CHAPTER 62T

COMMUNITY PURCHASING ARRANGEMENTS

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62T.01 DEFINITIONS.

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

Subd. 2. **Health care purchasing alliance.** "Health care purchasing alliance" means a business organization created under this chapter to negotiate the purchase of health care services for employers. Nothing in this chapter shall be deemed to regulate or impose any requirements on a self-insured employer or labor union. A health care purchasing alliance may include a grouping of:

(1) businesses, including small businesses with one employee. The businesses may or may not be organized under section 62Q.17 as a purchasing pool;

(2) trade association members or church organizations under section 60A.02 or union members who are not in a self-insured benefit plan;

(3) multiple employer welfare associations under chapter 62H;

(4) municipalities, townships, or counties;

(5) other government entities; or

(6) any combination of clauses (1) to (5).

The alliance may determine the definition of a business of one employee, but must adhere to its definition and show no bias in selection of members based on that definition.

Subd. 3. **Accountable provider network.** "Accountable provider network" means a group of health care providers organized to market health care services on a risk-sharing or non-risk-sharing basis with a health care purchasing alliance. Accountable provider networks shall operate as not-for-profit entities or as health care cooperatives, as allowed under chapter 62R. This chapter applies only when an accountable provider network is marketing and selling services and benefits to the employees of businesses as authorized in section 62T.05.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

History: *1997 c 225 art 5 s 1*

62T.02 PURCHASING ALLIANCES.

Subdivision 1. **Registration.** Purchasing alliances must register prior to offering coverage, and annually on July 1 thereafter, with the commissioner on a form prescribed by the commissioner.

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

History: *1997 c 225 art 5 s 2*

62T.025 EMPLOYER-MEMBER CONTRIBUTION.

If an employer-member of a purchasing alliance can demonstrate that the member has not offered employee health coverage for a year or more, the member may contribute 25 percent or more of the cost of employee coverage for up to 36 months. This provision only applies to rural purchasing alliances organized under this chapter and operating prior to May 1, 2000. The affected purchasing alliances may develop membership criteria which disallow an employer contribution below 50 percent.

History: *2000 c 295 s 1*

62T.03 APPLICATION OF OTHER LAWS.

Subdivision 1. **State law.** An accountable provider network is subject to all requirements applicable to a health plan company licensed in the state, except as otherwise noted in this chapter. An accountable provider network and a health care purchasing alliance must comply with all requirements of chapter 62L, except for modifications and waivers permitted under this chapter. A contracting arrangement between a health care purchasing alliance and an accountable provider network for provision of health care benefits must provide consumer protection functions comparable to those currently required of a health plan company licensed under section 62N.25, and other statutes referenced in that section, except for modifications and waivers permitted under this chapter.

Subd. 2. **Federal law.** A self-insured employer may participate as an affiliate member of a purchasing alliance without participation affecting the employer's standing under the federal Employee Retirement Income Security Act (ERISA) of 1974. An affiliate member is one that may purchase administrative services with the purchasing alliance and may participate in activities undertaken to educate and promote health improvement of the purchasing alliance enrollees or community residents.

History: *1997 c 225 art 5 s 3; 2000 c 295 s 2*

62T.04 COMPLAINT SYSTEM.

Accountable provider networks must establish and maintain an enrollee complaint system as required under sections 62Q.68 to 62Q.72 or as required by a contract with a purchasing alliance. The contract must be approved by the commissioner. The accountable provider network may contract with the health care purchasing alliance or a vendor for operation of this system. The commissioner may not waive any enrollee rights relating to external review.

History: *1997 c 225 art 5 s 4; 1999 c 239 s 40; 2000 c 295 s 3*

62T.05 BENEFITS.

An accountable provider network may offer and sell any benefits permitted to be offered and sold by health plan companies under Minnesota law. An accountable provider network may, after consultation with the purchasing alliance, offer only one benefit plan to employer-members of the alliance.

History: *1997 c 225 art 5 s 5; 2000 c 295 s 4*

62T.06 WAIVERS.

Subdivision 1. **Authorization.** The commissioner may grant waivers from the requirements of law for the contracting arrangement between a health care purchasing alliance and an accountable provider network in the areas listed in subdivisions 2 to 4. The commissioner may not waive the following state consumer protection and quality assurance laws:

(1) laws requiring that enrollees be informed of any restrictions, requirements, or limitations on coverage, services, or access to specialists and other providers;

(2) laws allowing consumers to complain to or appeal to a state regulatory agency if denied benefits or services;

(3) laws prohibiting gag clauses and other restrictions on communication between a patient and their physician or provider;

(4) laws allowing consumers to obtain information on provider financial incentives, which may affect treatment;

(5) laws requiring the submission of information needed to monitor quality of care and enrollee rights, except the submission may be done in a manner approved by the commissioner under subdivision 4;

(6) laws protecting enrollee privacy and confidentiality of records;

(7) minimum standards for adequate provider network capacity and geographic access to services;

(8) laws assuring continuity of care when a patient must change providers;

(9) laws governing coverage of emergency services;

(10) laws prohibiting excessive or unreasonable administrative fees or expenses; and

(11) other laws or rules that are directly related to quality of care, consumer protection, and due process rights.

