STATE OF MINNESOTA

SEVENTY-EIGHTH SESSION — 1994

NINETY-EIGHTH DAY

SAINT PAUL, MINNESOTA, TUESDAY, APRIL 26, 1994

The House of Representatives convened at 9:00 a.m. and was called to order by Irv Anderson, Speaker of the House.

Prayer was offered by the Reverend Armand J. Boehme, St. Paul Lutheran Church, Waseca, Minnesota.

The roll was called and the following members were present:

Abrams	Dehler	Holsten	Krinkie	Munger	Peterson	Tompkins
Anderson, R.	Delmont	Hugoson	Krueger	Murphy	Pugh	Trimble
Asch	Dempsey	Huntley	Lasley	Neary	Reding	Tunheim
Battaglia	Dorn	Jacobs	Lieder	Nelson	Rest	Van Dellen
Bauerly	Erhardt	Jaros	Limmer	Ness	Rhodes	Van Engen
Beard	Evans	Jefferson	Lindner	Olson, E.	Rice	Vellenga
Bergson	Farrell	Jennings	Long	Olson, K.	Rodosovich	Vickerman
Bertram	Finseth	Johnson, A.	Lourey	Olson, M.	Rukavina	Wagenius
Bettermann	Frerichs	Johnson, R.	Luther	Onnen	Sarna	Waltman
Brown, C.	Garcia	Johnson, V.	Lynch	Opatz	Seagren	Weaver
Brown, K.	Girard	Kahn	Macklin	Orenstein	Sekhon	Wejcman
Carlson	Goodno	Kalis	Mahon	Orfield	Simoneau	Wenzel
Carruthers	Greenfield	Kelley	Mariani	Osthoff	Skoglund	Winter
Clark	Greiling	Kelso	McCollum	Ostrom	Smith	Wolf
Commers	Gruenes	Kinkel	McGuire	Ozment	Solberg	Worke
Cooper	Gutknecht	Klinzing	Milbert	Pauly	Steensma	Workman
Dauner	Hasskamp	Knickerbocker	Molnau	Pawlenty	Sviggum	Spk. Anderson, I.
Davids	Haukoos	Knight	Morrison	Pelowski	Swenson	
Dawkins	Hausman	Koppendrayer	Mosel	Perlt	Tomassoni	

A quorum was present.

Leppik was excused until 10:20 a.m. Bishop and Stanius were excused until 11:40 a.m.

The Chief Clerk proceeded to read the Journal of the preceding day. Worke moved that further reading of the Journal be dispensed with and that the Journal be approved as corrected by the Chief Clerk. The motion prevailed.

REPORTS OF CHIEF CLERK

S. F. No. 2289 and H. F. No. 2520, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Weaver moved that the rules be so far suspended that S. F. No. 2289 be substituted for H. F. No. 2520 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2885 and H. F. No. 3095, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Beard moved that the rules be so far suspended that S. F. No. 2885 be substituted for H. F. No. 3095 and that the House File be indefinitely postponed. The motion prevailed.

SECOND READING OF SENATE BILLS

S. F. Nos. 2289 and 2885 were read for the second time.

INTRODUCTION AND FIRST READING OF HOUSE BILLS

The following House File was introduced:

Carlson, Tunheim and Johnson, A., introduced:

H. F. No. 3234, A bill for an act relating to drivers' licenses; reducing the fee for duplicate Minnesota identification cards; amending Minnesota Statutes 1992, section 171.07, subdivisions 3 and 3a; Minnesota Statutes 1993 Supplement, section 171.06, subdivision 2.

The bill was read for the first time and referred to the Committee on Transportation and Transit.

MESSAGES FROM THE SENATE

The following messages were received from the Senate:

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 2478, A bill for an act relating to retirement; first class city teachers; defining salary; authorizing purchase of service credit for parental or maternity leave; resumption of teaching by basic program retirees; authorizing certain bylaw amendments by the Minneapolis and St. Paul teachers retirement fund associations; amending Minnesota Statutes 1992, sections 354A.011, subdivision 24; 354A.095; and 354A.31, subdivision 3.

PATRICK E. FLAHAVEN, Secretary of the Senate

CONCURRENCE AND REPASSAGE

Reding moved that the House concur in the Senate amendments to H. F. No. 2478 and that the bill be repassed as amended by the Senate. The motion prevailed.

H. F. No. 2478, A bill for an act relating to retirement; first class city teachers; defining salary; authorizing purchase of service credit for parental or maternity leave; resumption of teaching by basic program retirees; authorizing the board of the Minneapolis teachers retirement fund association to amend the bylaws or articles of incorporation to provide for parental or maternity leave; amending Minnesota Statutes 1992, sections 354A.011, subdivision 24; 354A.095; and 354A.31, subdivision 3.

The bill was read for the third time, as amended by the Senate, and placed upon its repassage.

The question was taken on the repassage of the bill and the roll was called. There were 110 yeas and 9 nays as follows:

Those who voted in the affirmative were:

Abrams	Dehler	Hausman	Lasley	Murphy	Rest	Van Dellen
Anderson, R.	Delmont	Holsten	Lieder	Neary	Rhodes	Van Engen
Asch	Dempsey	Huntley	Limmer	Nelson	Rodosovich	Vellenga
Battaglia	Dorn	Jacobs	Lindner	Ness	Rukavina	Vickerman
Bauerly	Erhardt	Jaros	Long	Olson, E.	Sarna	Wagenius
Beard	Evans	Jefferson	Luther	Onnen	Seagren	Waltman
Bergson	Farrell	Jennings	Lynch	Opatz	Sekhon	Weaver
Bertram	Finseth	Johnson, A.	Macklin	Orenstein	Simoneau	Wejcman
Bettermann	Garcia	Johnson, R.	Mahon	Orfield	Skoglund	Wenzel
Brown, K.	Girard	Johnson, V.	Mariani	Ostrom	Smith	Winter
Carlson	Greenfield	Kalis	McCollum	Pauly	Solberg	Wolf
Commers	Greiling	Kelley	McGuire	Pelowski	Swenson	Worke
Cooper	Gruenes	Kelso	Milbert	Perlt	Tomassoni	Workman
Dauner	Gutknecht	Kinkel	Morrison	Peterson	Tompkins	Spk. Anderson, I.
Davids	Hasskamp	Klinzing	Mosel	Pugh	Trimble	
Dawkins	Haukoos	Krueger	Munger	Reding	Tunheim	

Those who voted in the negative were:

Frerichs	Hugoson	Koppendrayer	Molnau	Sviggum
Goodno	Knight	Krinkie	Olson, M.	

The bill was repassed, as amended by the Senate, and its title agreed to.

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 2839, A bill for an act relating to retirement; South St. Paul police relief association; clarifying probationary employment for purposes of relief association service credit for certain members.

PATRICK E. FLAHAVEN, Secretary of the Senate

CONCURRENCE AND REPASSAGE

Pugh moved that the House concur in the Senate amendments to H. F. No. 2839 and that the bill be repassed as amended by the Senate. The motion prevailed.

H. F. No. 2839, A bill for an act relating to retirement; changing employer contribution rates for the volunteer fire relief associations paying monthly pensions; changing employer contribution rates for the Bloomington fire relief association; clarifying probationary employment for South St. Paul police relief association; amending Minnesota Statutes 1992, section 69.773, subdivision 4.

The bill was read for the third time, as amended by the Senate, and placed upon its repassage.

The question was taken on the repassage of the bill and the roll was called. There were 126 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abrams	Battaglia	Bergson	Brown, K.	Commers	Davids	Delmont
Anderson, R.	Bauerly	Bertram	Carlson	Cooper	Dawkins	Dempsey
Asch	Beard	Bettermann	Carruthers	Dauner	Dehler	Dorn

Erhardt	Holsten	Klinzing	Mariani	Onnen	Rodosovich	Tunheim
Evans	Hugoson	Knickerbocker	McCollum	Opatz	Rukavina	Van Dellen
Farrell	Huntley	Knight	McGuire	Orenstein	Sarna	Van Engen
Finseth	Jacobs	Koppendrayer	Milbert	Orfield	Seagren	Vellenga
Frerichs	Jaros	Krinkie	Molnau	Ostrom	Sekhon	Vickerman
Garcia	Jefferson	Krueger	Morrison	Pauly	Simoneau	Wagenius
Girard	Jennings	Lasley	Mosel	Pawlenty	Skoglund	Waltman
Goodno	Johnson, A.	Lieder	Munger	Pelowski	Smith	Weaver
Greenfield	Johnson, R.	Limmer	Murphy	Perlt	Solberg	Wejcman
Greiling	Johnson, V.	Lindner	Neary	Peterson	Steensma	Wenzel
Gruenes	Kahn	Lourey	Nelson	Pugh	Sviggum	Winter
Gutknecht	Kalis	Luther	Ness	Reding	Swenson	Wolf
Hasskamp	Kelley	Lynch	Olson, E.	Rest	Tomassoni	Worke
Haukoos	Kelso	Macklin	Olson, K.	Rhodes	Tompkins	Workman
Hausman	Kinkel	Mahon	Olson, M.	Rice	Trimble	Spk. Anderson, I.

The bill was repassed, as amended by the Senate, and its title agreed to.

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 2135, A bill for an act relating to manufactured home parks; prohibiting manufactured home parks from prohibiting senior citizens from keeping house pet dogs, cats, and birds on the park premises; amending Minnesota Statutes 1992, section 327.27, by adding a subdivision.

PATRICK E. FLAHAVEN, Secretary of the Senate

CONCURRENCE AND REPASSAGE

Jefferson moved that the House concur in the Senate amendments to H. F. No. 2135 and that the bill be repassed as amended by the Senate. The motion prevailed.

H. F. No. 2135, A bill for an act relating to animals; prohibiting manufactured home parks from prohibiting senior citizens from keeping pet dogs, cats, and birds on the park premises; requiring standards for care of dogs and cats by dealers, breeders, and brokers; amending Minnesota Statutes 1992, section 327.27, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 346.

The bill was read for the third time, as amended by the Senate, and placed upon its repassage.

The question was taken on the repassage of the bill and the roll was called. There were 111 yeas and 19 nays as follows:

Those who voted in the affirmative were:

Abrams	Clark	Garcia	Jefferson	Krueger	Milbert	Orenstein
Anderson, R.	Cooper	Greenfield	Jennings	Lasley	Molnau	Orfield
Asch	Dauner	Greiling	Johnson, A.	Lieder	Morrison	Osthoff
Battaglia	Dawkins	Gruenes	Johnson, R.	Long	Mosel	Ostrom
Bauerly	Dehler	Gutknecht	Johnson, V.	Lourey	Munger	Ozment
Beard	Delmont	Hasskamp	Kahn	Luther	Murphy	Pauly
Bergson	Dempsey	Hausman	Kalis	Lynch	Neary	Pelowski
Bertram	Dorn	Holsten	Kelley	Macklin	Nelson	Perlt
Bettermann	Erhardt	Hugoson	Kelso	Mahon	Ness	Pugh
Brown, C.	Evans	Huntley	Kinkel	Mariani	Olson, E.	Reding
Carlson	Farrell	Jacobs	Klinzing	McCollum	Onnen	Rest
Carruthers	Finseth	Jaros	Knickerbocker	McGuire	Opatz	Rhodes

Rice	Seagren	Smith	Swenson	Tunheim	Waltman	Wolf
Rodosovich	Sekhon	Solberg	Tomassoni	Van Engen	Wejcman	Workman
Rukavina	Simoneau	Steensma	Tompkins	Vellenga	Wenzel	Spk. Anderson, I.
Sarna	Skoglund	Sviggum	Trimble	Wagenius	Winter	

Those who voted in the negative were:

Brown, K.	Frerichs	Haukoos	Krinkie	Olson, M.	Van Dellen	Worke
Commers	Girard	Knight	Limmer	Pawlenty	Vickerman	
Davids	Goodno	Koppendrayer	Lindner	Peterson	Weaver	

The bill was repassed, as amended by the Senate, and its title agreed to.

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 1999, A bill for an act relating to insurance; requiring disclosure of information relating to insurance fraud; granting immunity for reporting suspected insurance fraud; requiring insurers to develop antifraud plans; prescribing penalties; proposing coding for new law in Minnesota Statutes, chapter 60A.

PATRICK E. FLAHAVEN, Secretary of the Senate

Pugh moved that the House refuse to concur in the Senate amendments to H. F. No. 1999, that the Speaker appoint a Conference Committee of 3 members of the House, and that the House requests that a like committee be appointed by the Senate to confer on the disagreeing votes of the two houses. The motion prevailed.

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 2046, A bill for an act relating to wild animals; restricting the killing of dogs wounding, killing, or pursuing big game within the metropolitan area; amending Minnesota Statutes 1992, section 97B.011.

PATRICK E. FLAHAVEN, Secretary of the Senate

Wagenius moved that the House refuse to concur in the Senate amendments to H. F. No. 2046, that the Speaker appoint a Conference Committee of 3 members of the House, and that the House requests that a like committee be appointed by the Senate to confer on the disagreeing votes of the two houses. The motion prevailed.

Mr. Speaker:

I hereby announce the passage by the Senate of the following Senate Files, herewith transmitted:

S. F. Nos. 2072, 2354 and 2309.

PATRICK E. FLAHAVEN, Secretary of the Senate

FIRST READING OF SENATE BILLS

S. F. No. 2072, A bill for an act relating to commerce; agriculture; adding labeling requirements for salvaged food; adding licensing and permit requirements for salvaged food distributors; adding record keeping requirements; requiring salvaged food served for compensation to be identified; providing for labeling of Canadian wild rice; appropriating money; amending Minnesota Statutes 1992, sections 30.49, subdivision 2; and 31.495, subdivisions 1, 2, and 5, and by adding subdivisions.

The bill was read for the first time.

Trimble moved that S. F. No. 2072 and H. F. No. 2132, now on Special Orders, be referred to the Chief Clerk for comparison. The motion prevailed.

S. F. No. 2354, A bill for an act relating to transportation; regulating the transportation of hazardous material and hazardous waste; making technical changes; specifying that certain federal regulations do not apply to cargo tanks under 3,500 gallons used in the intrastate transportation of gasoline; establishing a uniform registration and permitting program for transporters of hazardous material and hazardous waste; defining terms; establishing requirements for applications; describing methods for calculating fees; specifying treatment of application data; establishing enforcement authority and administrative penalties; providing for suspension or revocation of registration and permits; providing for base state agreements; preempting and suspending conflicting programs; providing for the deposit and use of fees and grants; establishing exemptions; appropriating money; amending Minnesota Statutes 1992, sections 13.99, by adding a subdivision; and 221.033, subdivisions 1 and 2b; Minnesota Statutes 1993 Supplement, sections 115E.045, subdivision 2; and 221.036, subdivisions 1 and 3; proposing coding for new law in Minnesota Statutes, chapter 221; repealing Minnesota Statutes 1992, section 221.033, subdivision 4.

The bill was read for the first time.

Ozment moved that S. F. No. 2354 and H. F. No. 2183, now on General Orders, be referred to the Chief Clerk for comparison. The motion prevailed.

S. F. No. 2309, A bill for an act relating to civil actions; consolidating and recodifying statutes providing limitations on private personal injury liability; providing immunity for certain volunteer athletic physicians and trainers; limiting liability for certain injuries arising out of nonprofit livestock activities; modifying provisions dealing with recreational land use liability; providing limitations on liability of officers, directors, and agents of economic development authorities; amending Minnesota Statutes 1992, sections 144.761, subdivision 5; and 469.091, by adding a subdivision; proposing coding for new law as Minnesota Statutes, chapter 604A; repealing Minnesota Statutes 1992, sections 31.50; 87.021; 87.0221; 87.023; 87.024; 87.025; 87.026; 87.03; 604.05; 604.08; 604.09; and 609.662, subdivision 5.

The bill was read for the first time.

Pugh moved that S. F. No. 2309 and H. F. No. 2603, now on Special Orders, be referred to the Chief Clerk for comparison. The motion prevailed.

MOTION FOR RECONSIDERATION

Mariani moved that the vote whereby the House refused to concur on Monday, April 25, 1994, in the Senate amendments to H. F. No. 2519 and that the Speaker appoint a Conference Committee of 3 members be now reconsidered. The motion prevailed.

Mariani moved that the House refuse to concur in the Senate amendments to H. F. No. 2519, that the Speaker appoint a Conference Committee of 5 members of the House, and that the House requests that a like committee be appointed by the Senate to confer on the disagreeing votes of the two houses. The motion prevailed.

ANNOUNCEMENT BY THE SPEAKER

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 2519:

Mariani, Pugh, Dawkins, Wejcman and Bishop.

CONSIDERATION UNDER RULE 1.10

Pursuant to rule 1.10, Solberg requested immediate consideration of S. F. No. 1867 and H. F. No. 2951.

S. F. No. 1867, A bill for an act relating to health; requesting the legislative auditor to study the administrative costs of providing health care services; appropriating money.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 83 yeas and 47 nays as follows:

Those who voted in the affirmative were:

Anderson, R.	Dauner	Jacobs	Krueger	Munger	Perlt	Solberg
Asch	Dawkins	Jaros	Lasley	Murphy	Peterson	Steensma
Battaglia	Delmont	Jefferson	Lieder	Neary	Pugh	Tomassoni
Beard	Dorn	Jennings	Long	Nelson	Reding	Trimble
Bergson	Evans	Johnson, A.	Lourey	Olson, E.	Rest	Tunheim
Bertram	Farrell	Johnson, R.	Luther	Olson, K.	Rice	Vellenga
Brown, C.	Garcia	Kahn	Mahon	Opatz	Rodosovich	Wagenius
Brown, K.	Greenfield	Kalis	Mariani	Orenstein	Rukavina	Wejcman
Carlson	Greiling	Kelley	McCollum	Orfield	Sarna	Wenzel
Carruthers	Hasskamp	Kelso	McGuire	Osthoff	Sekhon	Winter
Clark	Hausman	Kinkel	Milbert	Ostrom	Simoneau	Spk. Anderson, I.
Cooper	Huntley	Klinzing	Mosel	Pelowski	Skoglund	

Those who voted in the negative were:

Abrams	Finseth	Holsten	Limmer	Olson, M.	Smith	Waltman
Bettermann	Frerichs	Hugoson	Lindner	Onnen	Sviggum	Weaver
Commers	Girard	Johnson, V.	Lynch	Ozment	Swenson	Wolf
Davids	Goodno	Knickerbocker	Macklin	Pauly	Tompkins	Worke
Dehler	Gruenes	Knight	Molnau	Pawlenty	Van Dellen	Workman
Dempsey	Gutknecht	Koppendrayer	Morrison	Rhodes	Van Engen	
Erhardt	Haukoos	Krinkie	Ness	Seagren	Vickerman	

The bill was passed and its title agreed to.

H. F. No. 2951 was reported to the House.

Lourey, Cooper and Rukavina moved to amend H. F. No. 2951, the first engrossment, as follows:

Page 1, after line 4, insert:

"Section 1. Minnesota Statutes 1993 Supplement, section 256.9352, subdivision 3, is amended to read:

Subd. 3. [FINANCIAL MANAGEMENT.] (a) The commissioner shall manage spending for the ~~health right plan~~ MinnesotaCare program in a manner that maintains a minimum reserve equal to five percent of the expected cost of state premium subsidies. The commissioner must make a quarterly assessment of the expected expenditures for the

covered services for the remainder of the current fiscal year and for the following two fiscal years. The estimated expenditure shall be compared to an estimate of the revenues that will be deposited in the health care access fund. Based on this comparison, and after consulting with the chairs of the house ways and means committee and the senate finance committee, and the legislative commission on health care access, the commissioner shall make adjustments as necessary to ensure that expenditures remain within the limits of available revenues. The adjustments the commissioner may use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the ~~health right plan~~ MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the ~~health right plan~~ MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner may further limit enrollment or decrease premium subsidies.

The reserve referred to in this subdivision is appropriated to the commissioner but may only be used upon approval of the commissioner of finance, if estimated costs will exceed the forecasted amount of available revenues after all adjustments authorized under this subdivision have been made.

By February 1, ~~1994~~ 1995, the department of human services and the department of health shall develop a plan to adjust benefit levels, eligibility guidelines, or other steps necessary to ensure that expenditures for the MinnesotaCare program are contained within the two percent ~~provider tax~~ taxes imposed under section 295.52 and the ~~one percent HMO~~ gross premiums tax imposed under section 60A.15, subdivision 1, paragraph (e), for ~~the 1996-1997 biennium~~ fiscal year 1997. ~~Notwithstanding any law to the contrary, no further enrollment in MinnesotaCare, and no additional hiring of staff for the departments shall take place after June 1, 1994, unless a plan to balance the MinnesotaCare budget for the 1996-1997 biennium has been passed by the 1994 legislature.~~

(b) Notwithstanding paragraph (a), the commissioner shall proceed with the enrollment of single adults and households without children in accordance with section 256.9354, subdivision 5, even if the expenditures do not remain within the limits of available revenues through fiscal year 1997 to allow the departments of human services and health to develop the plan required under paragraph (a)."

