

CHAPTER 62N

MINNESOTA COMMUNITY INTEGRATED
SERVICE NETWORK ACT

62N.01	Citation and purpose.	62N.29	Guaranteeing organization.
62N.02	Definitions.	62N.31	Standards for accredited capitated provider accreditation.
62N.22	Disclosure of commissions.	62N.32	Deposit requirement.
62N.23	Technical assistance; loans.	62N.33	Coverage for enrollees of insolvent networks.
62N.25	Community integrated service networks.	62N.35	Border issues.
62N.26	Shared services cooperative.	62N.40	Chemical dependency services.
62N.27	Definitions.		
62N.28	Net worth requirement.		

62N.01 CITATION AND PURPOSE.

Subdivision 1. **Citation.** This chapter may be cited as the "Minnesota Community Integrated Service Network Act."

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 [Repealed, 1997 c 225 art 2 s 63]

History: 1993 c 345 art 1 s 2; 1Sp1993 c 6 s 36; 1994 c 625 art 8 s 33; 1997 c 225 art 2 s 31

62N.02 DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to this chapter.

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 [Repealed, 1997 c 225 art 2 s 63]

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 [Repealed, 1997 c 225 art 2 s 63]

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health or the commissioner's designated representative.

Subd. 4a. **Community integrated service network or community network.** (a) "Community integrated service network" or "community network" means a formal arrangement licensed by the commissioner under section 62N.25 for providing prepaid health services to enrolled populations of 50,000 or fewer enrollees, including enrollees who are residents of other states.

(b) [Expired]

Subd. 4b. [Repealed, 1997 c 225 art 2 s 63]

Subd. 4c. [Repealed, 1997 c 225 art 2 s 63]

Subd. 5. **Enrollee.** "Enrollee" means an individual, including a member of a group, to whom a network is obligated to provide health services under this chapter.

Subd. 6. [Repealed, 1997 c 225 art 2 s 63]

Subd. 6a. **Health carrier.** "Health carrier" has the meaning given in section 62A.011.

Subd. 7. [Repealed, 1997 c 225 art 2 s 63]

Subd. 8. [Repealed, 1997 c 225 art 2 s 63]

Subd. 9. [Repealed, 1997 c 225 art 2 s 63]

Subd. 10. [Repealed, 1997 c 225 art 2 s 63]

Subd. 11. **Price.** "Price" means the actual amount of money paid, after discounts or other adjustments, by the person or organization paying money to buy health care coverage and health care services. "Price" does not mean the cost or costs incurred by a network or other entity to provide health care services to individuals.

Subd. 12. [Repealed, 1997 c 225 art 2 s 63]

History: 1993 c 345 art 1 s 3; 1994 c 625 art 1 s 3,4; art 8 s 34; 1995 c 234 art 1 s 10,11

62N.03 [Repealed, 1997 c 225 art 2 s 63]

MINNESOTA STATUTES 2002

1009

MINNESOTA COMMUNITY INTEGRATED SERVICE NETWORK ACT 62N.23

- 62N.04 [Repealed, 1997 c 225 art 2 s 63]
- 62N.05 [Repealed, 1997 c 225 art 2 s 63]
- 62N.06 [Repealed, 1997 c 225 art 2 s 63]
- 62N.065 [Repealed, 1997 c 225 art 2 s 63]
- 62N.07 [Repealed, 1994 c 625 art 8 s 74]
- 62N.071 [Repealed, 1997 c 225 art 2 s 63]
- 62N.072 [Repealed, 1997 c 225 art 2 s 63]
- 62N.073 [Repealed, 1997 c 225 art 2 s 63]
- 62N.074 [Repealed, 1997 c 225 art 2 s 63]
- 62N.075 [Repealed, 1994 c 625 art 8 s 74]
- 62N.076 [Repealed, 1997 c 225 art 2 s 63]
- 62N.077 [Repealed, 1997 c 225 art 2 s 63]
- 62N.078 [Repealed, 1997 c 225 art 2 s 63]
- 62N.08 [Repealed, 1994 c 625 art 8 s 74]
- 62N.085 [Repealed, 1994 c 625 art 8 s 74]
- 62N.10 [Repealed, 1997 c 225 art 2 s 63]
- 62N.11 [Repealed, 1997 c 225 art 2 s 63]
- 62N.12 [Repealed, 1997 c 225 art 2 s 63]
- 62N.13 [Repealed, 1997 c 225 art 2 s 63]
- 62N.14 [Repealed, 1997 c 225 art 2 s 63]
- 62N.15 [Repealed, 1997 c 225 art 2 s 63]
- 62N.16 [Repealed, 1994 c 625 art 8 s 74]
- 62N.17 [Repealed, 1997 c 225 art 2 s 63]
- 62N.18 [Repealed, 1997 c 225 art 2 s 63]

62N.22 DISCLOSURE OF COMMISSIONS.

