CHAPTER 62Q

REQUIREMENTS FOR HEALTH PLAN COMPANIES

62Q.01 DEFINITIONS.

[For text of subds 1 to 5, see M.S.2000]

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 supplement 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; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law Number 105-33), Sections 1851 to 1859 of the Social Security Act establishing part C of the Medicare program, known as the "Medicare + Choice program."

History: *2001 c 215 s 26*

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

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

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 commissioner of human services 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.2000]

History: *2001 c 161 s 15*

62Q.07 [Repealed, 2001 c 170 s 11]

62Q.075 LOCAL PUBLIC ACCOUNTABILITY AND COLLABORATION PLAN.

Subdivision 1. [Repealed by amendment, 2001 c 171 s 1]

Subd. 2. **Requirement.** Beginning October 31, 2004, all health maintenance organizations shall file a plan every four years with the commissioner of health describing the actions the health maintenance organization intends to take to contribute to achieving one or more high priority public health goals. 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 health maintenance 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 health maintenance organization to provide expertise and represent community needs and goals as identified under chapters 145A and 256E. Every other year, beginning October 31, 2002, all health maintenance organizations shall file reports updating progress on the four-year collaboration plan.

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

(1) specific measurement strategies and a description of any activities which contribute to one or more high priority public health goals;

(2) description of the process by which the health maintenance organization will coordinate its activities with the community health boards, and other relevant community organizations servicing the same area;

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

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

Subd. 4. **Review.** Upon receipt of the plan, the commissioner of health shall provide a copy to the local community health boards, and other relevant community organizations within the health maintenance organization's service area. After reviewing the plan, these community groups may submit written comments on the plan to the commissioner of health and may advise the commissioner of the health maintenance organization's effectiveness in assisting to achieve high priority 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 health maintenance 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 health maintenance organization. The county board, or applicable city council, may submit written comments to the commissioner of health, and may advise the commissioner of the health maintenance organization's effectiveness in assisting to meet the needs and goals as defined under the responsibilities of chapters 145A and 256E. Copies of these written comments must be provided to the health maintenance organization. The plan and any comments submitted must be filed with the information clearinghouse to be distributed to the public.

History: *2001 c 171 s 1*

62Q.121 LICENSURE OF MEDICAL DIRECTORS.

(a) No health plan company may employ a person as a medical director unless the person is licensed as a physician in this state. This section does not apply to a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota comprehensive health association.

(b) For purposes of this section, "medical director" means a physician employed by a health plan company who has direct decision-making authority, based upon medical training and knowledge, regarding the health plan company's medical protocols, medical policies, or coverage of treatment of a particular enrollee, regardless of the physician's title.

(c) This section applies only to medical directors who make recommendations or decisions that involve or affect enrollees who live in this state.

(d) Each health plan company that is subject to this section shall provide the commissioner with the names and licensure information of its medical directors and shall provide updates no later than 30 days after any changes.

History: *1Sp2001 c 9 art 16 s 6*

62Q.137 COVERAGE FOR CHEMICAL DEPENDENCY TREATMENT PROVIDED BY THE DEPARTMENT OF CORRECTIONS.

(a) Any health plan that provides coverage for chemical dependency treatment must cover chemical dependency treatment provided to an enrollee by the department of corrections while the enrollee is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense under section 169A.24 if: (1) a court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and (2) the department of corrections makes a determination based on a chemical assessment conducted while the individual is in the custody of the department that treatment is appropriate. Treatment provided by the department of corrections that meets the requirements of this section shall not be subject to a separate medical necessity determination under the health plan company's utilization review procedures.

(b) The health plan company must be given a copy of the court's preliminary determination and supporting documents and the assessment conducted by the department of corrections.

(c) Payment rates for treatment provided by the department of corrections shall not exceed the lowest rate for outpatient chemical dependency treatment paid by the health plan company to a participating provider of the health plan company.

(d) For purposes of this section, chemical dependency treatment means all covered services that are intended to treat chemical dependency and that are covered by the enrollee's health plan or by law.