Page 1, line 10, delete "biennium" and insert "fiscal year"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

H. F. No. 2951, A bill for an act relating to health care financing; modifying provisions for enrollment in the MinnesotaCare program; establishing a health care access reserve account; transferring money; amending Minnesota Statutes 1993 Supplement, section 256.9352, subdivision 3.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 69 yeas and 62 nays as follows:

Those who voted in the affirmative were:

Battaglia	Dorn	Jaros	Lieder	Murphy	Reding	Steensma
Beard	Evans	Jefferson	Long	Neary	Rest	Tomassoni
Brown, C.	Farrell	Jennings	Lourey	Olson, E.	Rice	Trimble
Brown, K.	Garcia	Johnson, A.	Luther	Olson, K.	Rodosovich	Tunheim
Carlson	Greenfield	Johnson, R.	Mariani	Orenstein	Rukavina	Vellenga
Carruthers	Greiling	Kahn	McCollum	Orfield	Sarna	Wagenius
Clark	Hasskamp	Kalis	McGuire	Ostrom	Sekhon	Wejcman
Cooper	Hausman	Kelley	Milbert	Perlt	Simoneau	Winter
Dawkins	Huntley	Kinkel	Mosel	Peterson	Skoglund	Spk. Anderson, I.
Delmont	Jacobs	Lasley	Munger	Pugh	Solberg	

Those who voted in the negative were:

Abrams	Davids	Gutknecht	Koppendrayer	Molnau	Pawlenty	Van Engen
Anderson, R.	Dehler	Haukoos	Krinkie	Morrison	Pelowski	Vickerman
Asch	Dempsey	Holsten	Krueger	Nelson	Rhodes	Waltman
Bauerly	Erhardt	Hugoson	Leppik	Ness	Seagren	Weaver
Bergson	Finseth	Johnson, V.	Limmer	Onnen	Smith	Wenzel
Bertram	Frerichs	Kelso	Lindner	Opatz	Sviggum	Wolf
Bettermann	Girard	Klinzing	Lynch	Osthoff	Swenson	Worke
Commers	Goodno	Knickerbocker	Macklin	Ozment	Tompkins	Workman
Dauner	Gruenes	Knight	Mahon	Pauly	Van Dellen	

The bill was passed, as amended, and its title agreed to.

There being no objection, the order of business reverted to Reports of Standing Committees.

REPORTS OF STANDING COMMITTEES

Kalis from the Committee on Capital Investment to which was referred:

H. F. No. 2648, A bill for an act relating to transportation; authorizing issuance of debt instruments for transit purposes; authorizing the issuance of state bonds; appropriating money; amending Minnesota Statutes 1992, section 473.39, by adding a subdivision.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 1992, section 473.39, is amended by adding a subdivision to read:

Subd. 1c. [OBLIGATIONS; 1995-1998.] The council may issue certificates of indebtedness, bonds, or other obligations under this section in an amount not to exceed $90,000,000, which may be used by the transit commission for transit vehicles and capital improvements, and related costs including the cost of issuance and sale of obligations.

Sec. 2. [APPLICATION.]

Section 1 applies in the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Sec. 3. [EFFECTIVE DATE.]

This act is effective July 1, 1994."

Amend the title accordingly

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Rules and Legislative Administration.

The report was adopted.

Carruthers moved that the House recess subject to the call of the Chair. The motion prevailed.

RECESS

RECONVENED

The House reconvened and was called to order by the Speaker.

CONSIDERATION UNDER RULE 1.10

Pursuant to rule 1.10, Solberg requested immediate consideration of S. F. No. 2192.

S. F. No. 2192 was reported to the House.

Greenfield moved to amend S. F. No. 2192 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

COMMUNITY INTEGRATED SERVICE NETWORKS

Section 1. [62J.016] [GOALS OF RESTRUCTURING.]

The state seeks to bring about changes in the health care delivery and financing system that will assure quality, affordable, and accessible health care for all Minnesotans. This goal will be accomplished by restructuring the delivery system, the financial incentives, and the regulatory environment in a way that will make health care providers and health plan companies more accountable to consumers, group purchasers, and communities for their costs and quality, their effectiveness in meeting the health care needs of all of their patients and enrollees, and their contributions to improving the health of the greater community.

Sec. 2. [62J.017] [IMPLEMENTATION TIMETABLE.]

The state seeks to complete the restructuring of the health care delivery and financing system by July 1, 1997. The restructured system will have two options: (1) integrated service networks, which will be accountable for meeting state cost containment, quality, and access standards; or (2) a uniform set of price and utilization controls for all health care services for Minnesota residents not provided through an integrated service network. Both systems will operate under the state's limits on cost increases and will be structured to promote competition in the health care marketplace.

Beginning July 1, 1994, measures will be taken to increase the public accountability of existing health plan companies, to promote the development of small, community-based integrated service networks, and to reduce administrative costs by standardizing third-party billing forms and procedures and utilization review requirements. Voluntary formation of other integrated service networks will begin January 1, 1996. Statutes for the entire restructured health care financing and delivery system must be enacted by January 1, 1996, and a phase-in of the all-payer reimbursement system must begin on that date. By July 1, 1997, all health coverage must be regulated under integrated service network or community integrated service network law pursuant to chapter 62N or all-payer law pursuant to chapter 62P.

Sec. 3. Minnesota Statutes 1993 Supplement, section 62N.02, is amended by adding a subdivision to read:

Subd. 4a. [COMMUNITY INTEGRATED SERVICE NETWORK.] "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.

Sec. 4. Minnesota Statutes 1993 Supplement, section 62N.02, subdivision 8, is amended to read:

Subd. 8. [INTEGRATED SERVICE NETWORK.] "Integrated service network" means a formal arrangement permitted by this chapter and licensed by the commissioner for providing health services under this chapter to enrollees for a fixed payment per time period. Integrated service network does not include a community integrated service network.

Sec. 5. [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 rules adopted under section 256B.0644 that apply to entities governed by chapter 62D.

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.] Notwithstanding 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.

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, except that the community integrated service network may impose a deductible, not to exceed $1,000 per person per year, provided that out-of-pocket expenses on covered services do not exceed $3,000 per person or $5,000 per family per year. The deductible must not apply to preventive health services as described in Minnesota Rules, part 4685.0801, subpart 8.

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.

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;

(5) reporting any changes in the address of a network provider or length of a provider contract or additions to the provider network to the commissioner within ten days under section 62D.08, subdivision 5. Community networks must report such information to the commissioner on a quarterly basis. Community networks that fail to make the required quarterly filing are subject to the penalties set forth in section 62D.08, subdivision 5; and

(6) 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.

Sec. 6. [62N.255] [EXPANDED PROVIDER NETWORKS.]

Subdivision 1. [PROVIDER ACCEPTANCE REQUIRED.] Every community network shall establish an expanded network of allied independent health providers, in addition to a preferred network. A community network shall accept as a provider in the expanded network any allied independent health provider who: (1) meets the community network's credentialing standards; (2) agrees to the terms of the community network's provider contract; and (3) agrees to comply with all managed care protocols of the community network.

Subd. 2. [MANAGED CARE.] The managed care protocols used by the community network may include: (1) a requirement that an enrollee obtain a referral from the community network before obtaining services from an allied independent health provider in the expanded network; (2) limits on the number and length of visits to allied independent health providers in the expanded network allowed by each referral, as long as the number and length of visits allowed is not less than the number and length allowed for comparable referrals to allied independent health providers in the preferred network; and (3) ongoing management and review by the community network of the care provided by an allied independent health provider in the expanded network after a referral is made.

Subd. 3. [MANDATORY OFFERING TO ENROLLEES.] Each community network may offer to enrollees the option of receiving covered services through the expanded network of allied independent health providers established under subdivisions 1 and 2. The network may establish separate premium rates and cost-sharing requirements for this expanded network plan, as long as these premium rates and cost-sharing requirements are actuarially justified and approved by the commissioner.

Subd. 4. [PROVIDER REIMBURSEMENT.] A community network shall pay each allied independent health provider in the expanded network the same rate per unit of service as paid to allied independent health providers in the preferred network.

Subd. 5. [EXEMPTION.] A community network is exempt from the requirements of this section, to the extent that it operates as a staff model health plan company, as defined in section 295.50, subdivision 12b, by employing allied independent health care providers to deliver health care services to enrollees.

Subd. 6. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Allied independent health provider" means an independently enrolled audiologist, chiropractor, dietician, home health care provider, marriage and family therapist, nurse practitioner or advanced practice nurse, occupational therapist, optometrist, optician, outpatient chemical dependency counselor, pharmacist who is not employed by and based on the premises of a community network, physical therapist, podiatrist, licensed consulting psychologist, psychological practitioner, licensed social worker, or speech therapist.

(c) "Home health care provider" means a personal care assistant, home health aide, or a provider of homemaker, respite care, adult day care, or home health nursing services.

(d) "Independently enrolled" means that a provider can bill, and receive direct payment for services from, a third-party payer or patient.

Sec. 7. [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 and 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.

Sec. 8. [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 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 community network's enrollees. For purposes of this section, a health care providing entity is "capitated" when its compensation arrangement with a community 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, or 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 for the purpose of reducing the community 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 community network to which it is accredited for a period of six months.

Sec. 9. [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) 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.

(b) A community network that elects to use the phase-in schedule provided in this subdivision cannot also use the real estate provision of section 62N.30 or the accredited capitated provider provision of section 62N.31.

Subd. 5. [NET WORTH CORRIDOR.] A community network shall not maintain net worth that exceeds two and one-half 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.

Sec. 10. [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.

Sec. 11. [62N.30] [REAL ESTATE AS NET WORTH.]

(a) The commissioner may, at the request of a community network, allow the community network a credit of up to 20 percent of the community network's net worth requirement for the community network's ownership of real estate of which the community network makes significant use in delivering care to enrollees. The credit must reflect reduced expenses and risk to the community network. In determining whether to allow the credit, the commissioner shall review operating expenses, debt service, and other costs connected with the real estate, as well as the use of the property by the community network in delivering care to enrollees, in order to ascertain whether ownership of the asset significantly reduces the community network's expenses and risk.

(b) A community network that uses this section to satisfy part of its net worth requirement may not use accredited capitated providers under section 62N.31 for that purpose.

Sec. 12. [62N.31] [ACCREDITED CAPITATED PROVIDERS.]

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 community network for which it seeks accreditation (a) on an ongoing basis, and (b) for a period of six months 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 7. The applicant may provide evidence of 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; a debt rating in the highest two categories for investment grade debt; 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.

An accredited capitated provider that provides services to its enrollees without compensation due to insolvency of the community network has no claim against the enrollees for payment. 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 chapter 60B.44, subdivision 10.

Subd. 2. [APPROVAL BY COMMISSIONER.] Before a provider may be used as an accredited capitated provider, the commissioner must determine whether the provider is sufficiently solvent to carry out its obligation without risk of bankruptcy. In making that determination, the commissioner may consider the provider's assets, liabilities, cash flow, operational and financial history, tax return information, expected cost of providing care to the community network's enrollees, expected revenues from other sources, fixed costs, and any information provided under subdivision 1.

Subd. 3. [ADDITIONAL SAFEGUARDS.] The commissioner may condition accredited status upon secured or unsecured personal guarantees by individual providers, security agreements and mortgages of assets owned by the provider, or other means of securing performance of the accredited capitated provider and preventing the provider from using bankruptcy to avoid its obligations to the community network and its enrollees. The state has an interest in performance of the obligations of accredited capitated providers, and the commissioner has standing to and may intervene in any insolvency proceeding involving an accredited capitated provider as the debtor, for the purpose of asserting the interests of the state and of the community network.

Subd. 4. [DATA SUBMISSIONS.] Each accredited capitated provider, as a condition of being granted accreditation, must submit to the commissioner annually, no later than April 15, an opinion by a qualified actuary regarding its ongoing ability to accept the loss of compensation under this section. The provider must also submit an annual data filing to the commissioner, including but not limited to:

(1) the expected direct costs to an accredited capitated provider for providing the contracted services to the enrollees of the community network to which it is accredited for a period of not less than six months;

(2) the number of enrollees served under the accredited capitated provider arrangement for the community network, both for the prior year and estimated for the current year;

(3) an audited financial statement, including an independent auditor's report, balance sheet, statement of support, revenue and expenses, statement of changes in capital balance, and statement of cash flow;

(4) any material change in the operational capacity of the accredited capitated provider since the last report to the commissioner;

(5) any material change in an accredited capitated provider's financial capacity to provide the contracted services; and

(6) any other information that the commissioner deems appropriate.

Subd. 5. [CONTRACT TERMINATION.] An accredited capitated provider may terminate its contract with a community network subject to the approval of the commissioner and under the conditions of this subdivision. An accredited capitated provider seeking to terminate its contract with a community network, whether by nonrenewal, cancellation, revocation, rescission, or otherwise, must give the commissioner and the community network six months' written notice of the termination. If the community network is notified of the termination and has sufficient net worth to be in compliance with its net worth requirement or has obtained alternative credit against the requirement, to the satisfaction of the commissioner, the notice requirement can be reduced to the greater of 90 days or the time required to secure the alternative credit.

Subd. 6. [NET WORTH AND WORKING CAPITAL.] (a) An accredited capitated provider must have an initial and continuing net worth of at least $250,000. An accredited capitated provider must also have an initial working capital of at least $250,000 and after that must maintain a positive working capital balance at all times.

(b) The commissioner may require an accredited capitated provider to maintain additional net worth requirements based on the type, nature, or volume of health services customarily rendered by the particular accredited capitated provider.

Subd. 7. [FAILURE TO COMPLY.] (a) If an accredited capitated provider fails to comply with the net worth, working capital, and other requirements of this section, the commissioner may take appropriate action, including increased monitoring of the financial and operational capacity of both the accredited capitated provider and the community network, administrative supervision of the accredited capitated provider or of the community network under chapter 60G, or suspension or revocation of an accredited capitated provider's accreditation.

(b) If an accredited capitated provider loses its accreditation, the accredited capitated provider is precluded from reapplying for accreditation for a period of one year from the date of the loss of accreditation.

Sec. 13. [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.

Sec. 14. [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 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 carriers 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 carriers 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 carrier when their contracts expire, on the same basis as any other individual or group. The replacement carrier 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.

Sec. 15. [62N.34] [INSOLVENCY FUNDING.]

(a) In the event of an insolvency of a community network, all other community networks and health carriers shall be assessed a surcharge, if necessary to pay expenses and claims set forth in paragraph (b), in proportion to their gross premium revenues.

(b) Money raised by the assessment shall be used to pay for the following, to the extent that they exceed the community network's deposit and other remaining assets:

(1) expenses in connection with the insolvency and transfer of enrollees;

(2) outstanding fee-for-service claims from nonparticipating providers, discounted by 25 percent of the claim amount. Claims incurred after the implementation of the fee schedules provided under chapter 62P will be reimbursed at the fee schedule amount discounted by 25 percent. Providers may not seek to recover the unpaid portion of their claim from enrollees; and

(3) premiums to community networks and health carriers that take enrollees of the insolvent community network, prorated to account for premiums already paid to the insolvent community network on behalf of those enrollees, to purchase coverage for time periods for which the insolvent community network can no longer provide coverage.

(c) In any year in which an assessment is made, the commissioner, in consultation with community networks and other health carriers, shall report to the legislature and governor on the continuing viability of the assessment approach and on the merits of potential alternative funding sources.

Sec. 16. [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.

Sec. 17. [62N.36] [NOTIFICATION OF PROVIDER NETWORK OPENING.]

A community integrated service network or integrated service network shall publish a notice of any health care provider network opening, vacancy, or contract in appropriate regional newspapers. This notice must be published at least 14 days before the closing date for applications for the open or vacant position. The requirement for notification shall not apply if the community integrated service network or integrated service network is replacing a network provider, and any delay in filling a vacancy causes an impairment to delivery of health care services.

Sec. 18. [STUDY OF SOLVENCY REGULATION OF INTEGRATED SERVICE NETWORKS.]

The commissioners of health and commerce shall develop the solvency standards for the integrated service networks created by chapter 62N. The solvency standards for integrated service networks must be effective no later than January 1, 1996.

The standards may use a risk-based capital standard as an integral tool to assess solvency of the integrated service networks. The standards may require that integrated service networks file the risk based capital calculation as part of the annual financial statement. The risk-based capital standard for integrated service networks may be based upon the national association of insurance commissioners health organization risk based capital standards currently under development, with any necessary modifications to reflect the unique risk characteristics of integrated service networks. Those modifications must be based upon an actuarial analysis of the effect on risk.

Sec. 19. [MONITORING OF REINSURANCE ACCESSIBILITY FOR COMMUNITY NETWORKS.]

The commissioners of commerce and health shall monitor the private sector market for reinsurance, in order to determine whether community integrated service networks are able to purchase reinsurance at competitive rates. If the commissioners find that the private market for reinsurance is not accessible or not affordable to community integrated service networks, the commissioners shall recommend to the legislature a voluntary or mandatory reinsurance purchasing pool for community integrated service networks. The commissioners' recommendations shall address the conditions under which community networks would be permitted or required to participate in the pool and the role of the state in overseeing or administering the pool.

Sec. 20. [EFFECTIVE DATE.]

Sections 1 to 19 are effective July 1, 1994.

ARTICLE 2

REQUIREMENTS FOR ALL HEALTH PLAN COMPANIES

Section 1. Minnesota Statutes 1993 Supplement, section 62J.33, is amended by adding a subdivision to read:

Subd. 3. [OFFICE OF CONSUMER INFORMATION.] The commissioner shall create an office of consumer information to assist health plan company enrollees and to serve as a resource center for enrollees. The office shall operate within the information clearinghouse. The functions of the office are:

(1) to assist enrollees in understanding their rights;

(2) to explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, integrated service networks, and the departments of health and commerce;

(3) to provide information on coverage options in each regional coordinating board region of the state;

(4) to provide information on the availability of purchasing pools and enrollee subsidies; and

(5) to help consumers use the health care system to obtain coverage.

The office of consumer information shall not provide legal services to consumers and shall not represent a consumer or enrollee. The office of consumer information shall not serve as an advocate for consumers in disputes with health plan companies. Nothing in this subdivision shall interfere with the ombudsman program established under section 256B.031, subdivision 6, or other existing ombudsman programs.

Sec. 2. Minnesota Statutes 1993 Supplement, section 62J.33, is amended by adding a subdivision to read:

Subd. 4. [INFORMATION ON HEALTH PLAN COMPANIES.] The information clearinghouse shall provide information on all health plan companies operating in a specific geographic area to consumers and purchasers who request it.

Sec. 3. Minnesota Statutes 1993 Supplement, section 62J.33, is amended by adding a subdivision to read:

Subd. 5. [DISTRIBUTION OF DATA ON QUALITY.] The commissioner shall make available through the clearinghouse hospital quality data collected under section 62J.45, subdivision 4b, and health plan company quality data collected under section 62J.45, subdivision 4c.

Sec. 4. Minnesota Statutes 1993 Supplement, section 62J.45, is amended by adding a subdivision to read:

Subd. 4a. [EVALUATION OF CONSUMER SATISFACTION; PROVIDER INFORMATION PILOT STUDY.] (a) The commissioner may make a grant to the data institute to develop and implement a mechanism for collecting comparative data on consumer satisfaction through adoption of a standard consumer satisfaction survey. As a condition of receiving this grant, the data institute shall appoint a consumer advisory group which shall consist of 13 individuals, representing enrollees from public and private health plan companies and programs and two uninsured consumers, to advise the data institute on issues of concern to consumers. The advisory group must have at least one member from each regional coordinating board region of the state. The advisory group expires June 30, 1997. No more than seven members may be of the same gender. This survey shall include enrollees in community integrated service networks, integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. The data institute shall determine a mechanism for the inclusion of the uninsured. Health plan companies and group purchasers shall provide enrollment information, including the names, addresses, and telephone numbers of enrollees and former enrollees and other data necessary for the completion of this study to the data institute. This enrollment information provided by the health plan companies and group purchasers is classified as private data on individuals, as defined in section 13.02, subdivision 12. The data institute shall provide raw unaggregated data to the data analysis unit. The data institute may analyze and prepare findings from the raw, unaggregated data, and the findings from this survey may be included in the health plan company report cards, and in other reports developed by the data analysis unit, in consultation with the data institute, to be disseminated by the information clearinghouse. The raw unaggregated data is classified as private data on individuals as defined in section 13.02, subdivision 12. The survey may include information on the following subjects:

(1) enrollees' overall satisfaction with their health care plan;

(2) consumers' perception of access to emergency, urgent, routine, and preventive care, including locations, hours, waiting times, and access to care when needed;

(3) premiums and costs;

(4) technical competence of providers;

(5) communication, courtesy, respect, reassurance, and support;

(6) choice and continuity of providers;

(7) continuity of care;

(8) outcomes of care;

(9) services offered by the plan, including range of services, coverage for preventive and routine services, and coverage for illness and hospitalization;

(10) availability of information; and

(11) paperwork.

(b) The commissioner, in consultation with the data institute, shall develop a pilot study to collect comparative data from health care providers on opportunities and barriers to the provision of quality, cost-effective health care. The provider information pilot study shall include providers in community integrated service networks, integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. Health plan companies and group purchasers shall provide to the commissioner providers' names, health plan assignment, and other appropriate data necessary for the commissioner to conduct the study. The provider information pilot study shall examine factors that increase and hinder access to the provision of quality, cost-effective health care. The study may examine:

(1) administrative barriers and facilitators;

(2) time spent obtaining permission for appropriate and necessary treatments;

(3) latitude to order appropriate and necessary tests, pharmaceuticals, and referrals to specialty providers;

(4) assistance available for decreasing administrative and other routine paperwork activities;

(5) continuing education opportunities provided;

(6) access to readily available information on diagnoses, diseases, outcomes, and new technologies;

(7) continuous quality improvement activities;

(8) inclusion in administrative decision-making;

(9) access to social services and other services that facilitate continuity of care;

(10) economic incentives and disincentives;

(11) peer review procedures; and

(12) the prerogative to address public health needs.