Subd. 2. **Solvency protection.** (a) The commissioner may waive the requirements of sections 62N.27 to 62N.32, and may substitute capital and surplus requirements that are reduced from the levels required of other risk-bearing entities in order to reflect its reduced risk exposure. If risk is being underwritten, the underwriter cannot have more than 25 percent of the representation on the governing board of the accountable provider network. The reduced requirements must include at least the following levels of capital and surplus: (i) a deposit of $500,000 and (ii) the greater of an estimated 15 percent of gross premium revenues or twice the net retained annual risk up to $750,000 on a single enrollee. Net retained annual risk may be, for example, the lowest annual deductible under a provider stop-loss insurance policy that covers all costs above the deductible. Assets supporting the deposit must meet the standards for deposits referenced in section 62N.32 or be guaranteed by an entity that is approved and can be monitored by the commissioner. Assets supporting the capital must meet the investment guidelines referenced in section 62N.27. Members of a purchasing alliance may assist in meeting the solvency requirements through a subordinated solvency contribution under a contract approved by the commissioner. For the purposes of this subdivision, "subordinated solvency contribution" means a contribution to the accountable provider network by a purchasing alliance member that is evidenced by a promissory note or other instrument that allows for repayment of the contribution in the manner provided in a contract approved by the commissioner.

(b) An accountable provider network may propose a method of reporting income, expenses, claims payments, and other financial information in a manner which adequately demonstrates ongoing compliance with the standards for capital, surplus, and claims reserves agreed to under this waiver.

(c) An accountable provider network may demonstrate ability to continue to deliver the contracted health care services to the purchasing alliance through arrangements which ensure that, subject to 60 days' notice of intent to discontinue the contracting arrangement, provider participants will continue to meet their obligation to provide health care services to enrollees for a period of 60 days.

Subd. 3. **Marketing and disclosure.** The accountable provider network, in conjunction with the health care purchasing alliance, may propose alternative methods to present marketing and disclosure information which assure the accountability to consumers who are offered and who receive their services.

Subd. 4. **Quality assurance.** The accountable provider network may propose an alternative quality assurance program which incorporates effective methods for reviewing and evaluating data related to quality of care and ways to identify and correct quality problems.

History: *1997 c 225 art 5 s 6; 2000 c 295 s 5,6*

62T.07 CRITERIA FOR GRANTING WAIVERS.

The commissioner may approve a request for waiver under section 62T.06 if the applicant demonstrates that the contracting arrangement between a health care purchasing alliance and an accountable provider network will meet the following criteria:

(a) The arrangement would be likely to result in:

(1) more choice in benefits and prices;

(2) lower costs;

(3) increased access to health care coverage by small businesses;

(4) increased access to providers who have demonstrated a long-term commitment to the community being serviced; or

(5) increased quality of health care than would otherwise occur under the existing market conditions. In the event that a proposed arrangement appears likely to improve one or two of the criteria at the expense of another one or two of the criteria, the commissioner shall not approve the waiver.

(b) The proposed alternative methods would provide equal or improved results in consumer protection than would result under the existing consumer protections requirements.

History: *1997 c 225 art 5 s 7*

62T.08 SUPERVISION AND REVOCATION OF WAIVERS.

(a) The commissioner shall appropriately supervise and monitor approved waivers.

(b) The commissioner may revoke approval of a waiver if the contracting arrangement no longer satisfies the criteria in section 62T.07, paragraphs (a) and (b).

History: *1997 c 225 art 5 s 8*

62T.09 MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION.

A health care purchasing alliance must pay the assessment required of contributing members pursuant to section 62E.11.

History: *1997 c 225 art 5 s 9*

62T.10 MINNESOTACARE TAX.

An accountable provider network shall file with the commissioner of revenue all returns and pay to the commissioner of revenue all amounts required under chapter 297I.

History: *1997 c 225 art 5 s 10; 2000 c 394 art 2 s 17*

62T.11 DUTIES OF COMMISSIONER.

(a) By July 1, 1997, the commissioner shall make available application forms for licensure as an accountable provider network. The accountable provider network may begin doing business after application has been approved.

(b) Upon receipt of an application for a certificate of authority, the commissioner shall grant or deny licensure and waivers requested within 90 days of receipt of a complete application if all requirements are substantially met. For a period of six years after July 1, 1997, the commissioner may approve up to five applications, none of which may be from health plan companies. If no written response has been received within 90 days, the application is approved. When the commissioner denies an application or waiver request, the commissioner shall notify the applicant in writing specifically stating the grounds for the denial and specific suggestions for how to remedy the denial. The commissioner will entertain reconsiderations. Within 90 days after the denial, the applicant may file a written request for an administrative hearing and review of the commissioner's determination. The hearing is subject to judicial review as provided by chapter 14.

(c) All monitoring, enforcement, and rulemaking powers available under chapter 62N are granted to the commissioner to assure continued compliance with provisions of

this chapter. The commissioner shall honor the intent of this section to foster community-focused, affordable health coverage for small employers and their employees.

(d) The commissioner may contract with other entities as necessary to carry out the responsibilities in this chapter.

History: *1997 c 225 art 5 s 11; 2000 c 295 s 7*

62T.12 FEES.

Every accountable provider network subject to this chapter shall pay to the commissioner fees as prescribed by the commissioner pursuant to section 144.122. The initial fees are:

(1) filing an application for licensure, $500;

(2) filing an amendment to a license, $90;

(3) filing an annual report, $200;

(4) filing of renewal of licensure based on a fee of $1,000 per 1,000 enrollees, with renewal every three years; and

(5) other filing fees as specified by rule.

History: *1997 c 225 art 5 s 12*

62T.13 [Repealed, 2000 c 295 s 8]