History: *1Sp2001 c 9 art 19 s 1*

NOTE: This section, as added by Laws 2001, First Special Session chapter 9, article 19, section 1, is effective August 1, 2002, and applies to crimes committed on or after that date. Laws 2001, First Special Session chapter 9, article 19, section 17.

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, underserved, and other special needs populations; and

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

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

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

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

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

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

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

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

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

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

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

[For text of subds 2 to 7, see M.S.2000]

History: *2001 c 170 s 3*

62Q.471 EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED.

(a) No health plan may exclude or reduce coverage for health care for an enrollee who is otherwise covered under the health plan on the basis that the need for the health care arose out of a suicide or suicide attempt by the enrollee.

(b) For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, clauses (7) and (10).

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

62Q.527 COVERAGE OF NONFORMULARY DRUGS FOR MENTAL ILLNESS AND EMOTIONAL DISTURBANCE.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

(c) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a).

(d) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (7) and (10).

Subd. 2. **Required coverage for antipsychotic drugs.** (a) A health plan that provides prescription drug coverage must provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the drug is in the health plan's drug formulary, if the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the health care provider has considered all equivalent drugs in the health plan's drug formulary and has determined that the drug prescribed will best treat the patient's condition.

(b) The health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

(c) For drugs covered under this section, no health plan company that has received a certification from the health care provider as described in paragraph (a), may:

(1) impose a special deductible, co-payment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or

(2) require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.

Subd. 3. **Continuing care.** (a) Enrollees receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, copayment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit:

(1) the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan;

(2) the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(3) the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(b) The continuing care benefit shall be extended annually when the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(c) The health plan company is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

Subd. 4. **Exception to formulary.** A health plan company must promptly grant an exception to the health plan's drug formulary for an enrollee when the health care provider prescribing the drug indicates to the health plan company that:

(1) the formulary drug causes an adverse reaction in the patient;

(2) the formulary drug is contraindicated for the patient; or

(3) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

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

62Q.535 COVERAGE FOR COURT-ORDERED MENTAL HEALTH SERVICES.

Subdivision 1. **Mental health services.** For purposes of this section, mental health services means all covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are covered by the policy, contract, or certificate of coverage of the enrollee's health plan company or by law.

Subd. 2. **Coverage required.** (a) All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The health plan company must be given a copy of the court order and the behavioral care evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is covered by the health plan and ordered to be provided by a participating provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.

(b) A party or interested person, including a health plan company or its designee, may make a motion for modification of the court-ordered plan of care pursuant to the

applicable rules of procedure for modification of the court's order. The motion may include a request for a new behavioral care evaluation according to this section.

History: *1Sp2001 c 9 art 9 s 3*

62Q.56 CONTINUITY OF CARE.

Subdivision 1. **Change in health care provider; general notification.** (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, specialists, or general hospital providers. The written plan must explain:

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

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

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

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

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

(b) For purposes of this section, contract termination includes nonrenewal.

Subd. 1a. **Change in health care provider; termination not for cause.** (a) If the contract termination was not for cause and the contract was terminated by the health plan company, the health plan company must provide the terminated provider and all enrollees being treated by that provider with notification of the enrollees' rights to continuity of care with the terminated provider.

(b) The health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization to receive services under this paragraph, the health plan company must grant the request unless the enrollee does not meet the criteria provided in this paragraph.

(c) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for enrollees who request continuity of care with their former provider, if the enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

Subd. 1b. **Change in health care provider; termination for cause.** 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) If an enrollee is subject to a change in health plans, the enrollee's new health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the new health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization under this paragraph, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria provided in this paragraph.

(b) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for new enrollees who request continuity of care with their former provider, if the new enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

(c) 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. 2a. **Limitations.** (a) Subdivisions 1, 1a, 1b, and 2 apply only if the enrollee's health care provider agrees to:

(1) accept as payment in full the lesser of the health plan company's reimbursement rate for in-network providers for the same or similar service or the enrollee's health care provider's regular fee for that service;

(2) adhere to the health plan company's preauthorization requirements; and

(3) provide the health plan company with all necessary medical information related to the care provided to the enrollee.