In selecting additional data for collection, the commissioner shall consider the: (1) statistical validity of the indicator; (2) public need for the information; (3) estimated expense of collecting and reporting the indicator; and (4) usefulness of the indicator to identify barriers and opportunities to improve quality care provision within health plan companies.

Sec. 5. Minnesota Statutes 1993 Supplement, section 62J.45, is amended by adding a subdivision to read:

Subd. 4b. [HOSPITAL QUALITY INDICATORS.] The commissioner, in consultation with the data institute, shall develop a system for collecting data on hospital quality. The commissioner shall require a licensed hospital to collect and report data as needed for the system. Data to be collected shall include structural characteristics including staff-mix and nurse-patient ratios. In selecting additional data for collection, the commissioner shall consider: (1) feasibility and statistical validity of the indicator; (2) purchaser and public demand for the indicator; (3) estimated expense of collecting and reporting the indicator; and (4) usefulness of the indicator for internal improvement purposes.

Sec. 6. Minnesota Statutes 1993 Supplement, section 62J.45, is amended by adding a subdivision to read:

Subd. 4c. [QUALITY REPORT CARDS.] Each health plan company shall report annually by April 1 to the commissioner specific quality indicators, in the form specified by the commissioner in consultation with the data institute. The quality indicators must be reported using standard definitions and measurement processes as specified by the commissioner. Wherever possible, the commissioner's specifications must be consistent with those outlined in the health plan employer data and information set (HEDIS 2.0). The commissioner, in consultation with the data institute, may modify the quality indicators to be reported to incorporate improvements in quality measurement tools.

When HEDIS 2.0 indicators or health care financing administration approved quality indicators for medical assistance and Medicare are used, the commissioner is exempt from rulemaking. For additions or modifications to the HEDIS indicators or if other quality indicators are added, the commissioner shall proceed through rulemaking pursuant to chapter 14. The data analysis unit shall develop quality report cards, and these report cards shall be disseminated through the information clearinghouse. Data shall be collected and reported by county and high-risk and special needs populations as well as by health plans, except when this would allow individuals to be identified.

Sec. 7. Minnesota Statutes 1992, section 62M.02, subdivision 5, is amended to read:

Subd. 5. [CERTIFICATION.] "Certification" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and that it, based on the information provided, meets the utilization review requirements of the applicable health plan and the health carrier will then pay for the covered benefit, provided the preexisting limitation provisions, the general exclusion provisions, and any deductible, copayment, coinsurance, or other policy requirements have been met.

Sec. 8. Minnesota Statutes 1992, section 62M.02, subdivision 21, is amended to read:

Subd. 21. [UTILIZATION REVIEW ORGANIZATION.] "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network or an integrated service network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and determines certification of an admission, extension of stay, or other health care services for a Minnesota resident; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state.

Sec. 9. Minnesota Statutes 1992, section 62M.03, subdivision 1, is amended to read:

Subdivision 1. [LICENSED UTILIZATION REVIEW ORGANIZATION.] Beginning January 1, 1993, any organization that ~~is licensed in this state and that~~ meets the definition of utilization review organization in section 62M.02, subdivision 21, must be licensed under chapter 60A, 62C, 62D, 62N, or 64B, or registered under this chapter and must comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a. Each licensed community integrated service network, integrated service network, or health maintenance organization that has an employed staff model of providing health care services shall comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a, for any services provided by providers under contract.

Sec. 10. Minnesota Statutes 1992, section 62M.03, subdivision 2, is amended to read:

Subd. 2. [NONLICENSED UTILIZATION REVIEW ORGANIZATION.] An organization that meets the definition of a utilization review organization under section 62M.02, subdivision 21, that is not licensed in this state that performs utilization review services for Minnesota residents must register with the commissioner of commerce and must certify compliance with sections 62M.01 to 62M.16.

Initial registration must occur no later than January 1, 1993. The registration is effective for two years and may be renewed for another two years by written request. Each utilization review organization registered under this chapter shall notify the commissioner of commerce within 30 days of any change in the name, address, or ownership of the organization.

Sec. 11. Minnesota Statutes 1992, section 62M.03, subdivision 3, is amended to read:

Subd. 3. [PENALTIES AND ENFORCEMENTS.] If a ~~nonlicensed~~ utilization review organization fails to comply with sections 62M.01 to 62M.16, the organization may not provide utilization review services for any Minnesota resident. The commissioner of commerce may issue a cease and desist order under section 45.027, subdivision 5, to enforce this provision. The cease and desist order is subject to appeal under chapter 14. A nonlicensed utilization review organization that fails to comply with the provisions of sections 62M.01 to 62M.16 is subject to all applicable penalty and enforcement provisions of section 72A.201. Each utilization review organization licensed under chapter 60A, 62C, 62D, 62N, or 64B shall comply with sections 62M.01 to 62M.16 as a condition of licensure.

Sec. 12. Minnesota Statutes 1992, section 62M.05, subdivision 3, is amended to read:

Subd. 3. [NOTIFICATION OF DETERMINATIONS.] A utilization review organization must have written procedures for providing notification of its determinations on all certifications in accordance with the following:

(a) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the hospital, attending physician, or applicable service provider within ten business days of the determination in accordance with section 72A.20, subdivision 4a, or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to, the enrollee or patient; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number."

(b) When a determination is made not to certify a hospital or surgical facility admission or extension of a hospital stay, or other service requiring review determination, within one working day after making the decision the attending physician and hospital must be notified by telephone and a written notification must be sent to the hospital, attending physician, and enrollee or patient. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the attending physician or provider with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

Sec. 13. Minnesota Statutes 1992, section 62M.06, subdivision 3, is amended to read:

Subd. 3. [STANDARD APPEAL.] The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) Each utilization review organization shall notify in writing the enrollee or patient, attending physician, and claims administrator of its determination on the appeal as soon as practical, but in no case later than 45 days after receiving the required documentation on the appeal.

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the health care provider.

(c) Prior to upholding the original decision not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the original determination not to certify.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the patient, enrollee, or attending physician when the initial determination is made.

(e) An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases ~~where an~~ of appeal to reverse a determination not to certify for clinical reasons ~~is unsuccessful~~, the utilization review organization must, upon request of the attending physician, ensure that a physician of the utilization review organization's choice in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

Sec. 14. Minnesota Statutes 1992, section 62M.09, subdivision 5, is amended to read:

Subd. 5. [WRITTEN CLINICAL CRITERIA.] A utilization review organization's decisions must be supported by written clinical criteria and review procedures. Clinical criteria and review procedures must be established with appropriate involvement from physicians, in accordance with acceptable and prevailing medical practice in Minnesota, and based upon data that is valid for Minnesota residents. A utilization review organization must use written clinical criteria, as required, for determining the appropriateness of the certification request. The utilization review organization must have a procedure for ensuring the periodic evaluation and updating of the written criteria.

Sec. 15. [62Q.01] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. [COMMISSIONER.] "Commissioner" means the commissioner of health.

Subd. 3. [HEALTH PLAN.] "Health plan" means a health plan as defined in section 62A.011 or a policy, contract, or certificate issued by a community integrated service network; an integrated service network; or an all-payer insurer as defined in section 62P.02.

Subd. 4. [HEALTH PLAN COMPANY.] "Health plan company" means:

(1) a health carrier as defined under section 62A.011, subdivision 2;

(2) an integrated service network as defined under section 62N.02, subdivision 8;

(3) an all-payer insurer as defined under section 62P.02; or

(4) a community integrated service network as defined under section 62N.02, subdivision 4a.

Sec. 16. [62Q.03] [PROCESS FOR DEFINING, DEVELOPING, AND IMPLEMENTING A RISK ADJUSTMENT SYSTEM.]

Subdivision 1. [PURPOSE.] Risk adjustment is a vital element of the state's strategy for achieving a more equitable, efficient system of health care delivery and financing for all state residents. Risk adjustment is needed to: remove current disincentives in the health care system to insure and serve high risk and special needs populations; promote fair competition among health plan companies on the basis of their ability to efficiently and effectively provide services rather than on the health status of those in a given insurance pool; and help assure the viability of all health plan companies, including community integrated service networks. It is the commitment of the state to develop and implement a risk adjustment system by July 1, 1997, and to continue to improve and refine risk adjustment over time. The process for designing and implementing risk adjustment shall be open, explicit, utilize resources and expertise from both the private and public sectors, and include at least the representation described in subdivision 4. The process shall take into account the formative nature of risk adjustment as an emerging science, and shall develop and implement risk adjustment to allow continual modifications, expansions, and refinements over time. The process shall have at least two stages, as described in subdivision 2 and 3.

Subd. 2. [FIRST STAGE OF RISK ADJUSTMENT DEVELOPMENT PROCESS.] The objective of the first stage is to report to the legislature by January 15, 1995, with recommendations on the process, organization, resource needs, and specific work plan to define, develop, and implement a risk adjustment mechanism by July 1, 1997, and to continually improve risk adjustment over time. The report shall address the specific issues listed in subdivision 5, and shall also identify any additional policy issues, questions and concerns that must be addressed to facilitate development and implementation of risk adjustment.

Subd. 3. [SECOND STAGE OF THE RISK ADJUSTMENT DEVELOPMENT PROCESS.] The second stage of the process, following review and any modification by the legislature of the January 15, 1995 report, shall be to carry out the work plan to develop and implement a risk adjustment mechanism by July 1, 1997, and to continue to improve and refine a risk adjustment over time. The second stage of the process shall be carried out by the association created in subdivision 6.

Subd. 4. [EXPERT PANEL.] The commissioners of health and commerce shall convene an expert advisory panel comprised of, but not limited to, the board members of the Minnesota risk adjustment association, as described in subdivision 8, and experts from the fields of epidemiology, health services research, and health economics. The commissioners may also convene technical work groups that may include members of the expert advisory panel and other persons, all selected in the sole discretion of the commissioners. The expert advisory panel and the workgroups shall assist and advise the commissioners of health and commerce in preparing the implementation report described in subdivision 5.

Subd. 5. [IMPLEMENTATION REPORT TO THE LEGISLATURE.] The commissioners of health and commerce shall submit a report to the legislature by January 15, 1995, with recommendations on the process, organization, resource needs, and specific work plan to define, develop, and implement a risk adjustment system by July 1, 1997, and to continually improve risk adjustment over time. In developing the January 15, 1995 report, the commissioners of commerce and health must consider and describe the following:

(1) the relationship of risk adjustment to the implementation of universal coverage and community rating;

(2) the role of reinsurance in the risk adjustment system, as a short-term alternative in the absence of a risk adjustment methodology;

(3) the relationship of the risk adjustment system to the implementation of reforms in underwriting and rating requirements;

(4) the potential role of the health coverage reinsurance association in the risk adjustment system;

(5) the need for mandatory participation of all health plan companies in the risk adjustment system;

(6) current and emerging applications of risk adjustment methodologies used for reimbursement purposes at the state and national level and the reliability and validity of current risk assessment and risk adjustment methodologies;

(7) the levels and types of risk to be distributed through the risk adjustment system;

(8) the extent to which prepaid contracting by public programs needs to be addressed by the risk adjustment methodology;

(9) a plan for testing of the risk adjustment options being proposed, including simulations using existing health plan data, and development and testing of models on simulated data to assess the feasibility and efficacy of specific methodologies;

(10) the appropriate role of the state in the supervision of the risk adjustment association created pursuant to subdivision 6;

(11) risk adjustment methodologies that take into account differences among health plan companies due to their relative efficiencies, characteristics, and relative to existing insured contracts, new business, underwriting, or rating restrictions required or permitted by law; and

(12) methods to encourage health plan companies to enroll higher risk populations.

To the extent possible, the implementation report shall identify a specific methodology or methodologies that may serve as a starting point for risk adjustment, explain the advantages and disadvantages of each such methodology, and provide a specific workplan for implementing the methodology.

Subd. 6. [CREATION OF RISK ADJUSTMENT ASSOCIATION.] The Minnesota risk adjustment association is created on July 1, 1994, and may operate as a nonprofit unincorporated association.

Subd. 7. [PURPOSE OF ASSOCIATION.] The association is established to carry out the purposes of subdivision 1, as further elaborated on by the implementation report described in subdivision 5 and by legislation enacted in 1995 or subsequently.

Subd. 8. [GOVERNANCE.] (a) The association shall be governed by an interim 19-member board as follows: one provider member appointed by the Minnesota Hospital Association; one provider member appointed by the Minnesota Medical Association; one provider member appointed by the governor; three members appointed by the Minnesota Council of HMOs to include an HMO with at least 50 percent of total membership enrolled through a public program; three members appointed by Blue Cross and Blue Shield of Minnesota, to include a member from a Blue Cross and Blue Shield of Minnesota affiliated health plan with fewer than 50,000 enrollees and located outside the Minneapolis-St. Paul metropolitan area; two members appointed by the Insurance Federation of Minnesota; one member appointed by the Minnesota Association of Counties; and three public members appointed by the governor, to include at least one representative of a public program. The commissioners of health, commerce, human services, and employee relations shall be nonvoting ex-officio members.

(b) The board may elect officers and establish committees as necessary.

(c) A majority of the members of the board constitutes a quorum for the transaction of business.

(d) Approval by a majority of the board members present is required for any action of the board.

(e) Interim board members shall be appointed by July 1, 1994, and shall serve until a new board is elected according to the plan developed by the association.

(f) A member may designate a representative to act as a member of the interim board in the member's absence.

Subd. 9. [DATA COLLECTION.] The board of the association shall consider antitrust implications and establish procedures to assure that pricing and other competitive information is appropriately shared among competitors in the health care market or members of the board. Any information shared shall be distributed only for the purposes of administering or developing any of the tasks identified in subdivisions 2 and 4. In developing these procedures, the board of the association may consider the identification of a state agency or other appropriate third party to receive information of a confidential or competitive nature.

Subd. 10. [SUPERVISION.] The association's activities shall be supervised by the commissioners of health and commerce.

Subd 11. [REPORTING.] The board of the association shall provide a status report on its activities to the health care commission on a quarterly basis.

Sec. 17. [62Q.05] [DATA.]

Health plan companies are subject to the data reporting requirements of the 1992 and 1993 MinnesotaCare acts, as amended.

Sec. 18. [62Q.07] [ACTION PLANS.]

Subdivision 1. [ACTION PLANS REQUIRED.] (a) To increase public awareness and accountability of health plan companies, all health plan companies must annually file with the applicable commissioner an action plan that satisfies the requirements of this section beginning July 1, 1994, as a condition of doing business in Minnesota. Each health plan company must also file its action plan with the information clearinghouse. Action plans are required solely to provide information to consumers, purchasers, and the larger community as a first step toward greater accountability of health plan companies. The sole function of the commissioner in relation to the action plans is to ensure that each health plan company files a complete action plan, that the action plan is truthful and not misleading, and that the action plan is reviewed by appropriate community agencies.

(b) If a commissioner responsible for regulating a health plan company required to file an action plan under this section has reason to believe an action plan is false or misleading, the commissioner may conduct an investigation to determine whether the action plan is truthful and not misleading, and may require the health plan company to submit any information that the commissioner reasonably deems necessary to complete the investigation. If the commissioner determines that an action plan is false or misleading, the commissioner may require the health plan company to file an amended plan or may take any action authorized under chapter 72A.

Subd. 2. [CONTENTS OF ACTION PLANS.] (a) An action plan must include a detailed description of all 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. This description must be updated by the health plan company and filed with the applicable agency on a quarterly basis.

(b) An action plan must include the number of full-time equivalent physicians, by specialty, nonphysician providers, and allied health providers used to provide services. The action plan must also describe how the health plan company intends to encourage the use of nonphysician providers, midlevel practitioners, and allied health professionals, through at least consumer education, physician education, and referral and advisement systems. The annual action plan must also include data that is broken down by type of provider, reflecting actual utilization of midlevel practitioners and allied professionals by enrollees of the health plan company during the previous year. Until July 1, 1995, a health plan company may use estimates if actual data is not available. For purposes of this paragraph, "provider" has the meaning given in section 62J.03, subdivision 8.

(c) An action plan must include a description of the health plan company's policy on determining the number and the type of providers that are necessary to deliver cost-effective health care to its enrollees. The action plan must also include the health plan company's strategy, including provider recruitment and retention activities, for ensuring that sufficient providers are available to its enrollees.

(d) An action plan must include a description of actions taken or planned by the health plan company to ensure that information from report cards, outcome studies, and complaints is used internally to improve quality of the services provided by the health plan company.

(e) An action plan must include a detailed description of the health plan company's policies and procedures for enrolling and serving high risk and special needs populations. This description must also include the barriers that are present for the high risk and special needs population and how the health plan company is addressing these barriers in order to provide greater access to these populations. "High risk and special needs populations" includes, but is not limited to, recipients of medical assistance, general assistance medical care, and MinnesotaCare; persons with chronic conditions or disabilities; individuals within certain racial, cultural, and ethnic communities; individuals and families with low income; adolescents; the elderly; individuals with limited or no English language proficiency; persons with high-cost preexisting conditions; chemically dependent persons; and persons who are at high-risk of requiring treatment. The action plan must also reflect actual utilization of providers by enrollees defined by this section as high risk or special needs populations during the previous year. For purposes of this paragraph, "provider" has the meaning given in section 62J.03, subdivision 8.

(f) An action plan must include a general description of any action the health plan company has taken and those it intends to take to offer health coverage options to rural communities and other communities not currently served by the health plan company.

(g) A health plan company may satisfy any of the requirements of the action plan in paragraphs (a) to (f) by stating that it has no policies, procedures, practices, or requirements, either written or unwritten, or formal or informal, and has undertaken no activities or plans on the issues required to be addressed in the action plan, provided that the statement is truthful and not misleading.

Sec. 19. [62Q.11] [DISPUTE RESOLUTION.]

Subdivision 1. [ESTABLISHED.] The commissioners of health and commerce shall make dispute resolution processes available to encourage early settlement of disputes in order to avoid the time and cost associated with litigation and other formal adversarial hearings. For purposes of this section, "dispute resolution" means the use of negotiation, mediation, arbitration, mediation-arbitration, neutral fact finding, and minitrials. These processes shall be nonbinding unless otherwise agreed to by all parties to the dispute.

Subd. 2. [REQUIREMENTS.] (a) If an enrollee of a health plan company chooses to use a dispute resolution process prior to the filing of a formal claim or of a lawsuit, the health plan company must participate.

(b) If an enrollee chooses to use a dispute resolution process after the filing of a lawsuit, the health plan company must participate in dispute resolution, including, but not limited to, alternative dispute resolution under Rule 114 of the Minnesota general rules of practice.

(c) The commissioners of health and commerce shall inform and educate health plan companies' enrollees about dispute resolution and its benefits.

(d) A health plan company may encourage but not require an enrollee to submit a complaint to alternative dispute resolution.

Sec. 20. [62Q.13] [LIMITATION ON EXCLUSIVE CONTRACTS.]

A contract requirement between a health care provider and health plan company that obligates the health care provider to provide health care services exclusively to enrollees or insureds of the health plan company applies only if the health plan company maintains the same licensure status that it did at the time the contract was entered into. If the health plan company changes its licensure status, a contract for the exclusive provision of services is not valid and is not enforceable. For purposes of this section, the provision of health care services through a preferred provider organization is considered a form of licensure status. This section does not apply to health care providers employed by a health plan company.

Sec. 21. [62Q.14] [FREEDOM OF CHOICE.]

No health plan company may restrict the choice of an enrollee as to where the enrollee receives the services defined under United States Code, title 42, section 1396d(a)(4)(c), or receives services for the treatment of sexually transmitted diseases.

Sec. 22. [62Q.16] [STANDARD POLICY TERMS.]

The termination of any health plan as defined in section 62A.011, subdivision 3, with the exception of individual health plans, issued or renewed after January 1, 1995, must provide coverage until the end of the month in which coverage was terminated.

Sec. 23. [UTILIZATION REVIEW STUDY.]

The commissioners of health and commerce shall study means of funding the registration required by Minnesota Statutes, section 62M.03, and of monitoring and enforcing the requirements of Minnesota Statutes, chapter 62M. They shall jointly report their recommendations to the legislature by January 15, 1995.

Sec. 24. [ALTERNATIVE DISPUTE RESOLUTION PILOT PROJECT.]

Subdivision 1. [ESTABLISHMENT.] The commissioner of health, in consultation with the commissioner of commerce, the Minnesota health care commission, and the state office of dispute resolution at the bureau of mediation services, shall establish an alternative dispute resolution pilot project. The project shall be administered by the commissioner of health. For purposes of this section, "dispute resolution" means the use of negotiation, mediation, mediation-arbitration, neutral fact finding, and minitrials.

Subd. 2. [REQUIREMENTS.] The pilot project may be used by health care providers and their patients to attempt to resolve disputes before litigation is commenced in any court. The pilot project requires the use of negotiation, mediation, arbitration, mediation-arbitration, neutral fact finding, and minitrials prior to the filing of a lawsuit. These processes shall be nonbinding unless otherwise agreed to by all parties to the dispute.

Subd. 3. [REPORT.] The commissioner of health shall report to the legislature by January 1, 1995, on the results of the pilot project and on any recommended legislative changes.

Sec. 25. [EXEMPTION.]

The commissioner of health shall apply to the health care financing administration for an exemption to the requirement that physicians report settlements of $10,000 or less to the National Practitioners Data Bank under Code of Federal Regulations, title 45, part 60.

Sec. 26. [EFFECTIVE DATE.]

