUTE.

[For text of subds 1 to 4, see M.S.2000]

Subd. 5. **Health care electronic data interchange system.** The health data institute shall establish an electronic data interchange system that electronically transmits, collects, archives, and provides users of data with the data necessary for their specific interests, in order to promote a high quality, cost-effective, consumer-responsive health care system. This public-private information system shall be developed to make health care claims processing and financial settlement transactions more efficient and to provide an efficient, unobtrusive method for meeting the shared electronic data interchange needs of consumers, group purchasers, providers, and the state.

[For text of subds 6 to 16, see M.S.2000]

History: *1Sp2001 c 9 art 1 s 2*

62J.46 MONITORING AND REPORTS.

Subdivision 1. **Long-term care costs.** The commissioner shall use existing state data resources to monitor trends in public and private spending on long-term care costs and spending in Minnesota. The commissioner shall recommend to the legislature any additional data collection activities needed to monitor these trends. State agencies collecting information on long-term care spending and costs shall coordinate with the interagency long-term care planning committee and the commissioner to facilitate the monitoring of long-term care expenditures in the state.

[For text of subd 2, see M.S.2000]

History: *2001 c 161 s 13*

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

Subdivision 1. **Minnesota uniform health care identification card.** All individuals with health care coverage shall be issued Minnesota uniform health care identification cards by group purchasers as of January 1, 1998, unless the requirements of section 62A.01, subdivisions 2 and 3, are met. If a health benefit plan issued by a group purchaser provides coverage for prescription drugs, the group purchaser shall include uniform prescription drug information on the uniform health care identification card issued to its enrollees on or after July 1, 2003. Nothing in this section requires a group purchaser to issue a separate card containing uniform prescription drug information, provided that the Minnesota uniform health care identification card can accommodate the information necessary to process prescription drug claims as required by this section. The Minnesota uniform health care identification cards shall comply with the standards prescribed in this section.

Subd. 1a. **Definition; health benefit plan.** For purposes of this section, "health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a group purchaser for the coverage of medical and hospital benefits. A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile or homeowners medical payment coverage;

(3) liability insurance or supplemental to liability insurance;

(4) accident-only coverage;

(5) credit accident and health insurance issued under chapter 62B;

(6) designed solely to provide dental or vision care;

(7) designed solely to provide coverage for a specified disease or illness;

(8) coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(9) hospital income or indemnity.

Subd. 2. **General characteristics.** (a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements left justified in the following top to bottom sequence: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements. The window must be left justified.

(c) Standardized labels are required next to human readable data elements and must come before the human readable data elements.

Subd. 2a. **Issuance.** A new Minnesota uniform health care identification card must be issued to individuals upon enrollment. Except for the medical assistance, general assistance medical care, and MinnesotaCare programs, a new card must be issued upon any change in an individual's health care coverage that impacts the content or format of the data included on the card or no later than 24 months after adoption of any change in the NCPDP implementation guide or successor document that affects the content or format of the data included on the card. Anytime that a card is issued upon enrollment or replaced by the medical assistance, general assistance medical care, or MinnesotaCare program, the card must conform to the adopted NCPDP standards in effect and to the implementation guide in use at the time of issuance. Newly issued cards must conform to the adopted NCPDP standards in effect at the time of issuance and to the implementation guide in use at the time of issuance. Stickers or other methodologies may be used to update cards temporarily.

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

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

(3) card issuer identification number. The standardized label for this element is "Issuer";

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

(5) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

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

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

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

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

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

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

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

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

(2) one of the following:

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

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

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

Subd. 4. **Machine readable data content.** The Minnesota uniform health care identification card may be machine readable or nonmachine readable. If the card is machine readable, the card must contain a magnetic stripe that conforms to ANSI and ISO standards for Tracks 1.

Subd. 5. **Annual reporting.** As part of an annual filing made with the commissioner of health or commerce on or after January 1, 2003, a group purchaser shall certify compliance with this section and shall submit to the commissioner of health or commerce a copy of the Minnesota uniform health care identification card used by the group purchaser.

History: *2001 c 110 s 1*

The amendment to this section by Laws 2001, chapter 110, section 1, is effective January 1, 2003, and applies to health benefit plans issued or renewed on or after that date. Laws 2001, chapter 110, section 2.

62J.692 MEDICAL EDUCATION.

[For text of subd 1, see M.S.2000]

Subd. 2. **Medical education and research advisory committee.** The commissioner shall appoint an advisory committee to provide advice and oversight on the distribution of funds appropriated for distribution under this section. In appointing the members, the commissioner shall:

(1) consider the interest of all stakeholders;

(2) appoint members that represent both urban and rural interests; and

(3) appoint members that represent ambulatory care as well as inpatient perspectives.