Before selling any coverage or enrollment in a community integrated service network, a person selling the coverage or enrollment shall disclose in writing to the prospective purchaser the amount of any commission or other compensation the person will receive as a direct result of the sale. The disclosure may be expressed in dollars or as a percentage of the premium. The amount disclosed need not include any anticipated renewal commissions.

History: 1993 c 345 art 1 s 18; 1994 c 625 art 8 s 38; 1997 c 225 art 2 s 32

62N.23 TECHNICAL ASSISTANCE; LOANS.

(a) The commissioner shall provide technical assistance to parties interested in establishing or operating a community integrated service network. This shall be known as the community integrated service network technical assistance program (CISNTAP).

The technical assistance program shall offer seminars on the establishment and operation of community integrated service networks in all regions of Minnesota. The commissioner shall advertise these seminars in local and regional newspapers, and attendance at these seminars shall be free.

The commissioner shall write a guide to establishing and operating a community integrated service network. The guide must provide basic instructions for parties wishing to establish a community integrated service network. The guide must be provided free of charge to interested parties. The commissioner shall update this guide when appropriate.

The commissioner shall establish a toll-free telephone line that interested parties may call to obtain assistance in establishing or operating a community integrated service network.

(b) The commissioner shall grant loans for organizational and start-up expenses to entities forming community integrated service networks, or to networks less than one year old, to the extent of any appropriation for that purpose. The commissioner shall allocate the available funds among applicants based upon the following criteria, as evaluated by the commissioner within the commissioner's discretion:

- (1) the applicant's need for the loan;
 - (2) the likelihood that the loan will foster the formation or growth of a network;
- and
- (3) the likelihood of repayment.

The commissioner shall determine any necessary application deadlines and forms.

History: 1993 c 345 art 1 s 19; 1994 c 625 art 12 s 1; 1997 c 187 art 2 s 2; 1997 c 225 art 2 s 33

62N.24 [Repealed, 1997 c 225 art 2 s 63]

62N.25 COMMUNITY INTEGRATED SERVICE NETWORKS.

Subdivision 1. **Scope of licensure.** Beginning July 1, 1994, the commissioner shall accept applications for licensure as a community integrated service network under this section. Licensed community integrated service networks may begin providing health coverage to enrollees no earlier than January 1, 1995, and may begin marketing coverage to prospective enrollees upon licensure.

Subd. 2. **Licensure requirements generally.** To be licensed and to operate as a community integrated service network, an applicant must satisfy the requirements of chapter 62D, and all other legal requirements that apply to entities licensed under chapter 62D, except as exempted or modified in this section. Community networks must, as a condition of licensure, comply with section 62D.04, subdivision 5. A community integrated service network that phases in its net worth over a three-year period is not required to respond to requests for proposals under section 62D.04, subdivision 5, during the first 12 months of licensure. These community networks are not prohibited from responding to requests for proposals, however, if they choose to do so during that time period. After the initial 12 months of licensure, these community networks are required to respond to the requests for proposals as required under section 62D.04, subdivision 5.

Subd. 3. **Regulation; applicable law.** Community integrated service networks are regulated and licensed by the commissioner under the same authority that applies to entities licensed under chapter 62D, except as exempted or modified under this section. All statutes or rules that apply to health maintenance organizations apply to community networks, unless otherwise specified. A cooperative organized under chapter 308A may establish a community integrated service network.

Subd. 4. **Governing body.** In addition to the requirements of section 62D.06, at least 51 percent of the members of the governing body of the community integrated service network must be residents of the community integrated service network's service area. Service area, for purposes of this subdivision, may include contiguous geographic areas outside the state of Minnesota.

MINNESOTA STATUTES 2002

Subd. 5. **Benefits.** Community integrated service networks must offer the health maintenance organization benefit set, as defined in chapter 62D, and other laws applicable to entities regulated under chapter 62D. Community networks and chemical dependency facilities under contract with a community network shall use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660, when assessing enrollees for chemical dependency treatment.