Sections 15 to 17 and 23 are effective the day following final enactment. Sections 1 to 6 and 18 are effective July 1, 1994. Sections 7 to 14, 19, and 21 are effective January 1, 1995.

ARTICLE 3

THE REGULATED ALL-PAYER OPTION

Section 1. Minnesota Statutes 1993 Supplement, section 62P.01, is amended to read:

62P.01 [REGULATED ALL-PAYER ~~SYSTEM~~ OPTION.]

~~The regulated all-payer system established under this chapter governs all health care services that are provided outside of an integrated service network. The regulated all-payer system is designed to control costs, prices, and utilization of all health care services not provided through an integrated service network while maintaining or improving the quality of services. The commissioner of health shall adopt rules establishing controls within the system to ensure that the rate of growth in spending in the system, after adjustments for population size and risk, remains within the limits set by the commissioner under section 62J.04. All providers that serve Minnesota residents and all health carriers that cover Minnesota residents shall comply with the requirements and rules established under this chapter for all health care services or coverage provided to Minnesota residents.~~ The purpose of the regulated all-payer option is to provide an alternative to integrated service networks for those consumers, providers, third-party payers, and group purchasers who prefer to participate in a fee-for-service system. The initial goal of the all-payer option is to reduce administrative costs and burdens by including the all-payer option in a uniform, standardized system of billing forms and procedures and utilization review. The longer-term goal of the all-payer option is to establish a uniform reimbursement system, reimbursement and utilization controls, and quality standards and monitoring; to ensure that the annual growth in the costs for all services not provided through integrated service networks will remain within the growth limits established under section 62J.04; and to ensure that quality for these services is maintained or improved.

Sec. 2. [62P.02] [DEFINITIONS.]

(a) For purposes of this chapter, the following definitions apply:

(b) "All-payer insurer" means a health carrier as defined in section 62A.011, subdivision 2. The term does not include community integrated service networks or integrated service networks licensed under chapter 62N.

(c) "All-payer reimbursement level" means the reimbursement amount specified by the all-payer reimbursement system.

(d) "All-payer reimbursement system" means the Minnesota-specific fee schedule, the Minnesota-specific diagnosis related groups system, and other provider payment methods established under this chapter or rules adopted under this chapter.

(e) "Commissioner" means the commissioner of health.

(f) "Health care provider" has the meaning given in section 62J.03, subdivision 8.

(g) "Cosmetic medical or cosmetic dental procedures" means elective medical or dental procedures not part of the universal standard benefits set which are primarily performed to improve physical appearance.

Sec. 3. Minnesota Statutes 1993 Supplement, section 62P.03, is amended to read:

62P.03 [IMPLEMENTATION.]

~~(a) By January 1, 1994, the commissioner of health, in consultation with the Minnesota health care commission, shall report to the legislature recommendations for the design and implementation of the all-payer system. The commissioner may use a consultant or other technical assistance to develop a design for the all-payer system. The commissioner's recommendations shall include the following:~~

~~(1) methods for controlling payments to providers such as uniform fee schedules or rate limits to be applied to all health plans and health care providers with independent billing rights;~~

~~(2) methods for controlling utilization of services such as the application of standardized utilization review criteria, incentives based on setting and achieving volume targets, recovery of excess spending due to overutilization, or required use of practice parameters;~~

~~(3) methods for monitoring quality of care and mechanisms to enforce the quality of care standards;~~

~~(4) requirements for maintaining and reporting data on costs, prices, revenues, expenditures, utilization, quality of services, and outcomes;~~

~~(5) measures to prevent or discourage adverse risk selection between the regulated all payer system and integrated service networks;~~

~~(6) measures to coordinate the regulated all payer system with integrated service networks to minimize or eliminate barriers to access to health care services that might otherwise result;~~

~~(7) an appeals process;~~

~~(8) measures to encourage and facilitate appropriate use of midlevel practitioners and eliminate undesirable barriers to their participation in providing services;~~

~~(9) measures to assure appropriate use of technology and to manage introduction of new technology;~~

~~(10) consequences to be imposed on providers whose expenditures have exceeded the limits established by the commissioner; and~~

~~(11) restrictions on provider conflicts of interest.~~

~~(b)~~ On July 1, 1994, the regulated all-payer ~~system~~ option shall begin to be phased in with full implementation of the all-payer reimbursement system by July 1, ~~1996~~ 1997. During the transition period, expenditure limits for health carriers shall be established in accordance with section 62P.04 and health care provider revenue limits shall be established in accordance with section 62P.05.

Sec. 4. Minnesota Statutes 1993 Supplement, section 62P.04, is amended to read:

62P.04 [EXPENDITURE LIMITS FOR HEALTH PLAN COMPANY.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Health ~~carrier~~ plan company" has the definition provided in section ~~62A.011~~ 62Q.01.

(c) ~~"Total expenditures" mean incurred claims or expenditures on health care services, administrative expenses, charitable contributions, and all other payments made by health carriers out of premium revenues, except taxes and assessments, and payments or allocations made to establish or maintain reserves. Total expenditures are equivalent to the amount of total revenues minus taxes and assessments. Taxes and assessments~~ "Exempted taxes and assessments" means direct payments ~~for taxes~~ to government agencies, contributions to the Minnesota comprehensive health association, the medical assistance provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the health coverage reinsurance association, assessments by the Minnesota life and health insurance guaranty association, assessments by the Minnesota reinsurance and risk adjustment association, and any new assessments imposed by federal or state law.

(d) "Consumer cost-sharing" means enrollee coinsurance, copayment, and deductible requirements.

(e) "Total expenditures" means incurred claims or expenditures on health care services, administrative expenses, charitable contributions, and all other payments made by health plan companies out of premium revenues, except taxes and assessments, and payments of allocations made to establish or maintain reserves. Total expenditures are equivalent to the amount of total revenue minus taxes and assessments.

Subd. 2. [ESTABLISHMENT.] The commissioner of health shall establish limits on the increase in total expenditures by each health ~~carrier~~ plan company for calendar years 1994 ~~and~~, 1995, 1996, and 1997. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). Health ~~carriers~~ plan companies that are affiliates may elect to meet one combined expenditure limit.

Subd. 3. [DETERMINATION OF EXPENDITURES.] Health ~~carriers~~ plan companies shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993~~, and by~~; April 1, 1995, for calendar year 1994~~;~~ April 1, 1996, for calendar year 1995; April 1, 1997, for calendar year 1996; and April 1, 1998, for calendar year 1997 all

information the commissioner determines to be necessary to implement and enforce this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health ~~carriers~~ plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health ~~carrier~~ plan company to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments and the election to meet one expenditure limit for affiliated health ~~carriers~~ plan companies must be submitted to the commissioner by ~~September 1, 1993~~ June 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to all periods of the interim limits.

Subd. 4. [MONITORING OF RESERVES.] (a) The ~~commissioner~~ commissioners of health and commerce shall monitor health ~~carrier~~ plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B with respect to the health plan companies that each commissioner respectively regulates, to ensure that savings resulting from the establishment of ~~expenditure~~ health care provider revenue limits are passed on to consumers in the form of lower premium rates.

(b) Health ~~carriers~~ plan companies shall fully reflect in the premium rates the savings generated by the expenditure limits and the health care provider revenue limits. No premium rate increase may be approved for those health ~~carriers~~ plan companies unless the health ~~carrier~~ plan company establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

Subd. 5. [NOTICE.] The commissioner of health shall publish in the State Register and make available to the public by July 1, 1995, a list of all health ~~carriers~~ plan companies that exceeded their expenditure target for the 1994 calendar year. The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health ~~carriers~~ plan companies that exceeded their combined expenditure limit for calendar years 1994 and 1995. The commissioner shall notify each health ~~carrier~~ plan company that the commissioner has determined that the ~~carrier~~ health plan company exceeded its expenditure limit, at least 30 days before publishing the list, and shall provide each ~~carrier~~ health plan company with ten days to provide an explanation for exceeding the expenditure target. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. [ASSISTANCE BY THE COMMISSIONER OF COMMERCE.] The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health ~~carriers~~ plan companies regulated by the commissioner of commerce. The commissioner of commerce, in consultation with the commissioner of health, shall enforce compliance by those health ~~carriers~~ plan companies.

Subd. 7. [ENFORCEMENT.] The commissioners of health and commerce shall enforce the reserve limits referenced in subdivision 4, with respect to the health ~~carriers~~ plan companies that each commissioner respectively regulates. Each commissioner shall require health ~~carriers~~ plan companies under the commissioner's jurisdiction to submit plans of corrective action when the reserve requirement is not met. Each commissioner may adopt rules necessary to enforce this section. ~~Carriers~~ Health plan companies that exceed the expenditure limits based on two-year average expenditure data (1994 and 1995, 1996 and 1997) or whose reserves exceed the limits referenced in subdivision 4 shall be required by the appropriate commissioner to pay back the amount overspent through an assessment on the ~~carrier~~ health plan company. A health plan company may appeal the commissioner's order to pay back the amount overspent by mailing to the commissioner a written notice of appeal within 30 days from the date the commissioner's order was mailed. The contested case and judicial review provisions of chapter 14 apply to the appeal. The health plan company shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 3.762 to 3.765, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the general fund. The appropriate commissioner may approve a different repayment method to take into account the ~~carrier's~~ health plan company's financial condition. Health plan companies shall comply with the limits but shall also guarantee that their contractual obligations are met. Health plan companies are prohibited from meeting spending obligations by increasing subscriber liability, including copayments and deductibles.

Sec. 5. Minnesota Statutes 1993 Supplement, section 62P.05, is amended to read:

62P.05 [HEALTH CARE PROVIDER REVENUE LIMITS.]

Subdivision 1. [DEFINITION.] For purposes of this section, "health care provider" has the definition given in section 62J.03, subdivision 8.

Subd. 2. [ESTABLISHMENT.] The commissioner of health shall establish limits on the increase in revenue for each health care provider, for calendar years 1994 ~~and~~, 1995, 1996, and 1997. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). The commissioner may adjust final revenue figures for case mix complexity, ~~inpatient to outpatient conversion~~, payer mix, out-of-period settlements, certain taxes and assessments including the MinnesotaCare provider tax and provider surcharge, any new assessments imposed by federal or state law, research and education costs, donations, grants, and legislative initiatives that materially change health care ~~costs~~ revenues, as long as these adjustments are consistent with the methodology submitted by the health care provider to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments must be submitted to the commissioner by ~~September 1, 1993~~ June 1, 1994. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to all periods of the interim limits. ~~A health care provider's revenues for purposes of these growth limits are net of the contributions, surcharges, taxes, and assessments listed in section 62P.04, subdivision 1, that the health care provider pays.~~

Subd. 3. [MONITORING OF REVENUE.] The commissioner of health shall monitor health care provider revenue, to ensure that savings resulting from the establishment of revenue limits are passed on to consumers in the form of lower charges. The commissioner shall monitor hospital revenue by examining net ~~patient~~ inpatient revenue per adjusted admission and net outpatient revenue per outpatient visit. The commissioner shall monitor the revenue of physicians and other health care providers by examining revenue per patient per year or revenue per encounter. If this information is not available, the commissioner may enforce an annual limit on the rate of growth of the provider's current fees ~~based on the limits on the rate of growth established for calendar years 1994 and 1995~~.

Subd. 4. [MONITORING AND ENFORCEMENT.] Health care providers shall submit to the commissioner of health, in the form and at the times required by the commissioner, all information the commissioner determines to be necessary to implement and enforce this section. ~~Health care providers shall submit to audits conducted by the commissioner.~~ The commissioner shall enforce limits based on survey data supplied to the commissioner by April 1 for the previous calendar year's revenue and spending data. Providers that do not submit survey data to the commissioner are required to meet the growth limits and may be subject to random audits. The commissioner shall regularly audit all health clinics employing or contracting with over 100 physicians. The commissioner shall also audit, at times and in a manner that does not interfere with delivery of patient care, a sample of smaller clinics, hospitals, and other health care providers. Providers that exceed revenue limits based on two-year average revenue data shall be required by the commissioner to pay back the amount overspent during the following calendar year.

The commissioner shall monitor providers meeting the growth limits based on their current fees on an annual basis. The fee charged for each service must be averaged across 12 months and compared to the previous 12-month period. The percentage increase in the average fee from 1993 to 1994, from 1994 to 1995, from 1995 to 1996, and from 1996 to 1997 is subject to the growth limits established under section 62J.04, subdivision 1, paragraph (b). The audit process must include a review of the provider's monthly fee schedule, and a random claims analysis for the provider during different parts of the year to monitor variations in fees. The commissioner shall require providers that exceed growth limits, based on annual fees, to pay back during the following calendar year the amount overspent.

The commissioner shall notify each provider that has exceeded its revenue limit, at least 30 days before taking action, and shall provide each provider with ten days to provide an explanation for exceeding the revenue target. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

The commissioner may approve a different repayment schedule for a health care provider that takes into account the provider's financial condition. ~~For those providers subject to fee limits established by the commissioner,~~ Based on claims data submitted under section 62J.38, the commissioner may adjust the percentage increase in the fee schedule to account for changes in utilization. The commissioner may adopt rules in order to enforce this section.

A provider may appeal the commissioner's order to pay back the amount overspent by mailing a written notice of appeal to the commissioner within 30 days after the commissioner's order was mailed. The contested case and judicial review provisions of chapter 14 apply to the appeal. The provider shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 3.762 to 3.765, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the general fund.

Sec. 6. [62P.07] [SCOPE.]

Subdivision 1. [GENERAL APPLICABILITY.] (a) Minnesota health care providers shall comply with the requirements and rules established under this chapter for: (1) all health care services provided to Minnesota residents who are not enrolled in a community integrated service network or an integrated service network; (2) all out-of-network services provided to enrollees of community integrated service networks and integrated service networks; and (3) all health care services provided to persons covered by an all-payer insurer.

(b) All-payer insurers shall comply with the requirements and rules established under this chapter for all coverage provided.

(c) Community integrated service networks and integrated service networks shall comply with the requirements and rules established under this chapter when reimbursing health care providers for out-of-network services.

(d) The rules and requirements of this chapter do not apply to cosmetic medical or cosmetic dental procedures performed by a physician or dentist.

Subd. 2. [PROGRAMS EXCLUDED.] This chapter does not apply to services reimbursed under Medicare, medical assistance, general assistance medical care, the MinnesotaCare program, or worker's compensation programs.

Subd. 3. [PAYMENT REQUIRED AT ALL-PAYER LEVEL.] (a) All reimbursements to Minnesota health care providers from all-payer insurers, for services provided to covered persons, shall be at the all-payer reimbursement level.

(b) All-payer insurers shall reimburse out-of-state health care providers for nonemergency services provided to covered persons at the all-payer reimbursement level. For purposes of this paragraph, "nonemergency services" means services that do not meet the definition of "emergency care" under Minnesota Rules, part 4685.0100, subpart 5.

(c) Community integrated service networks and integrated service networks shall reimburse Minnesota health care providers for out-of-network services at the all-payer reimbursement level.

(d) Community integrated service networks and integrated service networks shall reimburse out-of-network health care providers located out-of-state for nonemergency out-of-network services at the all-payer reimbursement level. For purposes of this paragraph, "nonemergency out-of-network services" means out-of-network services that do not meet the definition of "emergency care" under Minnesota Rules, part 4685.0100, subpart 5.

Subd. 4. [BALANCE BILLING PROHIBITED.] Minnesota health care providers shall accept reimbursement at the all-payer reimbursement level, including applicable copayments, deductibles, and coinsurance, as payment in full for services provided to Minnesota residents and persons covered by all-payer insurers, and for out-of-network services provided to enrollees of community integrated service networks and integrated service networks.

Sec. 7. [62P.09] [DUTIES OF THE COMMISSIONER.]

Subdivision 1. [GENERAL DUTIES.] The commissioner of health is responsible for developing and administering the all-payer option. The commissioner shall:

(1) develop, implement, and administer fee schedules for physicians and providers with independent billing rights;

(2) develop, implement, and administer a reimbursement system for hospitals and other institutional providers, but excluding intermediate care facilities for the mentally retarded, nursing homes, state-operated community service sites operated by the commissioner of human services, regional treatment centers, and child care facilities;

(3) modify and adjust all-payer reimbursement levels so that health care spending under the all-payer option does not exceed the growth limits on health care spending established under section 62J.04;

(4) collect data from all-payer insurers, health care providers, and patients to monitor spending and quality of care;

(5) provide incentives for the appropriate utilization of services and the appropriate use and distribution of technology;

(6) coordinate the development and administration of the all-payer option with the development and administration of the integrated service network system; and

(7) develop and implement a fair and efficient system for resolving appeals by providers and insurers.

Subd. 2. [COORDINATION.] The commissioner shall regularly consult with the commissioner of commerce in developing and administering the all-payer option and in applying the all-payer reimbursement system to health carriers regulated by the commissioner of commerce.

Subd. 3. [TIMELINES FOR IMPLEMENTATION.] In developing and implementing the all-payer option, the commissioner shall comply with the following implementation schedule:

(a) The phase-in of standardized billing requirements must be completed following the timetable set forth in article 9.

(b) The phase-in of the all-payer reimbursement system must begin January 1, 1996.

(c) The all-payer reimbursement system must be fully implemented by July 1, 1997.

Subd. 4. [IMPLEMENTATION PLAN.] The commissioner, as part of the implementation plan due January 1, 1995, shall present recommendations and draft legislation to the legislature to:

(1) establish reimbursement methods for the all-payer option reimbursement system;

(2) provide an implementation schedule to phase-in the all-payer reimbursement system, beginning January 1, 1996; and

(3) establish mechanisms to ensure compliance by all-payer insurers, health care providers, and patients with the all-payer option reimbursement system and all-payer option reimbursement limits established under section 62J.04.

Sec. 8. [62P.11] [PAYMENT TO PHYSICIANS AND INDEPENDENT PROVIDERS.]

Subdivision 1. [FEE SCHEDULE.] The commissioner shall adopt a Minnesota-specific fee schedule, based upon the Medicare resource based relative value scale, to reimburse physicians and other independent providers. The fee schedule must assign each service a relative value unit that measures the relative resources required to provide the service. Payment levels for each service must be determined by multiplying relative value units by a conversion factor that converts relative value units into monetary payment. The conversion factor used to derive the fee schedule must be set at a level that is consistent with current relevant health care spending, subject to the state's target for spending growth. The conversion factor must be set at a level that equalizes total aggregate expenditures for a given period before and after implementation of the all-payer option.

Subd. 2. [DEVELOPMENT AND MODIFICATION OF RELATIVE VALUE UNITS.] (a) When appropriate, the relative value unit for each service shall be the Medicare value adjusted to reflect Minnesota health care costs. The commissioner may assign a different relative value to a service if, in the judgment of the commissioner, the Medicare relative value unit is not accurate. The commissioner may also develop or adopt relative value units for services not covered under the Medicare resource based relative value scale. Except as provided in paragraph (b), modifications or additions to relative value units are subject to the rulemaking requirements of chapter 14.

(b) The commissioner may modify the relative value units used in the Minnesota-specific fee schedule, or increase the number of services assigned relative value units, to reflect changes and improvements in the Medicare resource based relative value scale. When adopting these federal changes, the commissioner is exempt from the rulemaking requirements of chapter 14, but shall publish a notice of modifications and additions to relative value units in the State Register 30 days before they take effect.

Subd. 3. [DEVELOPMENT OF THE CONVERSION FACTOR.] The commissioner shall develop a conversion factor using actual Minnesota claims data available to the commissioner.

Sec. 9. [62P.13] [VOLUME PERFORMANCE STANDARD FOR PHYSICIAN AND OUTPATIENT SERVICES.]

Subdivision 1. [DEVELOPMENT.] The commissioner shall establish an annual, statewide volume performance standard for physician and outpatient services. The volume performance standard shall serve as an expenditure target and must be set at a level that is consistent with achieving the limits on health care spending growth pursuant to section 62J.04. The volume performance standard must combine expenditures for all services provided by physicians and other independent providers and all ambulatory care services that are not provided through an integrated service network. The statewide volume performance standard must be developed from aggregated and encounter level data reported to the state, including the claims database established under section 62J.38, when it becomes operational.

Subd. 2. [APPLICATION.] The commissioner shall compare actual expenditures for physician and outpatient services with the volume performance standard in order to keep all-payer option expenditures within the statewide growth limits. If total expenditures during a particular year exceed the expenditure target for that year, the commissioner shall update the fee schedule rates for the second year following the year in which the target was exceeded, by adjusting the conversion factor, in order to offset this increase.

Sec. 10. [62P.15] [REIMBURSEMENT.]

The commissioner, as part of the implementation report due January 1, 1995, shall recommend to the legislature and the governor which health care professionals should be paid at the full fee schedule rate and which at a partial rate, for services covered in the fee schedule.

Sec. 11. [62P.17] [PAYMENT FOR SERVICES NOT IN THE FEE SCHEDULE.]

The commissioner shall examine options for paying for services not covered in the fee schedule and shall present recommendations to the legislature and the governor as part of the implementation report due January 1, 1995. The options examined by the commissioner must include, but are not limited to, updates and modifications to the Medicare resource based relative value scale; development of additional relative value units; development of a fee schedule based on a percentage of usual, customary, and reasonable charges; and use of rate of increase controls.

Sec. 12. [62P.19] [PAYMENT FOR URBAN AND SELECTED RURAL HOSPITALS.]

