CHAPTER 62Q

REQUIREMENTS FOR HEALTH PLAN COMPANIES

62Q.101 EVALUATION OF PROVIDER PERFORMANCE.

A health plan company, or a vendor of risk management services as defined under section 60A.23, subdivision 8, shall, in evaluating the performance of a health care provider:

(1) conduct the evaluation using a bona fide baseline based upon practice experience of the provider group; and

(2) disclose the baseline to the health care provider in writing and prior to the beginning of the time period used for the evaluation.

History: *2007 c 147 art 15 s 10*

62Q.165 UNIVERSAL COVERAGE.

Subdivision 1. **Definition.** It is the commitment of the state to achieve universal health coverage for all Minnesotans by the year 2011. Universal coverage is achieved when:

(1) every Minnesotan has access to a full range of quality health care services;

(2) every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care; and

(3) every Minnesotan pays into the health care system according to that person's ability.

Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward reducing the number of Minnesotans who do not have health coverage so that by January 1, 2011, all Minnesota residents have access to affordable health care. The goal will be achieved by improving access to private health coverage through insurance reforms and market reforms, by making health coverage more affordable for low-income Minnesotans through purchasing pools and state subsidies, and by reducing the cost of health coverage through cost containment programs and methods of ensuring that all Minnesotans are paying into the system according to their ability.

History: *2007 c 147 art 15 s 11,12*

62Q.19 ESSENTIAL COMMUNITY PROVIDERS.

[For text of subd 1, see M.S.2006]

Subd. 2. **Application.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner.

(b) Each application submitted must be accompanied by an application fee of $60. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

[For text of subds 2a to 5b, see M.S.2006]

Subd. 6. **Termination or renewal of designation; commissioner review.** The designation as an essential community provider shall be valid for a five–year period from the date of designation. Every five years after the designation or renewal of the designation of essential community provider is granted to a provider, the commissioner shall review the need for and appropriateness of continuing the designation for that provider. The commissioner may require a provider whose designation is to be reviewed to submit an application to the commissioner for renewal of the designation and may require an application fee of $60 to be submitted with the application to cover the administrative costs of processing the application. Based on that review, the commissioner may renew a provider's essential community provider designation for an additional five–year period or terminate the designation. Once the designation terminates, the former essential community provider has no rights or privileges beyond those of any other health care provider.

[For text of subd 7, see M.S.2006]

History: *2007 c 50 s 1,2*

62Q.675 HEARING AIDS; PERSONS 18 OR YOUNGER.

A health plan must cover hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co–payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed.

History: *2007 c 60 s 1*

62Q.80 COMMUNITY–BASED HEALTH CARE COVERAGE PROGRAM.

[For text of subd 1, see M.S.2006]

Subd. 1a. **Demonstration project.** The commissioner of health shall award a demonstration project grant to a community–based health care initiative to develop and operate a community–based health care coverage program to operate within Carlton, Cook, Lake, and St. Louis Counties. The demonstration project shall extend for five years and must comply with the requirements of this section.

[For text of subd 2, see M.S.2006]

Subd. 3. **Approval.** (a) Prior to the operation of a community–based health care coverage program, a community–based health initiative shall submit to the commissioner of health for approval the community–based health care coverage program developed by the initiative. The commissioner shall ensure that the program meets the federal grant requirements and any requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community–based health initiative in establishing premium rates for the community–based health care coverage program.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community–based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Subd. 4. **Establishment.** The initiative shall establish and operate upon approval by the commissioner of health a community–based health care coverage program. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost–sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

[For text of subds 5 to 12, see M.S.2006]

Subd. 13. **Report.** (a) The initiative shall submit quarterly status reports to the commissioner of health on January 15, April 15, July 15, and October 15 of each year, with the first report due January 15, 2008. The status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the commissioner of health or commerce or the legislature.

(b) The initiative shall contract with an independent entity to conduct an evaluation of the program to be submitted to the commissioners of health and commerce and the legislature by January 15, 2010. The evaluation shall include:

(1) an analysis of the health outcomes established by the initiative and the performance measurements to determine whether the outcomes are being achieved;

(2) an analysis of the financial status of the program, including the claims to premiums loss ratio and utilization and cost experience;

(3) the demographics of the enrollees, including their age, gender, family income, and the number of dependents;

(4) the number of employers and employees who have been denied access to the program and the basis for the denial;

(5) specific analysis on enrollees who have aggregate medical claims totaling over $5,000 per year, including data on the enrollee's main diagnosis and whether all the medical claims were covered by the program;

(6) number of enrollees referred to state public assistance programs;

(7) a comparison of employer–subsidized health coverage provided in a comparable geographic area to the designated community–based geographic area served by the program, including, to the extent available:

(i) the difference in the number of employers with 50 or fewer employees offering employer–subsidized health coverage;

(ii) the difference in uncompensated care being provided in each area; and

(iii) a comparison of health care outcomes and measurements established by the initiative; and

(8) any other information requested by the commissioner of health or commerce.

Subd. 14. **Sunset.** This section expires December 31, 2012.

History: *2007 c 147 art 9 s 10–13; art 10 s 1*