Subd. 6. **Solvency.** A community integrated service network is exempt from the deposit, reserve, and solvency requirements specified in sections 62D.041, 62D.042, 62D.043, and 62D.044 and shall comply instead with sections 62N.27 to 62N.32. To the extent that there are analogous definitions or procedures in chapter 62D or in rules promulgated thereunder, the commissioner shall follow those existing provisions rather than adopting a contrary approach or interpretation.

Subd. 7. **Exemptions from existing requirements.** Community integrated service networks are exempt from the following requirements applicable to health maintenance organizations:

- (1) conducting focused studies under Minnesota Rules, part 4685.1125;
- (2) preparing and filing, as a condition of licensure, a written quality assurance plan, and annually filing such a plan and a work plan, under Minnesota Rules, parts 4685.1110 and 4685.1130;
- (3) maintaining statistics under Minnesota Rules, part 4685.1200;
- (4) filing provider contract forms under sections 62D.03, subdivision 4, and 62D.08, subdivision 1; and
- (5) preparing and filing, as a condition of licensure, a marketing plan, and annually filing a marketing plan, under sections 62D.03, subdivision 4, paragraph (l), and 62D.08, subdivision 1.

Subd. 8. **Provider contracts.** The provisions of section 62D.123 are implied in every provider contract or agreement between a community integrated service network and a provider, regardless of whether those provisions are expressly included in the contract. No participating provider, agent, trustee, or assignee of a participating provider has or may maintain any cause of action against a subscriber or enrollee to collect sums owed by the community network.

Subd. 9. **Exceptions to enrollment limit.** A community integrated service network may enroll enrollees in excess of 50,000 if necessary to comply with guaranteed issue or guaranteed renewal requirements of chapter 62L or section 62A.65.

History: 1994 c 625 art 1 s 5; 1995 c 234 art 1 s 27; 1997 c 187 art 1 s 6; 1997 c 203 art 4 s 2; 1997 c 225 art 2 s 34; 2001 c 170 s 2

62N.255 [Renumbered 62Q.095]

62N.26 SHARED SERVICES COOPERATIVE.

The commissioner of health shall establish, or assist in establishing, a shared services cooperative organized under chapter 308A to make available administrative and legal services, technical assistance, provider contracting and billing services, and other services to those community integrated service networks that choose to participate in the cooperative. The commissioner shall provide, to the extent funds are appropriated, start-up loans sufficient to maintain the shared services cooperative until its operations can be maintained by fees and contributions. The cooperative must not be staffed, administered, or supervised by the commissioner of health. The cooperative shall make use of existing resources that are already available in the community, to the extent possible.

History: 1994 c 625 art 1 s 7; 1997 c 225 art 2 s 35

62N.27 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62N.27 to 62N.32, the terms defined in this section have the meanings given. Other terms used in those sections have the meanings given in sections 62D.041, 62D.042, 62D.043, and 62D.044.

Subd. 2. **Net worth.** "Net worth" means admitted assets as defined in subdivision 3, minus liabilities. Liabilities do not include those obligations that are subordinated in the same manner as preferred ownership claims under section 60B.44, subdivision 10. For purposes of this subdivision, preferred ownership claims under section 60B.44, subdivision 10, include promissory notes subordinated to all other liabilities of the community integrated service network.

Subd. 3. **Admitted assets.** "Admitted assets" means admitted assets as defined in section 62D.044, except that real estate investments allowed by section 62D.045 are not admitted assets. Admitted assets include the deposit required under section 62N.32.

Subd. 4. **Accredited capitated provider.** "Accredited capitated provider" means a health care providing entity that:

(1) receives capitated payments from a community network under a contract to provide health services to the network's enrollees. For purposes of this section, a health care providing entity is "capitated" when its compensation arrangement with a network involves the provider's acceptance of material financial risk for the delivery of a predetermined set of services for a specified period of time;

(2) is licensed to provide and provides the contracted services, either directly or through an affiliate. For purposes of this section, an "affiliate" is any person that directly or indirectly controls, is controlled by, or is under common control with the health care providing entity, and "control" exists when any person, directly or indirectly, owns, controls, or holds the power to vote or holds proxies representing no less than 80 percent of the voting securities or governance rights of any other person;

(3) agrees to serve as an accredited capitated provider of a community network or for the purpose of reducing the network's net worth and deposit requirements under section 62N.28; and

(4) is approved by the commissioner as an accredited capitated provider for a community network in accordance with section 62N.31.