Subdivision 1. [ESTABLISHMENT OF RATE.] The commissioner shall develop a Minnesota-specific diagnosis related groups system to pay for inpatient services in those acute-care general hospitals not qualifying for reimbursement under section 62P.25. In developing this system, the commissioner shall consider the all-patient refined diagnosis related groups system and other diagnosis related groups systems. Payment rates must be standardized on a statewide basis based on hospital cost data for operating and capital expenses, adjusted for area wage rates, and consistent with the overall growth target for health care spending. The commissioner shall consider whether other adjustments are needed, based on studies of the cost of graduate medical education and uncompensated care. The commissioner shall recommend any needed adjustments to the legislature and governor as part of the implementation report due January 1, 1995.

Subd. 2. [SHORT STAY AND LONG STAY OUTLIERS.] The reimbursement system must provide, on a budget neutral basis, lower charges for self-pay patients with short or low cost stays. The commissioner shall phase out this exception once universal coverage is achieved. The commissioner, as part of the implementation report due January 1, 1995, shall recommend to the legislature and the governor whether an outlier payment for long stays is needed.

Sec. 13. [62P.21] [STATEWIDE VOLUME PERFORMANCE STANDARD FOR HOSPITALS.]

Subdivision 1. [DEVELOPMENT.] The commissioner shall establish an annual, statewide volume performance standard for inpatient hospital expenditures. The volume performance standard shall serve as an expenditure target and must be set at a level that is consistent with meeting the limits on health care spending growth.

Subd. 2. [APPLICATION.] The commissioner shall compare actual inpatient hospital expenditures with the volume performance standard in order to keep all-payer option expenditures within the statewide growth limits. If aggregate inpatient hospital expenditures for a particular year exceed the volume performance standard, the commissioner shall adjust the annual increase in payment levels for diagnosis related groups for the following year.

Sec. 14. [62P.23] [FLEXIBILITY IN APPLYING THE VOLUME PERFORMANCE STANDARD; REVIEW.]

Subdivision 1. [REALLOCATION.] The commissioner may reallocate spending limits between the inpatient hospital services volume performance standard and the physician and outpatient services volume performance standard, if this promotes the efficient use of health care services and does not cause total health care spending in the all-payer option to exceed the level allowed by the growth limits on health care spending.

Subd. 2. [REVIEW.] The commissioner shall review the effectiveness of the volume performance standard after the first three years of operation and shall recommend any necessary changes to the legislature and the governor.

Sec. 15. [62P.25] [REIMBURSEMENT FOR SMALL RURAL HOSPITALS.]

All-payer insurers shall pay small rural hospitals on the basis of reasonable charges, subject to a rate of increase control. For purposes of this requirement, a "small rural hospital" means a hospital with 40 or fewer licensed beds that is located at least 25 miles from any other hospital. The commissioner shall recommend to the legislature and the governor a methodology for determining reasonable charges as part of the implementation report due January 1, 1995.

Sec. 16. [62P.27] [PAYMENT FOR OUTPATIENT SERVICES.]

Outpatient services provided in acute-care general hospitals and freestanding ambulatory surgery centers shall be paid on the basis of approved charges, subject to rate of increase controls. The rate of increase allowed must be consistent with the volume performance standard for physician and outpatient services.

Sec. 17. [62P.29] [OTHER INSTITUTIONAL PROVIDERS.]

Subdivision 1. [SPECIALTY HOSPITALS AND HOSPITAL UNITS.] The commissioner shall develop payment mechanisms for specialty hospitals providing pediatric and psychiatric care and distinct psychiatric and rehabilitation units in hospitals. The commissioner shall present these recommendations to the legislature and governor as part of the implementation report due January 1, 1995.

Subd. 2. [OTHER PROVIDERS.] The commissioner shall apply rate of increase limits on charges or fees to other nonhospital institutional providers. These providers include, but are not limited to, home health agencies, substance abuse treatment centers, and nursing homes, to the extent their services are included in the all-payer option.

Sec. 18. [62P.31] [LIMITATIONS ON ALL-PAYER OPTION.]

Beginning July 1, 1997, all-payer insurers shall not employ or contract with health care providers, establish a network of exclusive or preferred providers, or negotiate provider payments that differ from the all-payer fee schedule, except that all-payer insurers may establish and maintain preferred provider networks solely for utilization control and quality management and not for negotiation of provider payments. Preferred provider organizations may continue to provide care to their existing enrollees, without becoming licensed as an integrated service network or otherwise becoming subject to this section, through December 31, 1997.

Sec. 19. [62P.33] [RECOMMENDATIONS FOR A USER FEE.]

The commissioner of health shall present to the legislature, as part of the implementation plan due January 1, 1996, recommendations for establishing and collecting a user fee from all-payer insurers. The user fee must be set at a level that reflects the state's investment in fee schedules, standard utilization reviews, quality monitoring, and other regulatory and administrative functions provided for the regulated all-payer option. The commissioner may consult actuaries in developing recommendations for and setting the level of the user fee. The commissioner may also present recommendations to establish additional fees and assessments if the commissioner determines they are needed to assure equal levels of accountability between the integrated service network system and the regulated all-payer option in terms of public health goals, serving high-risk and special needs populations, and other obligations imposed on the integrated service network system.

Sec. 20. [STUDY OF STANDARD UTILIZATION REVIEW CRITERIA FOR SERVICES.]

The commissioner of health, after consulting with providers, utilization review organizations, the practice parameters advisory committee, and the health technology advisory committee, shall report to the legislature by July 1, 1995, and recommend clinical criteria for determining the necessity, appropriateness, and efficacy of five frequently used health care services for which standard criteria for utilization review would decrease providers' administrative costs.

Sec. 21. [INSTRUCTION TO THE REVISOR.]

The revisor, in the next edition of Minnesota Statutes, shall replace the term "regulated all-payer system" and similar terms with "regulated all-payer option" and similar terms in sections 62J.04, 62J.09, 62J.152, 62P.01, and 62P.03.

Sec. 22. [EFFECTIVE DATE.]

Sections 1 to 21 are effective the day following final enactment, except that section 6 is effective January 1, 1996, and section 18 is effective July 1, 1997.

ARTICLE 4

FUTURE REQUIREMENTS FOR HEALTH PLAN COMPANIES

Section 1. [62J.48] [CRITERIA FOR REIMBURSEMENT.]

All ambulance services licensed under section 144.802 are eligible for reimbursement under the integrated service network system and the regulated all-payer option. The commissioner shall require community integrated service networks, integrated service networks, and all-payer insurers to adopt the following reimbursement policies.

(1) All emergency calls must be reimbursed without prior approval. Reimbursement must not be denied through retroactive review.

(2) All scheduled or prearranged air and ground ambulance transports must be reimbursed if requested by an attending physician or nurse, or if approved by a designated representative of an integrated service network who is immediately available on a 24-hour basis.

(3) Reimbursement must be provided for all emergency ambulance calls in which a patient is transported or medical treatment rendered.

(4) Special transportation services must not be billed or reimbursed if the patient needs medical attention immediately before transportation.

Sec. 2. Minnesota Statutes 1993 Supplement, section 62N.06, subdivision 1, is amended to read:

Subdivision 1. [AUTHORIZED ENTITIES.] (a) An integrated service network may be organized as a separate nonprofit corporation under chapter 317A ~~or~~, as a cooperative under chapter 308A, or as an insurance company licensed under chapter 60A.

(b) A ~~nonprofit~~ health carrier, as defined in section 62A.011, may establish and operate one or more integrated service networks without forming a separate corporation or cooperative, but only if all of the following conditions are met:

(i) a an existing contract between the health carrier and a health care provider, for a term of less than seven years, ~~that was executed before June 1, 1993,~~ that does not explicitly mention the provider's relationship within an integrated service network, or a future integrated service network, does not bind the health carrier or provider as applied to integrated service network services, except with the mutual consent of the health carrier and provider ~~entered into on or after June 1, 1993~~. This clause does not apply to contracts between a health carrier and its salaried employees;

(ii) the health carrier shall not apply toward the net worth, working capital, or deposit requirements of this chapter any assets used to satisfy net worth, working capital, deposit, or other financial requirements under any other chapter of Minnesota law;

(iii) the health carrier shall not include in its premiums for health coverage provided under any other chapter of Minnesota law, an assessment or surcharge relating to net worth, working capital, or deposit requirements imposed upon the integrated service network under this chapter; and

(iv) the health carrier shall not include in its premiums for integrated service network coverage under this chapter an assessment or surcharge relating to net worth working capital or deposit requirements imposed upon health coverage offered under any other chapter of Minnesota law.

Sec. 3. [62N.14] [OFFICE OF CONSUMER AFFAIRS.]

Subdivision 1. [DUTIES.] Every integrated service network must have an office of consumer affairs which will be responsible for dealing with all enrollee complaints and inquiries. The integrated service network, through its office of consumer affairs, will be responsible for:

(1) soliciting consumer comment on the quality and accessibility of services available;

(2) disseminating information to consumers on the integrated service network's enrollee complaint resolutions system;

(3) receiving unsolicited comments on and complaints about services;

(4) taking prompt action upon consumer complaints; and

(5) providing for and participating in alternative dispute resolution processes.

Subd. 2. [CONTACT WITH COMMISSIONER.] Each integrated service network shall designate a contact person for direct communication with the commissioner. Integrated service network complaint files must be maintained by the integrated service network for seven years and must be made available upon the request of the commissioner. The health department may at any time inspect the integrated service network's office of consumer affairs complaint files.

Subd. 3. [ENROLLEE MEMBERSHIP CARDS.] Integrated service networks shall issue enrollee membership cards to each enrollee of the integrated service network. The enrollee card shall contain, at minimum, the following information:

(1) the telephone number of the integrated service network's office of consumer affairs;

(2) the telephone number of the state's office of consumer information; and

(3) the telephone number of the department of health.

The membership cards shall also conform to the requirements set forth in section 62J.60.

Subd. 4. [ENROLLEE DOCUMENTS.] Each integrated service network, through its office of consumer affairs, is responsible for providing enrollees, upon request, with any reasonable information desired by an enrollee. This information may include duplicate copies of the evidence of coverage form required under section 62N.11; an annually updated list of addresses and telephone numbers of available integrated service network providers, including midlevel practitioners and allied professionals; and information on the enrollee complaint system of the integrated service network.

Sec. 4. [62N.38] [FEDERAL AGENCY PARTICIPATION.]

Subdivision 1. [PARTICIPATION.] An integrated service network may be organized by a department, agency, or instrumentality of the United States government.

Subd. 2. [ENROLLEES.] An integrated service network organized under subdivision 1 may limit its enrollment to those persons entitled to care under the federal program responsible for the integrated service network.

Subd. 3. [PARTICIPATION IN STATE PROGRAMS.] An integrated service network organized under subdivision 1 may request that the commissioner of health waive the requirement of section 62N.10, subdivision 4 with regard to some or all of the programs listed in that provision. The commissioner shall grant the waiver unless the commissioner determines that the applicant does not plan to provide care to low-income persons who are otherwise eligible for enrollment in the integrated service network. The integrated service network may withdraw its waiver with respect to some or all of the programs listed in section 62N.10, subdivision 4 at any time, as long as it is willing and able to enroll in the programs previously waived on the same basis as other integrated service networks.

Subd. 4. [SOLVENCY.] The commissioner shall consult with federal officials to develop procedures to allow integrated service networks organized under subdivision 1 to use the United States government as a guaranteeing organization.

Subd. 5. [VETERANS.] In developing and implementing initiatives to expand access to health care, the commissioner shall recognize the unique problems of veterans and consider methods to reach underserved portions of the veteran population.

Sec. 5. [62N.381] [AMBULANCE SERVICE RATE NEGOTIATION.]

Subdivision 1. [APPLICABILITY.] This section applies to all reimbursement rate negotiations between ambulance services and community integrated service networks or integrated service networks.

Subd. 2. [RANGE OF RATES.] The reimbursement rate negotiated for a new contract period must not be lower than the rate for the current contract period, and must not be greater than the current rate plus the rate of growth allowed under section 62J.04, subdivision 1, unless the ambulance service proposes a lower rate or can justify a higher rate. If the network and ambulance service cannot agree on a rate, each party shall submit their rate proposal along with supportive data to the advisory committee established by the commissioner under subdivision 3.

Subd. 3. [ADVISORY COMMITTEE ON AMBULANCE RATES.] The commissioner shall establish an advisory committee on ambulance rates, by September 1, 1994. Membership of the committee shall consist of: three representatives of integrated service networks, three representatives of the ambulance industry chosen by the Minnesota Ambulance Association, and one representative selected by the commissioner who has expertise in business or finance and is not a state employee. Each member shall designate an alternate, who shall have full voting rights. The committee is governed by section 15.0575.

Subd. 4. [DEVELOPMENT OF CRITERIA.] The commissioner, in consultation with the advisory committee, shall develop criteria for the committee to use in reviewing rate proposals, and criteria for the commissioner to use in making a final determination.

Subd. 5. [REVIEW OF RATE PROPOSALS.] The committee, using the criteria developed under subdivision 4, shall review the rate proposals by ambulance services and integrated service networks, and shall: (1) endorse the network rate proposal; (2) endorse the ambulance service proposal; or (3) develop and recommend its own proposal. The committee shall forward its decision to the commissioner. The commissioner, using the criteria developed under subdivision 4 and after considering the committee's decision, shall make a final rate determination and require the network and the ambulance service to adhere to this reimbursement rate.

Sec. 6. [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 as defined in section 62Q.07, subdivision 2, paragraph (e), 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; or

(3) status as a community health board as defined in chapter 145A.

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.

Subd. 2. [APPLICATION.] Any provider may apply to the commissioner for designation as an essential community provider within two years after the effective date of the rules adopted by the commissioner to implement this section.

Subd. 3. [HEALTH PLAN COMPANY AFFILIATION.] A health plan company must offer a provider contract to any designated essential community provider located within the area served by the health plan company. A health plan company shall not unduly restrict enrollee access to the essential community provider for the population that the essential community provider is certified to serve. A health plan company may also make other providers available to this same population. A health plan company may require an essential community provider to meet all data requirements, utilization review, and quality assurance requirements on the same basis as other health plan providers.

Subd. 4. [ESSENTIAL COMMUNITY PROVIDER RESPONSIBILITIES.] Essential community providers must agree to serve enrollees of all health plan companies operating in the area that the essential community provider is certified to serve.

Subd. 5. [CONTRACT PAYMENT RATES.] An essential community provider and a health plan company may negotiate the payment rate for covered services provided by the essential community provider. This rate must be competitive with rates paid to other health plan providers for the same or similar services.

Subd. 6. [TERMINATION.] The designation as an essential community provider is terminated five years after it is granted, and the former essential community provider has no rights or privileges beyond those of any other health care provider.

Subd. 7. [RECOMMENDATIONS ON ESSENTIAL COMMUNITY PROVIDERS.] As part of the implementation plan due January 1, 1995, the commissioner shall present recommendations and draft legislation for defining essential community providers, using the criteria established under subdivision 1, and defining the relationship between essential community providers and health plan companies.

Sec. 7. [62Q.21] [UNIVERSAL STANDARD BENEFITS SET.]

Subdivision 1. [MANDATORY OFFERING.] Effective January 1, 1996, each health plan company shall offer the universal standard benefits set to its enrollees.

Subd. 2. [STANDARD BENEFIT SET.] Effective July 1, 1997, health plan companies shall offer, sell, issue, or renew only the universal standard benefits set and the cost-sharing and supplemental coverage options allowed under sections 62Q.25 and 62Q.27.

Subd. 3. [GENERAL DESCRIPTION.] The universal standard benefits set must contain all appropriate and necessary health care services. Benefits necessary to meet public health goals, adequately serve high risk and special needs populations, facilitate the utilization of cost-effective alternatives to traditional inpatient acute and extended health care delivery, or meet other objectives of health care reform shall be considered by the commissioner for inclusion in the universal standard benefits set. Appropriate and necessary dental services must be included.

Subd. 4. [BENEFIT SET RECOMMENDATIONS.] The commissioner, in consultation with the Minnesota health care commission and the commissioners of commerce and human services, shall develop the universal standard benefits set and report these recommendations to the legislature by January 1, 1995. The commissioner shall include in this report a definition for "appropriate and necessary." In developing this definition, the commissioner shall consider that a benefit set that excludes genuinely appropriate and necessary services will not reduce or contain costs, but will only transfer those costs onto individuals and the public sector. Therefore, the definition of appropriate and necessary must be sufficiently broad to address the type, frequency, level, setting, and duration of services that address an individual's mental or physical condition, the needs of those with chronic conditions or disabilities, including those who need health services to improve their functioning, those for whom maintenance of health may not be possible, and those for whom preventing deterioration in their health conditions might not be achievable, and meet other health care reform objectives. In developing the universal standard benefits set, the commissioner shall take into account factors including, but not limited to:

(1) information regarding the benefits, risks, and cost-effectiveness of health care interventions;

(2) development of practice parameters;

(3) technology assessments;

(4) medical innovations;

(5) health status assessments;

(6) identification of unmet needs or particular barriers to access;

(7) public health goals;

(8) expenditure limits available funding; and

(9) cost-efficient and effective alternatives to inpatient health care services for acute or extended health care needs, such as home health care services; and

(10) cost savings resulting from the inclusion of a health care service that will decrease the utilization of other health care services in the benefit set.

Subd. 5. [ADVISORY COMMITTEE ON THE UNIVERSAL BENEFITS SET.] The commissioner shall appoint an advisory committee to develop recommendations regarding nondental health care services to be included in the universal benefits set. The committee must include representatives of health care providers, consumers, health plan companies, and counties. No more than half plus one of the members may be of the same gender. Recommendations of the committee must be provided to the Minnesota health care commission by October 1, 1994. The advisory committee expires January 1, 1995.

Subd. 6. [ADVISORY COMMITTEE ON DENTAL SERVICES.] The commissioner shall appoint an advisory committee to develop recommendations regarding the level of appropriate and necessary dental services to be included in the universal standard benefits set. No more than half plus one of the members may be of the same gender. The committee shall also develop recommendations on an appropriate system to deliver dental services. In its analysis, the committee shall study the quality and cost-effectiveness of dental services delivered through capitated dental networks, discounted dental preferred provider organizations, and independent practice dentistry. The committee shall report these recommendations to the Minnesota health care commission by October 1, 1994. The advisory committee expires January 1, 1995.

Subd. 7. [CHEMICAL DEPENDENCY SERVICES.] If chemical dependency services are included in the universal standard benefits set, the commissioner shall consider the cost-effectiveness of requiring health plan companies and chemical dependency facilities to use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660.

Sec. 8. [62Q.22] [CHEMICAL DEPENDENCY SERVICES.]

In developing benefit set recommendations the commissioner shall develop criteria to 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 from primary inpatient to outpatient care, aftercare, and long-term care; the safety of the individual's domestic and community environment; gender appropriate and culturally appropriate programs; and access to appropriate social services.

Sec. 9. [62Q.23] [GENERAL SERVICES.]

(a) Health plan companies shall comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(b) Health plan companies shall comply with sections 62A.047, 62A.27, and any other coverage required under chapter 62A of newborn infants, dependent children who do not reside with a covered person, handicapped children and dependents, and adopted children. A health plan company providing dependent coverage shall comply with section 62A.302.

(c) Health plan companies shall comply with the equal access requirements of section 62A.15, subdivision 2.

Sec. 10. [62Q.25] [SUPPLEMENTAL COVERAGE.]

Health plan companies may choose to offer separate supplemental coverage for services not covered under the universal benefits set. Health plan companies may offer any Medicare supplement, Medicare select, or other

Medicare-related product otherwise permitted for any type of health plan company in this state. Each Medicare-related product may be offered only in full compliance with the requirements in chapters 62A, 62D, and 62E that apply to that category of product.

Sec. 11. [62Q.27] [ENROLLEE COST-SHARING.]

(a) The commissioner, as part of the implementation plan due January 1, 1995, shall present to the legislature recommendations and draft legislation to establish up to five standardized benefit plans which may be offered by each health plan company. The plans must vary only on the basis of enrollee cost sharing and encompass a range of cost-sharing options from (1) lower premium costs combined with higher enrollee cost-sharing, to (2) higher premium costs combined with lower enrollee cost-sharing. Each plan offered may include out-of-network coverage options.

(b) For purposes of this section, "enrollee cost-sharing" or "cost-sharing" means copayments, deductibles, coinsurance, and other out-of-pocket expenses paid by the individual consumer of health care services.

(c) The following principles must apply to cost-sharing:

(1) enrollees must have a choice of cost-sharing arrangements;

(2) enrollee cost-sharing must be administratively feasible and consistent with efforts to reduce the overall administrative burden on the health care system;

(3) cost-sharing for recipients of medical assistance, general assistance medical care, or the MinnesotaCare program must be determined by applicable law and rules governing these programs;

(4) cost-sharing must be capped at an annual limit determined by the commissioner to protect individuals and families from financial catastrophe and to protect individuals with substantial health care needs;

(5) child health supervision services, immunizations, prenatal care, and other preventive services must not be subjected to cost-sharing;

(6) the impact of enrollee cost-sharing requirements on appropriate utilization must be considered when cost-sharing requirements are developed;

(7) additional requirements may be established to assist enrollees for whom an inducement in addition to the elimination of cost-sharing is necessary in order to encourage them to use cost-effective preventive services. These requirements may include the provision of educational information, assistance or guidance, and opportunities for responsible decision making by enrollees that minimize potential out-of-pocket costs;

(8) a copayment may be no greater than 25 percent of the paid charges for the service or product;

(9) cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services; and

(10) cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) The commissioner shall consider whether a health plan company may return all or part of an enrollee's cost-sharing to the enrollee as an incentive for completing preventive care, participating in health education, improving health, or reducing health risks.