The commissioner shall appoint to the advisory committee representatives of the following groups to ensure appropriate representation of all eligible provider groups and other stakeholders: public and private medical researchers; public and private academic medical centers, including representatives from academic centers offering accredited training programs for physicians, pharmacists, chiropractors, dentists, nurses, and physician assistants; managed care organizations; employers; consumers and other relevant stakeholders. The advisory committee is governed by section 15.059.

[For text of subds 3 to 6, see M.S.2000]

Subd. 7. **Transfers from the commissioner of human services.** (a) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), shall be distributed by the commissioner to clinical medical education programs that meet the qualifications of subdivision 3 based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and

(2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool created under this subdivision.

In this formula, the education factor shall be weighted at 50 percent and the public program volume factor shall be weighted at 50 percent.

Public program revenue for the distribution formula shall include revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue shall be ineligible for funds available under this paragraph.

(b) Fifty percent of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), shall be distributed by the commissioner to the University of Minnesota board of regents for the purposes described in sections 137.38 to 137.40. Of the remaining amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), 24 percent of the amount shall be distributed by the commissioner to the Hennepin County Medical Center for clinical medical education. The remaining 26 percent of the amount transferred shall be distributed by the commissioner in accordance with subdivision 7a. If the federal approval is not obtained for the matching funds under section 256B.69, subdivision 5c, paragraph (a), clause (2), 100 percent of the amount transferred under this paragraph shall be distributed by the commissioner to the University of Minnesota board of regents for the purposes described in sections 137.38 to 137.40.

Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner shall award grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. In awarding the grants, the commissioner, in consultation with the commissioner of human services, shall consider the following:

(1) potential to successfully increase access to an underserved population;

(2) the long-term viability of the project to improve access beyond the period of initial funding;

(3) evidence of collaboration between the applicant and local communities;

(4) the efficiency in the use of the funding; and

(5) the priority level of the project in relation to state clinical education, access, and workforce goals.

(b) The commissioner shall periodically evaluate the priorities in awarding the innovations grants in order to ensure that the priorities meet the changing workforce needs of the state.

[For text of subds 8 and 9, see M.S.2000]

History: *2001 c 161 s 14; 1Sp2001 c 9 art 2 s 2,3*

62J.694 MEDICAL EDUCATION ENDOWMENT FUND.

Subdivision 1. **Creation.** (a) The medical education endowment fund is created in the state treasury. The state board of investment shall invest the fund under section 11A.24. All earnings of the fund must be credited to the fund. The principal of the fund must be maintained inviolate, except that the principal may be used to make expenditures from the fund for the purposes specified in this section when the market value of the fund falls below 105 percent of the cumulative total of the tobacco settlement payments received by the state and credited to the tobacco settlement fund under section 16A.87, subdivision 2. For purposes of this section, "principal" means an amount equal to the cumulative total of the tobacco settlement payments received by the state and credited to the tobacco settlement fund under section 16A.87, subdivision 2.

(b) The academic health center account is created as a separate account in the medical education endowment fund. The account is invested under paragraph (a). All earnings of the account must be credited to the account. The principal of the account must be maintained inviolate, except that the principal may be used to make expenditures from the account for the purposes specified in subdivision 2a when the value of the account falls below an amount equal to deposits made to the account under section 16A.87, subdivision 3, paragraph (b).

Subd. 2. **Expenditures.** (a) Up to five percent of the fair market value of the fund excluding the value of the academic health center account, is annually appropriated for medical education activities in the state of Minnesota. The appropriations are to be transferred quarterly for the purposes identified in the following paragraphs.

(b) For fiscal year 2000, 70 percent of the appropriation in paragraph (a) is for transfer to the board of regents for the instructional costs of health professional programs at the academic health center and affiliated teaching institutions, and 30 percent of the appropriation is for transfer to the commissioner of health to be distributed for medical education under section 62J.692.

(c) For fiscal year 2001, 49 percent of the appropriation in paragraph (a) is for transfer to the board of regents for the instructional costs of health professional programs at the academic health center and affiliated teaching institutions, and 51 percent is for transfer to the commissioner of health to be distributed for medical education under section 62J.692.

(d) For fiscal year 2002, and each year thereafter, 42 percent of the appropriation in paragraph (a) is appropriated for the instructional costs of health professional programs at the University of Minnesota academic health center, and 58 percent is for transfer to the commissioner of health to be distributed for medical education under section 62J.692.

(e) A maximum of $150,000 of each annual appropriation to the commissioner of health in paragraph (d) may be used by the commissioner for administrative expenses associated with implementing section 62J.692.

Subd. 2a. **Expenditure; academic health center account.** Beginning in January 2002, up to five percent of the fair market value of the academic health center account is annually appropriated to the board of regents for the costs of the academic health center. Appropriations are to be transferred quarterly and may only be used for instructional costs of health professional programs at the academic health center and for interdisciplinary academic initiatives within the academic health center.

[For text of subds 3 and 4, see M.S.2000]

History: *1Sp2001 c 1 art 2 s 3-5*