Subd. 5. **Percentage of risk ceded.** "Percentage of risk ceded" means the ratio, expressed as a percentage, between capitated payments made or, in the case of a new entity, expected to be made by a community network to all accredited capitated providers during any contract year and the total premium revenue, adjusted to eliminate expected administrative costs, received for the same time period by the community network.

Subd. 6. **Provider amount at risk.** "Provider amount at risk" means a dollar amount certified by a qualified actuary to represent the expected direct costs to an accredited capitated provider for providing the contracted, covered health care services to the enrollees of the network to which it is accredited for a period of 120 days.

History: 1994 c 625 art 1 s 8

62N.28 NET WORTH REQUIREMENT.

Subdivision 1. **Requirement.** Except as otherwise permitted by this chapter, each community network must maintain a minimum net worth equal to the greater of:

- (1) \$1,000,000;
- (2) two percent of the first \$150,000,000 of annual premium revenue plus one percent of annual premium revenue in excess of \$150,000,000;
- (3) eight percent of the annual health services costs, except those paid on a capitated or managed hospital payment basis, plus four percent of the annual capitation and managed hospital payment costs; or
- (4) four months uncovered health services costs.

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

(1) "capitated basis" means fixed per member per month payment or percentage of premium paid to a provider that assumes the full risk of the cost of contracted services without regard to the type, value, or frequency of services provided. For

purposes of this definition, capitated basis includes the cost associated with operating staff model facilities;

(2) "managed hospital payment basis" means agreements in which the financial risk is primarily related to the degree of utilization rather than to the cost of services; and

(3) "uncovered health services costs" means the cost to the community network of health services covered by the community network for which the enrollee would also be liable in the event of the community network's insolvency, and that are not guaranteed, insured, or assumed by a person other than the community network.

Subd. 3. **Reinsurance credit.** A community network may use the subtraction for premiums paid for insurance permitted under section 62D.042, subdivision 4.

Subd. 4. **Phase-in for net worth requirement.** A community network may choose to comply with the net worth requirement on a phase-in basis according to the following schedule:

(1) 50 percent of the amount required under subdivisions 1 to 3 at the time that the community network begins enrolling enrollees;

(2) 75 percent of the amount required under subdivisions 1 to 3 at the end of the first full calendar year of operation;

(3) 87.5 percent of the amount required under subdivisions 1 to 3 at the end of the second full calendar year of operation; and

(4) 100 percent of the amount required under subdivisions 1 to 3 at the end of the third full calendar year of operation.

Subd. 5. **Net worth corridor.** A community network shall not maintain net worth that exceeds three times the amount required of the community network under subdivision 1. Subdivision 4 is not relevant for purposes of this subdivision.

Subd. 6. **Net worth reduction.** If a community network has contracts with accredited capitated providers, and only for so long as those contracts or successor contracts remain in force, the net worth requirement of subdivision 1 shall be reduced by the percentage of risk ceded, but in no event shall the net worth requirements be reduced by this subdivision to less than \$1,000,000. The phase-in requirements of subdivision 4 shall not be affected by this reduction.

History: 1994 c 625 art 1 s 9; 1999 c 51 s 1

62N.29 GUARANTEEING ORGANIZATION.

A community network may satisfy its net worth and deposit requirements, in whole or in part, through the use of one or more guaranteeing organizations, with the approval of the commissioner, under the conditions permitted in chapter 62D. Governmental entities, such as counties, may serve as guaranteeing organizations subject to the requirements of chapter 62D.

History: 1994 c 625 art 1 s 10

62N.31 STANDARDS FOR ACCREDITED CAPITATED PROVIDER ACCREDITATION.