Sec. 12. [62Q.29] [STATE-ADMINISTERED PUBLIC PROGRAMS.]

Public agencies, on behalf of eligible recipients enrolled in public programs such as medical assistance, general assistance medical care, and MinnesotaCare, may contract with health plan companies to provide services included in these programs, but not included in the universal standard benefits set.

Sec. 13. [62Q.30] [EXPEDITED FACT FINDING AND DISPUTE RESOLUTION PROCESS.]

The commissioner shall establish an expedited fact finding and dispute resolution process to assist enrollees of integrated service networks and all-payer insurers with contested treatment, coverage, and service issues to be in effect July 1, 1997. The commissioner may order an integrated service network or an all-payer insurer to provide or pay for a service that is within the universal standard benefits set. If the disputed issue relates to whether a service is appropriate and necessary, the commissioner may issue an order only after consulting with appropriate experts, reviewing pertinent literature, and considering the availability of satisfactory alternatives. The commissioner may fine or revoke the license of an integrated service network or an all-payer insurer that is the subject of repeated orders by the commissioner that suggests a pattern of inappropriate underutilization.

Sec. 14. [EFFECTIVE DATE.]

Sections 2, 3, 6, 7, and 11 to 13 are effective the day following final enactment, except that sections 9 and 10 are effective July 1, 1997.

ARTICLE 5

IMPLEMENTATION AND TRANSITION PLANS

Section 1. [62Q.41] [ANNUAL IMPLEMENTATION PLAN.]

The commissioner of health, in consultation with the Minnesota health care commission, shall develop an annual implementation plan to be submitted to the legislature each year beginning January 1, 1995, describing the progress and status of rule development and implementation of the integrated service network system and the regulated all-payer option, and providing recommendations for legislative changes that the commissioner determines may be needed.

Sec. 2. [TRANSITION PLAN.]

The commissioner of health, in consultation with the Minnesota health care commission, shall develop a plan to facilitate the transition from the existing health care delivery and financing system to the integrated service network system and the regulated all-payer option. The plan may include recommendations for integrated service network requirements or other requirements that should become applicable to some or all health plan companies prior to July 1, 1997, and recommendations for requirements that should be modified or waived during a transition period after July 1, 1997, as health plan companies convert to integrated service networks or to the regulated all-payer option. The transition plan must be submitted to the legislature by January 1, 1995.

Sec. 3. [STATE ADMINISTERED HEALTH PROGRAM PHASE-IN.]

(a) The commissioner of human services shall present to the legislature and the governor, as part of the implementation plan due January 1, 1996, a plan to incorporate state administered health programs, into the all-payer option and the integrated service network system. The plan must identify the federal waivers and approvals required. The plan must also provide a schedule for phasing in the state administered health programs beginning July 1, 1997, and for increasing reimbursement levels in stages over the phase-in period. For purposes of this section, "state administered health programs" means the medical assistance, general assistance medical care, and MinnesotaCare programs.

(b) The commissioner shall include with the plan required under paragraph (a) recommendations, including proposed legislation, for a coordinated program for receiving bids from managed care plans to serve enrollees of the state health plan and recipients of state administered health programs, to be phased in beginning July 1, 1997.

(c) The recommendations shall include a requirement that managed care plans interested in contracting to serve enrollees or recipients of any program listed in paragraph (b) submit a bid to provide services to all enrollees and recipients of those programs residing within the plan's service area.

(d) The commissioner must convene an advisory task force to assist with the preparation of plans, recommendations, and legislation required by this section. The task force must include representatives of recipients of state administered health programs, providers with substantial experience in providing services to recipients of these programs, the department of human services, county human services representatives, and other affected persons. No more than one-half plus one of the members may be of the same gender.

Sec. 4. [RECODIFICATION AND HEALTH PLAN COMPANY REGULATORY REFORM.]

Subdivision 1. [PROPOSED LEGISLATION.] The commissioner of health, in consultation with the commissioner of commerce, the Minnesota health care commission, and the legislative commission on health care access, shall draft proposed legislation to recodify, simplify, and standardize all statutes, rules, regulatory requirements, and procedures relating to health plan companies. The recodification and regulatory reform must become effective simultaneously with the full implementation of the integrated service network system and the regulated all-payer option on July 1, 1997. The commissioner of health shall submit to the legislature by January 1, 1996, a report on the recodification and regulatory reform with proposed legislation.

Subd. 2. [ADVISORY TASK FORCE.] The commissioner of health shall convene an advisory task force to advise the commissioner on the recodification and reform of regulatory requirements under this section. The task force must include representatives of health plan companies, consumers, public and private employers, labor unions, providers, and other affected persons. No more than half plus one of the members may be of the same gender.

Sec. 5. [HEALTH REFORM DEMONSTRATION MODELS.]

The commissioner of health, in consultation with appropriate state agencies, is authorized to seek federal and private foundation grants to supplement any funds appropriated under this act in order to conduct demonstration models to develop the implementation strategies for the various components of health care reform. The model projects may include the following:

(1) risk adjustment formulas;

(2) integration of special needs populations into integrated service networks;

(3) organization of health services delivery by post-secondary educational facilities;

(4) establishment of rural purchasing pools and cooperative service arrangements;

(5) integration of rural public health nursing agency services with rural community integrated service networks;

(6) development of appropriate access services which facilitate enrollment of low-income or special needs populations into integrated service networks;

(7) evaluation methods for the action plans prepared by health plan companies; and

(8) integration of services provided by licensed school nurses into integrated service networks.

Sec. 6. [AMBULANCE RATE REGULATION STUDY.]

The commissioner, in consultation with the Minnesota Ambulance Association and the regional emergency medical services systems, shall develop an ambulance rate regulation system for ambulance services provided in both the integrated service network and all-payer option sectors. The commissioner shall present recommendations and an implementation plan for this rate regulation system to the legislature by January 1, 1996.

Sec. 7. [PREPAID MEDICAL ASSISTANCE PLAN STUDY.]

The commissioners of health and human services shall study the coordination between health care reform and the prepaid medical assistance plan. The study must also determine whether there have been cost savings, cost increases, or cost shifting under current implementation of the prepaid medical assistance plan. The commissioners shall jointly report their findings to the legislature by January 1, 1995.

Sec. 8. [POOLED PRESCRIPTION DRUG PURCHASING PROGRAM.]

Subdivision 1. [FINDINGS AND PURPOSE.] The legislature finds that increasing costs are threatening the ability of a number of Minnesotans without prescription drug coverage to afford the purchase of prescription drugs. The legislature also finds that innovative private and public arrangements involving pooled prescription drug benefit management have provided many Minnesotans with economical access to prescription drugs. The legislature desires to make available the advantages of similar arrangements to those Minnesotans not currently enjoying such advantages without disrupting existing and future private and public arrangements in which other Minnesotans participate.

Subd. 2. [PROPOSED LEGISLATION.] By January 15, 1995, the commissioner of health shall provide the legislature with proposed legislation containing the commissioner's recommendations for creation of a pooled prescription drug purchasing program. The program to be created by the proposed legislation shall:

(1) make available the cost savings associated with pooled prescription drug purchasing to those Minnesotans lacking private or public prescription drug coverage who are not eligible to participate in other private or public pooled prescription drug benefit management programs;

(2) not disrupt, displace or otherwise affect existing private and public arrangements for management of prescription drug benefits;

(3) provide that the program may be administered by a private vendor supervised by the state and selected on the basis of competitive bidding; and

(4) take into account the effect of ongoing changes in state and federal health care policy.

Sec. 9. [EFFECTIVE DATE.]

Sections 1 to 8 are effective the day following final enactment.

ARTICLE 6

UNIVERSAL COVERAGE

Section 1. [62Q.16] [UNIVERSAL COVERAGE.]

It is the commitment of the state to achieve universal health coverage for all Minnesotans by July 1, 1997. In order to achieve this commitment, the following goals must be met:

(1) every Minnesotan shall have health coverage and shall contribute to the costs of coverage based on ability to pay;

(2) no Minnesotan shall be denied coverage or forced to pay more because of health status;

(3) quality health care services must be accessible to all Minnesotans;

(4) all health care purchasers must be placed on an equal footing in the health care marketplace; and

(5) a comprehensive and affordable health plan must be available to all Minnesotans.

Sec. 2. [62Q.17] [VOLUNTARY PURCHASING POOLS.]

Subdivision 1. [PERMISSION TO FORM.] Notwithstanding section 62A.10, employers, groups, and individuals may voluntarily form purchasing pools, for the purpose of negotiating and purchasing health plan coverage from health plan companies for members of the pool.

Subd. 2. [COMMON FACTORS.] All participants in a purchasing pool must live within a common geographic region, be employed in a similar occupation, or share some common factor as approved by the commissioner.

Subd. 3. [GOVERNING STRUCTURE.] Each pool must have a governing structure controlled by its members. The governing structure of the pool is responsible for administration of the pool. The governing structure shall review and evaluate all bids for coverage from health plan companies, shall determine criteria for joining and leaving the pool, and may design incentives for healthy lifestyles and health promotion programs. The governing structure may design uniform entrance standards for all employers, except small employers as defined under section 62L.02. Small employers must be permitted to enter any pool if the small employer meets the pool's membership requirements. Pools must provide as much choice in health plans to members as is financially possible. The governing structure may charge all members a fee for administrative purposes.

Subd. 4. [ENROLLMENT.] Pools must have an annual open enrollment period of not less than 15 days, during which all individuals or groups that qualify for membership may enter the pool without any preexisting condition limitations or exclusions or exclusionary riders, except those permitted under chapter 62L for groups or section 62A.65

for individuals. Pools must reach and maintain an enrolled population of at least 1,000 members within six months of formation. If a pool fails to reach or maintain the minimum enrollment, all coverage subsequently purchased through the purchasing pool must be regulated through existing applicable laws and forego all advantages under this section.

Subd. 5. [MEMBERS.] The governing structure of the pool shall set a minimum time period for membership. Members must stay in the purchasing pool for the entire minimum period to avoid paying a penalty. Penalties for early withdrawal from the purchasing pool shall be established by the governing structure.

Subd. 6. [EMPLOYER-BASED PURCHASING POOLS.] Employer-based purchasing pools must, with respect to small employers as defined in section 62L.02, meet all the requirements of chapter 62L. The experience of the pool must be pooled and the rates blended across all groups. Pools may decide to create tiers within the pool, based on experience of group members. These tiers must be designed within the requirements of section 62L.08. The governing structure may establish criteria limiting movement between tiers. Tiers must be phased out within two years of the pool's creation.

Subd. 7. [INDIVIDUAL MEMBERS.] Purchasing pools that contain individual members must meet all of the underwriting and rate restrictions found in the individual health plan market.

Subd. 8. [REPORTS.] Prior to the initial effective date of coverage, and annually thereafter, each pool shall file a report with the information clearinghouse. The information clearinghouse must use the report to promote the purchasing pools. The annual report must contain the following information:

(1) the number of lives in the pool;

(2) the geographic area the pool intends to cover;

(3) the number of health plans offered;

(4) a description of the benefits under each plan;

(5) a description of the premium structure, including any copayments or deductibles, of each plan offered;

(6) evidence of compliance with chapter 62L;

(7) a sample of marketing information, including a phone number where the pool may be contacted; and

(8) a list of all administrative fees charged.

Sec. 3. [62Q.18] [UNIVERSAL COVERAGE; INSURANCE REFORMS.]

Subdivision 1. [DEFINITION.] For purposes of this section,

(1) "continuous coverage" has the meaning given in section 62L.02;

(2) "guaranteed issue" means:

(i) for individual health plans, that a health plan company shall not decline an application by an individual for any individual health plan offered by that health plan company, including coverage for a dependent of the individual to whom the health plan has been or would be issued; and

(ii) for group health plans, that a health plan company shall not decline an application by a group for any group health plan offered by that health plan company and shall not decline to cover under the group health plan any person eligible for coverage under the group's eligibility requirements, including persons who become eligible after initial issuance of the group health plan;

(3) "qualifying coverage" has the meaning given in section 62L.02; and

(4) "underwriting restrictions" has the meaning given in section 62L.03, subdivision 4.

Subd. 2. [INDIVIDUAL MANDATE.] Effective July 1, 1997, each Minnesota resident shall obtain and maintain qualifying coverage.

Subd. 3. [GUARANTEED ISSUE.] (a) Effective July 1, 1997, each health plan company shall offer, sell, issue, or renew each of its individual health plan forms on a guaranteed issue basis to any Minnesota resident.

(b) Effective July 1, 1997, each health plan company shall offer, sell, issue, or renew each of its group health plan forms to any employer that has its principal place of business in this state on a guaranteed issue basis, provided that the guaranteed issue requirement does not apply to employees, dependents, or other persons to be covered, who are not residents of this state.

(c) Effective July 1, 1997, each health plan company that issues a group health plan to an employer that does not have its principal place of business in this state, where the health plan covers or is intended to cover 20 or more residents of this state, must cover residents of this state on a guaranteed issue basis.

Subd. 4. [UNDERWRITING RESTRICTIONS LIMITED.] Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan that has underwriting restrictions that apply to a Minnesota resident, except as expressly permitted under this section.

Subd. 5. [PREEXISTING CONDITION LIMITATIONS.] Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan that contains a preexisting condition limitation or exclusion or exclusionary rider that applies to a Minnesota resident, except a limitation which is no longer than 12 months and applies only to a person who has not maintained continuous coverage. An unexpired preexisting condition limitation from previous qualifying coverage may be carried over to new coverage under a health plan, if the unexpired condition is one permitted under this section. A Minnesota resident who has not maintained continuous coverage may be subjected to a new 12-month preexisting condition limitation after each break in continuous coverage.

Subd. 6. [LIMITS ON PREMIUM RATE VARIATIONS.] (a) Effective July 1, 1995, the premium rate variations permitted under sections 62A.65 and 62L.08 become:

(1) for factors other than age and geography, 12.5 percent of the index rate; and

(2) for age, 25 percent of the index rate.

(b) Effective July 1, 1996, the premium variations permitted under sections 62A.65 and 62L.08 become:

(1) for factors other than age and geography, 7.5 percent of the index rate; and

(2) for age, 15 percent of the index rate.

(c) Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew a health plan, that is subject to section 62A.65 or 62L.08, for which the premium rate varies between covered persons on the basis of any factor other than:

(1) for individual health plans, differences in benefits or benefit design, and for group health plans, actuarially valid differences in benefits or benefit design;

(2) the number of persons to be covered by the health plan;

(3) actuarially valid differences in expected costs between adults and children;

(4) healthy lifestyle discounts authorized by statute; and

(5) for individual health plans, geographic variations permitted under section 62A.65, and for group health plans, geographic variations permitted under section 62L.08.

(d) All premium rate variations permitted under paragraph (c) are subject to the approval of the commissioner.

Subd. 7. [PORTABILITY OF COVERAGE.] (a) Effective July 1, 1997, no health plan company shall offer, sell, issue, or renew any group or individual health plan that does not provide for guaranteed issue, with full credit for previous qualifying coverage against any preexisting condition limitation that would otherwise apply under subdivision 5. No health plan shall be subject to any other type of underwriting restriction.

(b) Effective July 1, 1994, no health plan company shall offer, sell, issue, or renew any group or individual health plan that does not, with respect to individuals who maintain continuous coverage and whose immediately preceding qualifying coverage is a health plan issued by the same health plan company, medical assistance under chapter 256B, general assistance medical care under chapter 256D, or the MinnesotaCare plan established under section 256.9352,

(1) make coverage available on a guaranteed issue basis; and

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or exclusion.

(c) Paragraph (b) applies to individuals whose immediately preceding qualifying coverage is medical assistance under chapter 256B, general assistance medical care under chapter 256D, or the MinnesotaCare plan established under section 256.9352, only if the individual has disenrolled from the public program or will disenroll upon issuance of the new coverage. Paragraph (b) does not apply if the public program uses or will use public funds to pay the premiums for an individual who remains or will remain enrolled in the public program. This paragraph does not prohibit public payment of premiums to continue private sector coverage originally obtained prior to enrollment in the public program, where otherwise permitted by state or federal law.

(d) Effective July 1, 1994, no health plan company shall offer, sell, issue, or renew any group health plan that does not, with respect to individuals who maintain continuous coverage:

(1) make coverage available on a guaranteed issue basis; and

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or exclusion.

To the extent that this paragraph conflicts with chapter 62L, with respect to small employers as defined in section 62L.02, chapter 62L governs.

Subd. 8. [COMPREHENSIVE HEALTH ASSOCIATION.] Effective July 1, 1997, the comprehensive health association created in section 62E.10 shall not accept new applicants for enrollment, except for medicare-related coverage described in section 62E.12 and for coverage described in section 62E.18.

Subd. 9. [CONTINGENCY; FUTURE LEGISLATION.] This section, except for subdivision 6, paragraphs (a) and (b), and subdivision 7, paragraphs (b), (c), and (d), is not intended to be implemented prior to legislation enacted to achieve the objectives of sections 1, 5, 6, and 7.

Sec. 4. [MARKET REFORM STRATEGIES STUDY.]

The health care commission shall study and recommend to the legislature by January 1, 1995, insurance market reforms designed to promote the formation of large purchasing pools to be available to individuals and small employers by July 1, 1997. The health care commission shall study:

(1) whether mergers between or among health care providers and group purchasers that expand market share beyond a specified percentage should be regulated or prohibited, in order to preserve competition on price and quality;

(2) integrating public and private sector financing mechanisms to extend MinnesotaCare subsidies to employees and dependents who are eligible for employer-based coverage without eroding existing coverage;

(3) requiring purchasing pools to make available to consumers all plans that submit bids to the pool;

(4) whether some or all purchasers should be required to obtain coverage through a public or private pool;

(5) the impact and effectiveness of the Minnesota employees insurance program under section 43A.317 and the public employees insurance plan under section 43A.316; and

(6) how statewide or regional purchasing pools could be developed for all individuals and small groups that do not have access to a private purchasing pool, and for the MinnesotaCare program and other state-subsidized health care programs, by expanding the Minnesota employees insurance program currently operated by the department of employee relations or by other means.

Sec. 5. [SURVEY OF THE UNINSURED AND EVALUATION OF EXISTING REFORMS.]

Subdivision 1. [SURVEY.] The Minnesota health care commission shall authorize a survey of Minnesota households and employers to provide current data on the uninsured population and assess the effectiveness of the existing health care reforms. As part of this survey, the commissioner of human services shall conduct a survey of the MinnesotaCare population to determine the effects of existing health care reforms on this population. Results of this survey shall be presented to the legislature by January 15, 1995.

Subd. 2. [EVALUATION.] The commissioner of health, in consultation with the health care commission and the commissioners of human services and commerce, shall evaluate the effect of existing reforms and the effect of the MinnesotaCare program on the uninsured population. Based on this evaluation, the commissioners of health, commerce, and human services shall recommend modifications to existing reforms as necessary to continue to make progress toward universal coverage by 1997 and report these modifications to the legislature by January 15, 1996.

Sec. 6. [HEALTH CARE AFFORDABILITY STUDY.]

(a) The commissioner of health, in consultation with the commissioners of human services, commerce, and revenue, shall study and report to the Minnesota health care commission by October 1, 1994, the various factors that affect health care affordability, including out-of-pocket spending, insurance premiums, and taxes.

(b) Based on the study in paragraph (a), the Minnesota health care commission shall recommend to the legislature by January 15, 1995, a specific percentage of income that overall health care costs to a family or individual should not exceed.

(c) The recommendations in paragraph (b) must be used by the commissioners of health and human services to develop an appropriate premium subsidy and sliding fee scale for a permanent health care subsidy program.

Sec. 7. [FINANCING STUDY.]

The Minnesota health care commission, in consultation with the commissioners of health, commerce, human services, and revenue, and representatives of county government shall report to the legislature by January 1, 1995, with an implementation schedule and plan for a stable, long-term health care funding system for all government health programs. The report must include recommendations for overhauling the current system, specific financing methods, and detailed cost estimates for an expanded, fully-funded subsidy program to guarantee universal coverage to all Minnesota residents. The report must include an inventory and analysis of the existing system of government financing of health care. It must include recommendations for capturing savings that will accrue under health care reform and reallocating them to offset additional costs of universal coverage. The commission may contract for actuarial, finance, and taxation expertise.

The study must take into account the following goals and guiding principles:

(a) To the extent possible, universal coverage should be achieved without a net increase in total health spending, taxes, or government spending by recapturing savings and reallocating resources within the system.

(b) To the extent that universal coverage will require additional financing mechanisms, revenues should be raised through an income or payroll tax with consideration given to providing appropriate offsets for low-income individuals. Taxing items that are considered to be health risks and contribute to preventable illness and injury shall be considered as a possible funding source.

(c) Financing reform should ensure adequate and equitable financing of all necessary components of the health system.

(d) Activities that benefit the entire community, such as core public health activities, including collection of data on health status and community health needs, and medical education should be financed by broad-based funding sources. Funding mechanisms should promote collaboration between the public and private sectors.

(e) Personal health care services for individuals who are enrolled in a health plan should be provided or paid for by the health plan.

(f) Government subsidy programs for low-income Minnesotans should be financed by broad-based funding sources such as an income or payroll tax.

(g) Funding mechanisms that are inequitable or create undesirable incentives, such as the Minnesota comprehensive health association assessment, should be restructured.

Sec. 8. [PREEXISTING CONDITIONS STUDY.]