(b) Nothing in this section requires a health plan company to provide coverage for a health care service or treatment that is not covered under the enrollee's health plan.

Subd. 2b. **Request for authorization.** The health plan company may require medical records and other supporting documentation to be submitted with the requests for authorization made under subdivision 1, 1a, 1b, or 2. If the authorization is denied, the health plan company must explain the criteria it used to make its decision on the request for authorization. If the authorization is granted, the health plan company must explain how continuity of care will be provided.

Subd. 3. **Disclosure.** Information regarding an enrollee's rights under this section must be included in member contracts or certificates of coverage and must be provided by a health plan company upon request of an enrollee or prospective enrollee.

History: *1Sp2001 c 9 art 16 s 7*

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 and, if appropriate, receive 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 managed care review and approval an enrollee must obtain before such a standing referral is permitted.

Subd. 1a. **Mandatory standing referral.** (a) An enrollee who requests a standing referral to a specialist qualified to treat the specific condition described in clauses (1) to (5) must be given a standing referral for visits to such a specialist if benefits for such treatment are provided under the health plan and the enrollee has any of the following conditions:

(1) a chronic health condition;

(2) a life-threatening mental or physical illness;

(3) pregnancy beyond the first trimester of pregnancy;

(4) a degenerative disease or disability; or

(5) any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist.

(b) Nothing in this section limits the application of section 62Q.52 specifying direct access to obstetricians and gynecologists.

(c) Paragraph (a) does not apply to health plans issued under sections 43A.23 to 43A.31.

Subd. 2. **Coordination of services.** 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 the enrollee, authorize tests and services, and make secondary referrals according to procedures established by the health plan company. The health plan company may limit the primary care services, tests and services, and secondary referrals authorized under this subdivision to those that are related to the specific condition or conditions for which the standing referral was made.

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.

Subd. 4. **Referral.** (a) If a standing referral is authorized under subdivision 1 or is mandatory under subdivision 1a, the health plan company must provide a referral to an

appropriate participating specialist who is reasonably available and accessible to provide the treatment or to a nonparticipating specialist if the health plan company does not have an appropriate participating specialist who is reasonably available and accessible to treat the enrollee's condition or disease.

(b) If an enrollee receives services from a nonparticipating specialist because a participating specialist is not available, services must be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received from a participating specialist.

History: *1Sp2001 c 9 art 16 s 8*

62Q.73 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.

[For text of subds 1 and 2, see M.S.2000]

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. Notification of the enrollee's right to external review must accompany the denial issued by the insurer. 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.

[For text of subds 4 to 10, see M.S.2000]

History: *2001 c 215 s 27*

62Q.74 NETWORK SHADOW CONTRACTING.

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

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 affirmative 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) Unless the provider has affirmatively agreed to participate within 60 days after the postmark date of the notice, the provider is deemed to have not accepted the proposed new category of coverage.

[For text of subds 4 and 5, see M.S.2000]

History: *2001 c 170 s 4,5*

62Q.745 PROVIDER CONTRACT AMENDMENT DISCLOSURE.

(a) Any amendment or change in the terms of an existing contract between a network organization and a health care provider must be disclosed to the provider.

(b) Any amendment or change in the contract that alters the financial reimbursement or alters the written contractual policies and procedures governing the relationship between the provider and the network organization must be disclosed to the provider before the amendment or change is deemed to be in effect.

(c) For purposes of this section, "network organization" and "health care provider" or "provider" have the meanings given in section 62Q.74.

History: *2001 c 170 s 6*

62Q.746 ACCESS TO CERTAIN INFORMATION REGARDING PROVIDERS.

Upon request of the commissioner, a health plan company licensed under chapters 62C and 62D must provide the following information:

(1) a detailed description 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;

(2) the number of full-time equivalent physicians, by specialty, nonphysician providers, and allied health providers used to provide services; and

(3) summary data that is broken down by type of provider, reflecting actual utilization of network and non-network practitioners and allied professionals by enrollees of the health plan company.

History: *2001 c 170 s 7*