Subdivision 1. **General.** Each health care providing entity seeking initial accreditation as an accredited capitated provider shall submit to the commissioner of health sufficient information to establish that the applicant has operational capacity, facilities, personnel, and financial capability to provide the contracted covered services to the enrollees of the network for which it seeks accreditation (1) on an ongoing basis; and (2) for a period of 120 days following the insolvency of the network without receiving payment from the network. Accreditation shall continue until abandoned by the accredited capitated provider or revoked by the commissioner in accordance with subdivision 4. The applicant may establish financial capability by demonstrating that the provider amount at risk can be covered by or through any of allocated or restricted funds, a letter of credit, the taxing authority of the applicant or governmental sponsor of the applicant, an unrestricted fund balance at least two times the provider amount at

risk, reinsurance, either purchased directly by the applicant or by the community network to which it will be accredited, or any other method accepted by the commissioner. Accreditation of a health care providing entity shall not in itself limit the right of the accredited capitated provider to seek payment of unpaid capitated amounts from a community network, whether the community network is solvent or insolvent; provided that, if the community network is subject to any liquidation, rehabilitation, or conservation proceedings, the accredited capitated provider shall have the status accorded creditors under section 60B.44, subdivision 10.

Subd. 2. Annual reporting period. Each accredited capitated provider shall submit to the commissioner annually, no later than April 15, the following information for each network to which it is accredited: the provider amount at risk for that year, the number of enrollees for the network, both for the prior year and estimated for the current year, any material change in the provider's operational or financial capacity since its last report, and any other information reasonably requested by the commissioner.

Subd. 3. Additional reporting. Each accredited capitated provider shall provide the commissioner with 60 days' advance written notice of termination of the accredited capitated provider relationship with a network.

Subd. 4. Revocation of accreditation. The commissioner may revoke the accreditation of an accredited capitated provider if the accredited capitated provider's ongoing operational or financial capabilities fail to meet the requirements of this section. The revocation shall be handled in the same fashion as placing a health maintenance organization under administrative supervision.

History: 1994 c 625 art 1 s 11

62N.32 DEPOSIT REQUIREMENT.

A community network must satisfy the deposit requirement provided in section 62D.041. The deposit counts as an admitted asset and as part of the required net worth. The deposit requirement cannot be reduced by the alternative means that may be used to reduce the net worth requirement, other than through the use of a guaranteeing organization.

History: 1994 c 625 art 1 s 12

62N.33 COVERAGE FOR ENROLLEES OF INSOLVENT NETWORKS.

In the event of a community network insolvency, the commissioner shall determine whether one or more community networks or health plan companies are willing and able to provide replacement coverage to all of the failed community network's enrollees, and if so, the commissioner shall facilitate the provision of the replacement coverage. If such replacement coverage is not available, the commissioner shall randomly assign enrollees of the insolvent community network to other community networks and health plan companies in the service area, in proportion to their market share, for the remaining terms of the enrollees' contracts with the insolvent network. The other community networks and health plan companies must accept the allocated enrollees under their policy or contract most similar to the enrollees' contracts with the insolvent community network. The allocation must keep groups together. Enrollees with special continuity of care needs may, in the commissioner's discretion, be given a choice of replacement coverage rather than random assignment. Individuals and groups that are assigned randomly may choose a different community network or health plan company when their contracts expire, on the same basis as any other individual or group. The replacement health plan company must comply with any guaranteed renewal or other renewal provisions of the prior coverage, including but not limited to, provisions regarding preexisting conditions and health conditions that developed during prior coverage.

History: 1994 c 625 art 1 s 13

62N.34 [Repealed, 1995 c 234 art 1 s 29]

62N.35 BORDER ISSUES.

To the extent feasible and appropriate, community networks that also operate under the health maintenance organization or similar prepaid health care law of another state must be licensed and regulated by this state in a manner that avoids unnecessary duplication and expense for the community network. The commissioner shall communicate with regulatory authorities in neighboring states to explore the feasibility of cooperative approaches to streamline regulation of border community networks, such as joint financial audits, and shall report to the legislature on any changes to Minnesota law that may be needed to implement appropriate collaborative approaches to regulation.

History: 1994 c 625 art 1 s 15

62N.38 [Repealed, 1997 c 225 art 2 s 63]

62N.381 [Expired]

62N.40 CHEMICAL DEPENDENCY SERVICES.

Each community integrated service network regulated under this chapter must ensure that chemically dependent individuals have access to cost-effective treatment options that address the specific needs of individuals. These include, but are not limited to, the need for: treatment that takes into account severity of illness and comorbidities; provision of a continuum of care, including treatment and rehabilitation programs licensed under Minnesota Rules, parts 9530.4100 to 9530.4410 and 9530.5000 to 9530.6500; the safety of the individual's domestic and community environment; gender appropriate and culturally appropriate programs; and access to appropriate social services.

History: 1995 c 234 art 1 s 28; 1997 c 225 art 2 s 36