The health care commission shall study the feasibility and impact of the following:

(1) eliminating preexisting condition limitations in steps;

(2) standardizing preexisting condition limitations;

(3) narrowing the preexisting condition limitation period from 12 months to six months; and

(4) requiring limited coverage of services for preexisting conditions.

The health care commission shall provide a written report to the legislature on or before December 15, 1994.

Sec. 9. [REQUIRED OFFER OF INDIVIDUAL HEALTH PLANS.]

The health care commission shall study the effects and desirability of the requirement that all health plan companies offer individual health plans, as provided in section 62Q.18, subdivision 9. The health care commission shall provide a written report to the legislature on or before December 15, 1994.

Sec. 10. [EFFECTIVE DATE.]

Sections 1 and 4 to 9 are effective the day following final enactment. Sections 2 and 3 are effective July 1, 1994.

ARTICLE 7

PUBLIC HEALTH

Section 1. [62Q.075] [LOCAL PUBLIC ACCOUNTABILITY AND COLLABORATION PLAN.]

Subdivision 1. [DEFINITION.] For purposes of this section, "managed care organization" means a health maintenance organization, community integrated service network, or integrated service network.

Subd. 2. [REQUIREMENT.] Beginning July 1, 1995, all managed care organizations shall annually file with the action plans required under section 62Q.07 a plan describing the actions the managed care organization has taken and those it intends to take to contribute to achieving public health goals for each service area in which an enrollee of the managed care organization resides. This plan must be jointly developed in collaboration with the local public health units, appropriate regional coordinating boards, and other community organizations providing health services within the same service area as the managed care 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 managed care organization to provide expertise and represent community needs and goals as identified under chapters 145A and 256E.

Subd. 3. [CONTENTS.] The plan must address the following:

(a) specific measurement strategies and a description of any activities which contribute to public health goals and needs of high risk and special needs populations as defined and developed under chapters 145A and 256E;

(b) description of the process by which the managed care organization will coordinate its activities with the community health boards, regional coordinating boards, and other relevant community organizations servicing the same area;

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

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

Subd. 4. [REVIEW.] Upon receipt of the plan, the appropriate commissioner shall provide a copy to the regional coordinating boards, local community health boards, and other relevant community organizations within the managed care organization's service area. After reviewing the plan, these community groups may submit written comments on the plan to either the commissioner of health or commerce, as applicable, and may advise the commissioner of the managed care organization's effectiveness in assisting to achieve regional 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 managed care 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 managed care organization. The county board, or applicable city council, may submit written comments to the appropriate commissioner, and may advise the commissioner of the managed care 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 managed care organization. The plan and any comments submitted must be filed with the information clearinghouse to be distributed to the public.

Sec. 2. [62Q.32] [LOCAL OMBUDSPERSON.]

Community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services through an integrated service network system or through the regulated all-payer option. The ombudsperson's functions may include but are not limited to:

(a) mediation or advocacy on behalf of a person who is having difficulty accessing health care services through either an integrated service network or through the regulated all-payer option; and

(b) investigation of the quality of services provided to a person and determine the extent to which quality assurance mechanisms are needed or any other system change may be needed.

Sec. 3. [62Q.33] [LOCAL GOVERNMENT PUBLIC HEALTH FUNCTIONS.]

Subdivision 1. [FINDINGS.] The legislature finds that the local government public health functions of community assessment, policy development, and assurance of service delivery are essential elements in consumer protection and in achieving the objectives of health care reform in Minnesota. The legislature further finds that the site-based and population-based services provided by state and local health departments are a critical strategy for the long-term containment of health care costs. The legislature further finds that without adequate resources, the local government public health system will lack the capacity to fulfill these functions in a manner consistent with the needs of a reformed health care delivery system.

Subd. 2. [REPORT ON SYSTEM DEVELOPMENT.] The commissioner of health, in consultation with the state community health services advisory committee and the commissioner of human services, and representatives of local health departments, county government, a municipal government acting as a local board of health, the Minnesota health care commission, area Indian health services, health care providers, and citizens concerned about public health, shall coordinate the process for defining implementation and financing responsibilities of the local government core public health functions. The commissioner shall submit recommendations and an initial and final report on local government core public health functions according to the timeline established in subdivision 5.

Subd. 3. [CORE PUBLIC HEALTH FUNCTIONS.] (a) The report required by subdivision 2 must describe the local government core public health functions of: assessment of community health needs; goal-determination, public policy, and program development for addressing these needs; and assurance of service availability and accessibility to meet community health goals and needs. The report must further describe activities for implementation of these functions that are the continuing responsibility of the local government public health system, taking into account the ongoing reform of the health care delivery system.

(b) The activities to be defined in terms of the local government core public health functions include, but are not limited to:

(1) consumer protection and advocacy;

(2) targeted outreach and linkage to personal services;

(3) health status monitoring and disease surveillance;

(4) investigation and control of diseases and injuries;

(5) protection of the environment, work places, housing, food, and water;

(6) laboratory services to support disease control and environmental protection;

(7) health education and information;

(8) community mobilization for health-related issues;

(9) training and education of public health professionals;

(10) public health leadership and administration;

(11) emergency medical services;

(12) violence prevention; and

(13) other activities that have the potential to improve the health of the population or special needs populations and reduce the need for or cost of health care services.

Subd. 4. [CAPACITY BUILDING, ACCOUNTABILITY AND FUNDING.] The recommendations required by subdivision 2 shall include:

(1) a definition of minimum outcomes for implementing core public health functions, including a local ombudsperson under the assurance of services function;

(2) the identification of counties and applicable cities with public health programs that need additional assistance to meet the minimum outcomes;

(3) a budget for supporting all functions needed to achieve the minimum outcomes, including the local ombudsperson assurance of services function;

(4) an analysis of the costs and benefits expected from achieving the minimum outcomes;

(5) strategies for improving local government public health functions throughout the state to meet the minimum outcomes including: (i) funding distribution for local government public health functions necessary to meet the minimum outcomes; and (ii) strategies for the financing of personal health care services within the uniform benefits set and identifying appropriate mechanisms for the delivery of these services; and

(6) a recommended level of dedicated funding for local government public health functions in terms of a percentage of total health service expenditures by the state or in terms of a per capita basis, including methods of allocating the dedicated funds to local government.

Subd. 5. [TIMELINE.] (a) By October 1, 1994, the commissioner shall submit to the legislative commission on health care access the initial report and recommendations required by subdivisions 2 to 4.

(b) By February 15, 1995, the commissioner, in cooperation with the legislative commission on health care access, shall submit a final report to the legislature, with specific recommendations for capacity building and financing to be implemented over the period from January 1, 1996, through December 31, 1997.

(c) By January 1, 1997, and by January 1 of each odd-numbered year thereafter, the commissioner shall present to the legislature an updated report and recommendations.

Sec. 4. [PUBLIC HEALTH GOALS REPORT.]

The commissioner of health shall provide a written report to the legislature by January 1, 1996, of recommendations on how providers and payers participating in the regulated all-payer option shall participate in achieving public health goals.

Sec. 5. [EFFECTIVE DATE.]

Sections 1 to 4 are effective the day following final enactment.

ARTICLE 8

CONFORMING AND MISCELLANEOUS CHANGES

Section 1. [43A.312] [LIMITATION ON COMPENSATION.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following definitions apply:

(a) "Administrative employee" means an individual whose primary duty as an employee is the performance of office or nonmanual work directly related to management policies or general business operations.

(b) "Compensation" means the annual value of wages, salary, benefits, deferred compensation, and stock options.

(c) "Executive employee" means an individual whose primary duty as an employee consists of the management of the enterprise in which the individual is employed.

(d) "Health care provider" means a person or organization that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. "Health care provider" includes a for-profit affiliate of the health care provider. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health plan company, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

(e) "Health plan company" means:

(1) a health carrier as defined under section 62A.011, subdivision 2;

(2) an integrated service network as defined under section 62N.02;

(3) an all-payer insurer regulated under chapter 62P;

(4) a community integrated service network regulated under chapter 62N; or

(5) a for-profit affiliate of an entity listed in this paragraph.

(f) "State health care plan" means the medical assistance program, the general assistance medical care program, the MinnesotaCare program, health insurance plans for state employees established under section 43A.18, the public employees insurance plan under section 43A.316, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.19.

Subd. 2. [SALARY RATIO LIMITATION.] No health care provider or health plan company serving enrollees or clients of a state health care plan, or serving as a contractor or third-party administrator for a state health care plan, may compensate its most highly paid executive or administrative employee an amount exceeding 25 times the compensation paid to its lowest paid employee. For purposes of this requirement, stock options are valued at fair market value at the time they become the property of the employee.

Subd. 3. [REPORTING.] Each health care provider and health plan company subject to the salary ratio limitation in subdivision 2 shall report the compensation received by its most highly paid executive or administrative employee, based upon full-time equivalents, and its lowest paid employee, based upon full-time equivalents, to the commissioner of employee relations. This information shall be provided in the form and at the times specified by the commissioner. This information on compensation is classified as public data under chapter 13. Health plan companies subject to subdivision 2, and state health care programs, shall report the names and business addresses of all health care providers serving as participating providers to the commissioner of employee relations. This information is classified as private data under chapter 13.

Subd. 4. [ENFORCEMENT.] The commissioner of employee relations shall verify that all health care providers and health plan companies subject to subdivision 2 have reported the information required in subdivision 3 and shall verify that all health care providers and health plan companies have complied with the salary ratio limitation. The commissioner shall notify all health care providers and health plan companies in violation of subdivision 2 and shall provide four years for the health care provider or health plan company to comply with the salary ratio limitation. The commissioner shall require health care providers and health plan companies to submit the information necessary to demonstrate compliance. If at the end of four years the health care provider or health plan company has not complied, the commissioner, in conjunction with the appropriate agency commissioner or commissioners, shall prohibit the health care provider or health plan company from serving enrollees or clients of a state health care plan, or from serving as a contractor or third-party administrator for state health care plans. All state agency commissioners shall cooperate with the commissioner of employee relations in administering and enforcing this section.

Sec. 2. Minnesota Statutes 1992, section 60A.15, subdivision 1, is amended to read:

Subdivision 1. [DOMESTIC AND FOREIGN COMPANIES.] (a) On or before April 1, June 1, and December 1 of each year, every domestic and foreign company, including town and farmers' mutual insurance companies, domestic mutual insurance companies, marine insurance companies, health maintenance organizations, integrated service networks, community integrated service networks, and nonprofit health service plan corporations, shall pay to the commissioner of revenue installments equal to one-third of the insurer's total estimated tax for the current year. Except as provided in paragraphs (b) and (e), installments must be based on a sum equal to two percent of the premiums described in paragraph (c).

(b) For town and farmers' mutual insurance companies and mutual property and casualty insurance companies other than those (i) writing life insurance, or (ii) whose total assets on December 31, 1989, exceeded $1,600,000,000, the installments must be based on an amount equal to the following percentages of the premiums described in paragraph (c):

(1) for premiums paid after December 31, 1988, and before January 1, 1992, one percent; and

(2) for premiums paid after December 31, 1991, one-half of one percent.

(c) Installments under paragraph (a), (b), or (e) are percentages of gross premiums less return premiums on all direct business received by the insurer in this state, or by its agents for it, in cash or otherwise, during such year.

(d) Failure of a company to make payments of at least one-third of either (1) the total tax paid during the previous calendar year or (2) 80 percent of the actual tax for the current calendar year shall subject the company to the penalty and interest provided in this section, unless the total tax for the current tax year is $500 or less.

(e) For health maintenance organizations ~~and~~, nonprofit health services plan corporations, integrated service networks, and community integrated service networks, the installments must be based on an amount equal to one percent of premiums described in paragraph (c) that are paid after December 31, 1995.

(f) Premiums under ~~the children's health plan~~ medical assistance, the ~~health right plan~~ MinnesotaCare program, and the Minnesota comprehensive health insurance plan are not subject to tax under this section.

Sec. 3. Minnesota Statutes 1992, section 62A.48, subdivision 1, is amended to read:

Subdivision 1. [POLICY REQUIREMENTS.] No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term

care policy must cover prescribed long-term care in nursing facilities and at least the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy AA must include: a maximum lifetime benefit limit of at least $100,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums. Coverage under a long-term care policy A must include: a maximum lifetime benefit limit of at least $50,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums. Prior hospitalization may not be required under a long-term care policy.

Coverage under either policy designation must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage. Coverage under either policy designation may include a waiting period of up to 90 days before benefits are paid, but there must be no more than one waiting period per benefit period; for purposes of this sentence, "days" means calendar days. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to be homebound or house confined to receive home care services. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

No individual long-term care policy shall be offered or delivered in this state until the insurer has received from the insured a written designation of at least one person, in addition to the insured, who is to receive notice of cancellation of the policy for nonpayment of premium. The insured has the right to designate up to a total of three persons who are to receive the notice of cancellation, in addition to the insured. The form used for the written designation must inform the insured that designation of one person is required and that designation of up to two additional persons is optional and must provide space clearly designated for listing between one and three persons. The designation shall include each person's full name, home address, and telephone number. Each time an individual policy is renewed or continued, the insurer shall notify the insured of the right to change this written designation.

The insurer may file a policy form that utilizes a plan of care prepared as provided under section 62A.46, subdivision 5, clause (1) or (2).

Sec. 4. Minnesota Statutes 1993 Supplement, section 61B.20, subdivision 13, is amended to read:

Subd. 13. [MEMBER INSURER.] "Member insurer" means an insurer licensed or holding a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 61B.19, subdivision 2, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn. The term does not include:

(1) a nonprofit hospital or medical service organization, other than a nonprofit health service plan corporation that operates under chapter 62C;

(2) a health maintenance organization;

(3) a fraternal benefit society;

(4) a mandatory state pooling plan;

(5) a mutual assessment company or an entity that operates on an assessment basis;

(6) an insurance exchange; ~~or~~

(7) an integrated service network or a community integrated service network; or

(8) an entity similar to those listed in clauses (1) to ~~(6)~~ (7).

Sec. 5. Minnesota Statutes 1992, section 62D.04, is amended by adding a subdivision to read:

Subd. 5. [PARTICIPATION; GOVERNMENT PROGRAMS.] Health maintenance organizations shall, as a condition of receiving and retaining a certificate of authority, participate in the medical assistance, general assistance medical care, and MinnesotaCare programs. The participation required from health maintenance organizations shall be pursuant to rules adopted under section 256B.0644.

Sec. 6. Minnesota Statutes 1992, section 62E.02, subdivision 10, is amended to read:

Subd. 10. [INSURER.] "Insurer" means those companies operating pursuant to chapter 62A or 62C and offering, selling, issuing, or renewing policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations, integrated service networks, or community integrated service networks.

Sec. 7. Minnesota Statutes 1992, section 62E.02, subdivision 18, is amended to read:

Subd. 18. [WRITING CARRIER.] "Writing carrier" means the insurer or insurers ~~and~~, health maintenance organization or organizations, integrated service network or networks, and community integrated service network or networks selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

Sec. 8. Minnesota Statutes 1992, section 62E.02, subdivision 20, is amended to read:

Subd. 20. [COMPREHENSIVE INSURANCE PLAN OR STATE PLAN.] "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization, integrated service network, or community integrated service network coverage offered by the association through the writing carrier.

Sec. 9. Minnesota Statutes 1992, section 62E.02, subdivision 23, is amended to read:

Subd. 23. [CONTRIBUTING MEMBER.] "Contributing member" means those companies regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; integrated service network and community integrated service networks regulated under chapter 62N; fraternal benefit societies regulated under chapter 64B; the private employers insurance program established in section 43A.317, effective July 1, 1993; and joint self-insurance plans regulated under chapter 62H. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization, integrated service network, or community integrated service network shall be considered to be accident and health insurance premiums.

Sec. 10. Minnesota Statutes 1992, section 62E.10, subdivision 1, is amended to read:

Subdivision 1. [CREATION; TAX EXEMPTION.] There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers; self-insurers; fraternals; joint self-insurance plans regulated under chapter 62H; the private employers insurance program established in section 43A.317, effective July 1, 1993; ~~and~~ health maintenance organizations; integrated service networks; and community integrated service networks licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

Sec. 11. Minnesota Statutes 1992, section 62E.10, subdivision 2, is amended to read:

Subd. 2. [BOARD OF DIRECTORS; ORGANIZATION.] The board of directors of the association shall be made up of nine members as follows: five insurer directors selected by participating members, subject to approval by the commissioner; four public directors selected by the commissioner, at least two of whom must be plan enrollees. Public members may include licensed insurance agents. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, ~~or~~ health maintenance contract payment, integrated service network, or community integrated service network payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Insurer directors may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Sec. 12. Minnesota Statutes 1992, section 62E.10, subdivision 3, is amended to read:

Subd. 3. [MANDATORY MEMBERSHIP.] All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, ~~or~~ health maintenance organization, integrated service network, or community integrated service network business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 14.001 to 14.69.

Sec. 13. Minnesota Statutes 1993 Supplement, section 62J.03, subdivision 6, is amended to read:

Subd. 6. [GROUP PURCHASER.] "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, integrated service networks; community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Sec. 14. Minnesota Statutes 1992, section 62J.03, is amended by adding a subdivision to read:

Subd. 10. [HEALTH PLAN COMPANY.] "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4.

Sec. 15. Minnesota Statutes 1993 Supplement, section 62J.04, subdivision 1, is amended to read:

Subdivision 1. [LIMITS ON THE RATE OF GROWTH.] (a) The commissioner of health shall set annual limits on the rate of growth of public and private spending on health care services for Minnesota residents, as provided in paragraph (b). The limits on growth must be set at levels the commissioner determines to be realistic and achievable but that will reduce the rate of growth in health care spending by at least ten percent per year for the next five years. The commissioner shall set limits on growth based on available data on spending and growth trends, including data from group purchasers, national data on public and private sector health care spending and cost trends, and trend information from other states.

(b) The commissioner shall set the following annual limits on the rate of growth of public and private spending on health care services for Minnesota residents:

(1) for calendar year 1994, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1993 plus 6.5 percentage points;

(2) for calendar year 1995, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1994 plus 5.3 percentage points;

(3) for calendar year 1996, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1995 plus 4.3 percentage points;

(4) for calendar year 1997, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1996 plus 3.4 percentage points; and

(5) for calendar year 1998, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1997 plus 2.6 percentage points.

~~If the health care financing administration forecast for the total growth in national health expenditures for a calendar year is lower than the rate of growth for the calendar year as specified in clauses (1) to (5), the commissioner shall adopt this forecast as the growth limit for that calendar year.~~ The commissioner shall adjust the growth limit set for calendar year 1995 to recover savings in health care spending required for the period July 1, 1993 to December 31, 1993. The commissioner shall publish:

(1) the projected limits in the State Register by April 15 of the year immediately preceding the year in which the limit will be effective except for the year 1993, in which the limit shall be published by July 1, 1993;

(2) the quarterly change in the regional consumer price index for urban consumers; and

(3) the health care financing administration forecast for total growth in the national health care expenditures. In setting an annual limit, the commissioner is exempt from the rulemaking requirements of chapter 14. The commissioner's decision on an annual limit is not appealable.

Sec. 16. Minnesota Statutes 1993 Supplement, section 62J.04, subdivision 1a, is amended to read:

Subd. 1a. [ADJUSTED GROWTH LIMITS AND ENFORCEMENT.] (a) The commissioner shall publish the final adjusted growth limit in the State Register by January ~~15~~ 31 of the year that the expenditure limit is to be in effect. The adjusted limit must reflect the actual regional consumer price index for urban consumers for the previous calendar year, and may deviate from the previously published projected growth limits to reflect differences between the actual regional consumer price index for urban consumers and the projected Consumer Price Index for urban consumers. The commissioner shall report to the legislature by ~~January~~ February 15 of each year on differences between the projected increase in health care expenditures, ~~the implementation of growth limits, and the reduction in the trend in the growth based on the limits imposed~~ the actual expenditures based on data collected, and the impact and validity of growth limits within the overall health care reform strategy.

(b) The commissioner shall enforce limits on growth in spending and revenues for integrated service networks and for the regulated all-payer system. If the commissioner determines that artificial inflation or padding of costs or prices has occurred in anticipation of the implementation of growth limits, the commissioner may adjust the base year spending totals or growth limits or take other action to reverse the effect of the artificial inflation or padding.

(c) The commissioner shall impose and enforce overall limits on growth in revenues and spending for integrated service networks, with adjustments for changes in enrollment, benefits, severity, and risks. If an integrated service network exceeds a spending limit, the commissioner may reduce future limits on growth in aggregate premium revenues for that integrated service network by up to the amount overspent. If the integrated service network system exceeds a systemwide spending limit, the commissioner may reduce future limits on growth in premium revenues for the integrated service network system by up to the amount overspent.

(d) The commissioner shall set prices, utilization controls, and other requirements for the regulated all-payer system to ensure that the overall costs of this system, after adjusting for changes in population, severity, and risk, do not exceed the growth limits. If spending growth limits for a calendar year are exceeded, the commissioner may reduce reimbursement rates or otherwise recoup overspending for all or part of the next calendar year, to recover in savings up to the amount of money overspent. To the extent possible, the commissioner may reduce reimbursement rates or otherwise recoup overspending from individual providers who exceed the spending growth limits.

(e) The commissioner, in consultation with the Minnesota health care commission, shall research and make recommendations to the legislature regarding the implementation of growth limits for integrated service networks and the regulated all-payer option. The commissioner must consider both spending and revenue approaches and will report on the implementation of the interim limits as defined in sections 62P.04 and 62P.05. The commissioner must examine and make recommendations on the use of annual update factors based on volume performance standards as a mechanism for achieving controls on spending in the all-payer option. The commissioner must make recommendations regarding the enforcement mechanism and must consider mechanisms to adjust future growth limits as well as mechanisms to establish financial penalties for noncompliance. The commissioner must also address the feasibility of system-wide limits imposed on all integrated service networks.

Sec. 17. Minnesota Statutes 1993 Supplement, section 62J.09, subdivision 2, is amended to read:

Subd. 2. [MEMBERSHIP.] (a) [NUMBER OF MEMBERS.] Each regional coordinating board consists of 17 members as provided in this subdivision. A member may designate a representative to act as a member of the board in the member's absence. The governor shall appoint the chair of each regional board from among its members. The appointing authorities under each paragraph for which there is to be chosen more than one member shall consult prior to appointments being made to ensure that, to the extent possible, the board includes a representative from each county within the region.

(b) [PROVIDER REPRESENTATIVES.] Each regional board must include four members representing health care providers who practice in the region. One member is appointed by the Minnesota Medical Association. One member is appointed by the Minnesota Hospital Association. One member is appointed by the Minnesota Nurses' Association. The remaining member is appointed by the governor to represent providers other than physicians, hospitals, and nurses.

(c) [HEALTH PLAN COMPANY REPRESENTATIVES.] Each regional board includes four members representing health plan companies who provide coverage for residents of the region, including one member representing health insurers who is elected by a vote of all health insurers providing coverage in the region, one member elected by a vote of all health maintenance organizations providing coverage in the region, and one member appointed by Blue Cross and Blue Shield of Minnesota. The fourth member is appointed by the governor.

(d) [EMPLOYER REPRESENTATIVES.] Regional boards include three members representing employers in the region. Employer representatives are ~~elected by a vote of the employers who are~~ appointed by the Minnesota chamber of commerce from nominations provided by members of chambers of commerce in the region. At least one member must represent self-insured employers.

(e) [EMPLOYEE UNIONS.] Regional boards include one member appointed by the AFL-CIO Minnesota who is a union member residing or working in the region or who is a representative of a union that is active in the region.

(f) [PUBLIC MEMBERS.] Regional boards include three consumer members. One consumer member is elected by the community health boards in the region, with each community health board having one vote. One consumer member is elected by the state legislators with districts in the region. One consumer member is appointed by the governor.

(g) [COUNTY COMMISSIONER.] Regional boards include one member who is a county board member. The county board member is elected by a vote of all of the county board members in the region, with each county board having one vote.

(h) [STATE AGENCY.] Regional boards include one state agency commissioner appointed by the governor to represent state health coverage programs.

Sec. 18. Minnesota Statutes 1993 Supplement, section 62J.2916, subdivision 2, is amended to read:

Subd. 2. [PROCEDURES AVAILABLE.] (a) [DECISION ON THE WRITTEN RECORD.] The commissioner may issue a decision based on the application, the comments, and the applicant's responses to the comments, to the extent each is relevant. In making the decision, the commissioner may consult with staff of the department of health and may rely on department of health data.

(b) [LIMITED HEARING.] (1) The commissioner may order a limited hearing. A copy of the order must be mailed to the applicant and to all persons who have submitted comments or requested to be kept informed of the proceedings involving the application. The order must state the date, time, and location of the limited hearing and must identify specific issues to be addressed at the limited hearing. The issues may include the feasibility and desirability of one or more alternatives to the proposed arrangement. The order must require the applicant to submit written evidence, in the form of affidavits and supporting documents, addressing the issues identified, within 20 days after the date of the order. The order shall also state that any person may arrange to receive a copy of the written evidence from the commissioner, at the person's expense, and may provide written comments on the evidence within 40 days after the date of the order. A person providing written comments shall provide a copy of the comments to the applicant.

(2) The limited hearing must be held before the commissioner or department of health staff member or members designated by the commissioner. The commissioner or the commissioner's designee or designees shall question the applicant about the evidence submitted by the applicant. The questions may address relevant issues identified in the comments submitted in response to the written evidence or identified by department of health staff or brought to light by department of health data. At the conclusion of the applicant's responses to the questions, any person who submitted comments about the applicant's written evidence may make a statement addressing the applicant's responses to the questions. The commissioner or the commissioner's designee or designees may ask questions of any person making a statement. At the conclusion of all statements, the applicant may make a closing statement.

(3) The commissioner's decision after a limited hearing must be based upon the application, the comments, the applicant's response to the comments, the applicant's written evidence, the comments in response to the written evidence, and the information presented at the limited hearing, to the extent each is relevant. In making the decision, the commissioner may consult with staff of the department of health and may rely on department of health data.

(c) [CONTESTED CASE HEARING.] The commissioner may order a contested case hearing. A contested case hearing shall be tried before an administrative law judge who shall issue a written recommendation to the commissioner and shall follow the procedures in sections 14.57 to 14.62. All factual issues relevant to a decision must be presented in the contested case. The attorney general may appear as a party. Additional parties may appear to the extent permitted under sections 14.57 to 14.62. The record in the contested case includes the application, the comments, the applicant's response to the comments, and any other evidence that is part of the record under sections 14.57 to 14.62.

Sec. 19. Minnesota Statutes 1993 Supplement, section 62J.32, subdivision 4, is amended to read:

Subd. 4. [PRACTICE PARAMETER ADVISORY COMMITTEE.] (a) The commissioner shall convene a 15-member practice parameter advisory committee comprised of eight health care professionals, and representatives of the research community and the medical technology industry. One representative of the research community must be an individual with expertise in pharmacology or pharmaceutical economics who is familiar with the results of the pharmaceutical care research project at the University of Minnesota and the potential cost savings that can be achieved through use of a comprehensive pharmaceutical care model. The committee shall present recommendations on the adoption of practice parameters to the commissioner and the Minnesota health care commission and provide technical assistance as needed to the commissioner and the commission. The advisory committee is governed by section 15.059, except that its existence does not terminate and members do not receive per diem compensation.

(b) The commissioner, upon the advice and recommendation of the practice parameter advisory committee, may convene expert review panels to assess practice parameters and outcome research associated with practice parameters.

Sec. 20. Minnesota Statutes 1993 Supplement, section 62J.35, subdivision 2, is amended to read:

Subd. 2. [FAILURE TO PROVIDE DATA.] The intentional failure to provide the data requested under this chapter is grounds for revocation of a license or other disciplinary or regulatory action against a regulated provider or group purchaser. The commissioner may assess a fine against a provider or group purchaser who refuses to provide data required by the commissioner. If a provider or group purchaser refuses to provide the data required, the commissioner may obtain a court order requiring the provider or group purchaser to produce documents and allowing the commissioner to inspect the records of the provider or group purchaser for purposes of obtaining the data required.

Sec. 21. Minnesota Statutes 1993 Supplement, section 62J.35, subdivision 3, is amended to read:

Subd. 3. [DATA PRIVACY.] All data received under this section or under section 62J.04, 62J.37, 62J.38, 62J.41, or 62J.42 is private or nonpublic, ~~as applicable~~ except to the extent that it is given a different classification elsewhere in this chapter. The commissioner shall establish procedures and safeguards to ensure that data released by the commissioner is in a form that does not identify specific patients, providers, employers, purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter.

Sec. 22. Minnesota Statutes 1993 Supplement, section 62J.38, is amended to read:

62J.38 [DATA FROM GROUP PURCHASERS.]

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for calendar years 1990, 1991, and 1992, and for calendar year 1993 and successive calendar years. Group purchasers shall submit data for the 1993 calendar year by ~~February 15~~ 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, including raw data from claims, must be provided separately for the following categories: physician services, dental

services, other professional services, inpatient hospital services, outpatient hospital services, emergency and out-of-area care, pharmacy services and prescription drugs, mental health services, chemical dependency services, other expenditures, subscriber liability, and administrative costs.

(c) State agencies and all other group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

Sec. 23. Minnesota Statutes 1993 Supplement, section 62J.41, subdivision 2, is amended to read:

Subd. 2. [ANNUAL MONITORING AND ESTIMATES.] The commissioner shall require health care providers to submit the required data for the period July 1, 1993 to December 31, 1993, by ~~February 15~~ April 1, 1994. Health care providers shall submit data for the 1994 calendar year by ~~February 15~~ April 1, 1995, and each ~~February 15~~ April 1 thereafter shall submit data for the preceding calendar year. The commissioner of revenue may collect health care service revenue data from health care providers, if the commissioner of revenue and the commissioner agree that this is the most efficient method of collecting the data. The commissioner of revenue shall provide any data collected to the commissioner of health.

Sec. 24. Minnesota Statutes 1993 Supplement, section 62J.45, subdivision 11, is amended to read:

Subd. 11. [USE OF DATA.] (a) The board of the data institute, with the advice of the data collection advisory committee and the practice parameter advisory committee through the commissioner, is responsible for establishing the methodology for the collection of the data and is responsible for providing direction on what data would be useful to the plans, providers, consumers, and purchasers.

(b) The health care analysis unit is responsible for the analysis of the data and the development and dissemination of reports.

(c) The commissioner, in consultation with the board, shall determine when and under what conditions data disclosure to group purchasers, health care providers, consumers, researchers, and other appropriate parties may occur to meet the state's goals. The commissioner may require users of data to contribute toward the cost of data collection through the payment of fees. The commissioner shall require users of data to maintain the data according to the data privacy provisions applicable to the data.

(d) The commissioner and the board shall not allow a group purchaser or health care provider to use or have access to data collected by the data institute, unless the group purchaser or health care provider fully cooperates with the data collection efforts of the data institute by submitting all data requested in the form and manner specified by the board. The commissioner and the board shall prohibit group purchasers and health care providers from transferring, providing, or sharing data obtained from the data institute with a group purchaser or health care provider that does not fully cooperate with the data collection efforts of the data institute.

Sec. 25. [62J.65] [EXEMPTION.]

Patient revenues derived from non-Minnesota patients are exempt from the regulated all-payer system and Medicare balance billing prohibition under section 62J.25.

Sec. 26. Minnesota Statutes 1993 Supplement, section 62N.01, is amended to read:

62N.01 [CITATION AND PURPOSE.]

Subdivision 1. [CITATION.] ~~Sections 62N.01 to 62N.24~~ This chapter may be cited as the "Minnesota integrated service network act."

Subd. 2. [PURPOSE.] ~~Sections 62N.01 to 62N.24 allow~~ This chapter allows the creation of integrated service networks that will be responsible for arranging for or delivering a full array of health care services, from routine primary and preventive care through acute inpatient hospital care, to a defined population for a fixed price from a purchaser.

Each integrated service network is accountable to keep its total revenues within the limit of growth set by the commissioner of health under section 62N.05, subdivision 2. Integrated service networks can be formed by health care providers, health maintenance organizations, insurance companies, employers, or other organizations. Competition between integrated service networks on the quality and price of health care services is encouraged.

Sec. 27. Minnesota Statutes 1993 Supplement, section 62N.02, subdivision 1, is amended to read:

Subdivision 1. [APPLICATION.] The definitions in this section apply to ~~sections 62J.04, subdivision 8, and 62N.01 to 62N.24~~ this chapter.

Sec. 28. Minnesota Statutes 1993 Supplement, section 62N.065, subdivision 1, is amended to read:

Subdivision 1. [UNREASONABLE EXPENSES.] No integrated service network shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of ~~sections 62N.01 to 62N.24~~ this chapter; in order to safeguard the underlying nonprofit status of integrated service networks; and to ensure that payment of integrated service network money to any person or organization results in a corresponding benefit to the integrated service network and its enrollees; when determining whether an integrated service network has incurred an unreasonable expense in relation to payments made to a person or organization, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the integrated service network have acted with good faith and in the best interests of the integrated service network in entering into, and performing under, a contract under which the integrated service network has incurred an expense. In addition to the compliance powers under subdivision 3, the commissioner has standing to sue, on behalf of an integrated service network, officers or trustees of the integrated service network who have breached their fiduciary duty in entering into and performing such contracts.

Sec. 29. Minnesota Statutes 1993 Supplement, section 62N.10, subdivision 1, is amended to read:

Subdivision 1. [REQUIREMENTS.] All integrated service networks must be licensed by the commissioner. Licensure requirements are:

(1) the ability to be responsible for the full continuum of required health care and related costs for the defined population that the integrated service network will serve;

(2) the ability to satisfy standards for quality of care;

(3) financial solvency; ~~and~~

(4) the ability to develop and complete the action plans required by law; and

(5) the ability to fully comply with this chapter and all other applicable law.

The commissioner may adopt rules to specify licensure requirements for integrated service networks in greater detail, consistent with this subdivision.

Sec. 30. Minnesota Statutes 1993 Supplement, section 62N.10, subdivision 2, is amended to read:

Subd. 2. [FEES.] Licensees shall pay an initial fee and a renewal fee each following year to be established by the commissioner of health. The fee must be imposed at a rate sufficient to cover the cost of regulation.

Sec. 31. Minnesota Statutes 1993 Supplement, section 62N.22, is amended to read:

62N.22 [DISCLOSURE OF COMMISSIONS.]

Before selling~~, or offering to sell,~~ any coverage or enrollment in a community integrated service network or an 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.

Sec. 32. Minnesota Statutes 1993 Supplement, section 62N.23, is amended to read:

62N.23 [TECHNICAL ASSISTANCE~~; LOANS~~.]

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

The technical assistance program shall offer seminars on the establishment and operation of community integrated service networks or 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 or an integrated service network. The guide must provide basic instructions for parties wishing to establish a community integrated service network or an 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 or an integrated service network.

(b) The commissioner, in consultation with the commission, shall provide recommendations for the creation of a loan program that would provide loans or grants to entities forming community integrated service networks or integrated service networks or to community networks or networks less than one year old. The commissioner shall propose criteria for the loan program.

Sec. 33. Minnesota Statutes 1992, section 144.1485, is amended to read:

144.1485 [DATA BASE ON HEALTH PERSONNEL.]

(a) The commissioner of health shall develop and maintain a data base on health services personnel. The commissioner shall use this information to assist local communities and units of state government to develop plans for the recruitment and retention of health personnel. Information collected in the data base must include, but is not limited to, data on levels of educational preparation, specialty, and place of employment. The commissioner may collect information through the registration and licensure systems of the state health licensing boards.

(b) Health professionals who report their practice/place of employment address to the commissioner of health under section 144.052 may request in writing that their practice/place of employment address be classified as private data on individuals, as defined in section 13.02, subdivision 12. The commissioner shall grant the classification upon receipt of a signed statement by the health professional that the classification is required for the safety of the health professional, if the statement also provides a valid, existing address where the health professional consents to receive service of process. The commissioner shall use the mailing address in place of the practice/place of employment address in all documents available to the general public. The practice/place of employment address and any information provided in the classification request, other than the mailing address, are private data on individuals and may be provided to other state agencies. The practice/place of employment address may be used to develop summary reports that show in aggregate the distribution of health care providers in Minnesota.

Sec. 34. Minnesota Statutes 1993 Supplement, section 144.1486, is amended to read:

144.1486 [RURAL COMMUNITY HEALTH CENTERS.]

~~The commissioner of health shall develop and implement a program to establish community health centers in rural areas of Minnesota that are underserved by health care providers. The program shall provide rural communities and community organizations with technical assistance, capital grants for start-up costs, and short term assistance with operating costs. The technical assistance component of the program must provide assistance in review of practice management, market analysis, practice feasibility analysis, medical records system analysis, and scheduling and patient flow analysis. The program must: (1) include a local match requirement for state dollars received; (2) require local communities, through instrumentalities of the state of Minnesota or nonprofit boards comprised of local residents, to operate and own their community's health care program; (3) encourage the use of midlevel practitioners; and (4) incorporate a quality assurance strategy that provides regular evaluation of clinical performance and allows peer review comparisons for rural practices. The commissioner shall report to the legislature on implementation of the program by February 15, 1994.~~

Subdivision 1. [COMMUNITY HEALTH CENTER.] "Community health center" means a community owned and operated primary and preventive health care practice that meets the unique, essential health care needs of a specified population.

Subd. 2. [PROGRAM GOALS.] The Minnesota community health center program shall increase health care access for residents of rural Minnesota by creating new community health centers in areas where they are needed and maintaining essential rural health care services. The program is not intended to duplicate the work of current health care providers.

Subd. 3. [GRANTS.] (a) The commissioner shall provide grants to communities for planning and establishing community health centers through the Minnesota community health center program. Grant recipients shall develop and implement a strategy that allows them to become self-sufficient and qualify for other supplemental funding and enhanced reimbursement. The commissioner shall coordinate the grant program with the federal rural health clinic, federally qualified health center, and migrant and community health center programs to encourage federal certification. The commissioner may award planning, project, and initial operating expense grants, as provided in paragraphs (b) to (d).

(b) Planning grants may be awarded to communities to plan and develop state funded community health centers, federally qualified health centers, or migrant and community health centers.

(c) Project grants may be awarded to communities for community health center start-up or expansion, and the conversion of existing practices to community health centers. Start-up grants may be used for facilities, capital equipment, moving expenses, initial staffing, and setup. Communities must provide reasonable assurance of their ability to obtain health care providers and effectively utilize existing health care provider resources. Funded community health center projects must become operational before funding expires. Communities may obtain funding for conversion of existing health care practices to community health centers. Communities with existing community health centers may apply for grants to add sites in underserved areas. Governing boards must include representatives of new service areas.

(d) Centers may apply for grants for up to two years to subsidize initial operating expenses. Applicants for initial operating expense grants must demonstrate that expenses exceed revenues by a minimum of ten percent or demonstrate other extreme need that cannot be met using organizational reserves.

Subd. 4. [ELIGIBILITY REQUIREMENTS.] In order to qualify for community health center program funding, a project must:

(1) be located in a rural shortage area that is a medically underserved, federal health professional shortage, or governor designated shortage area. "Rural" means an area of the state outside the ten-county Twin Cities metropolitan area and outside of the Duluth, St. Cloud, East Grand Forks, Moorhead, Rochester, and LaCrosse census defined urbanized areas;

(2) represent or propose the formation of a nonprofit corporation with local resident governance, or be a governmental entity. Applicants in the process of forming a nonprofit corporation may have a nonprofit coapplicant serve as financial agent through the remainder of the formation period. With the exception of governmental entities, all applicants must submit application for nonprofit incorporation and 501(c)(3) tax-exempt status within six months of accepting community health center grant funds;

(3) result in a locally owned and operated community health center that provides primary and preventive health care services, and incorporates quality assurance, regular reviews of clinical performance, and peer review;

(4) seek to employ midlevel professionals, where appropriate;

(5) demonstrate community and popular support and provide a 20 percent local match of state funding; and

(6) propose to serve an area that is not currently served by a federally certified medical organization.

Subd. 5. [REVIEW PROCESS, RATING CRITERIA AND POINT ALLOCATION.] (a) The commissioner shall establish grant application guidelines and procedures that allow the commissioner to assess relative need and the applicant's ability to plan and manage a health care project. Program documentation must communicate program objectives, philosophy, expectations, and other conditions of funding to potential applicants.

The commissioner shall establish an impartial review process to objectively evaluate grant applications. Proposals must be categorized, ranked, and funded using a 100-point rating scale. Fifty-two points shall be assigned to relative need and 48 points to project merit.

(b) The scoring of relative need must be based on proposed service area factors, including but not limited to:

(1) population below 200 percent of poverty;

(2) geographic barriers based on average travel time and distance to the next nearest source of primary care that is accessible to Medicaid and Medicare recipients and uninsured low-income individuals;

(3) a shortage of primary care health professionals, based on the ratio of the population in the service area to the number of full-time equivalent primary care physicians in the service area; and

(4) other community health issues including a high unemployment rate, high percentage of uninsured population, high growth rate of minority and special populations, high teenage pregnancy rate, high morbidity rates due to specific diseases, late entry into prenatal care, high percentage geriatric population, high infant mortality rate, high percentage of low birth weight, cultural and language barriers, high percentage minority population, excessive average travel time and distance to next nearest source of subsidized primary care.

(c) Project merit shall be determined based on expected benefit from the project, organizational capability to develop and manage the project, and probability of success, including but not limited to the following factors:

(1) proposed scope of health services;

(2) clinical management plan;

(3) governance;

(4) financial and administrative management; and

(5) community support, integration, collaboration, resources, and innovation.

The commissioner may elect not to award any of the community health center grants if applications fail to meet criteria or lack merit. The commissioner's decision on an application is final.

Subd. 6. [ELIGIBLE EXPENDITURES.] Grant recipients may use grant funds for the following types of expenditures:

(1) salaries and benefits for employees, to the extent they are involved in project planning and implementation;

(2) purchase, repair, and maintenance of necessary medical and dental equipment and furnishings;

(3) purchase of office, medical, and dental supplies;

(4) in-state travel to obtain training or improve coordination;

(5) initial operating expenses of community health centers;

(6) programs or plans to improve the coordination, effectiveness, or efficiency of the primary health care delivery system;

(7) facilities;

(8) necessary consultant fees; and

(9) reimbursement to rural-based primary care practitioners for equipment, supplies, and furnishings that are transferred to community health centers. Up to 65 percent of the grant funds may be used to reimburse owners of rural practices for the reasonable market value of usable facilities, equipment, furnishings, supplies, and other resources that the community health center chooses to purchase.

Grant funds shall not be used to reimburse applicants for preexisting debt amortization, entertainment, and lobbying expenses.

Subd. 7. [SPECIAL CONSIDERATION.] The commissioner, through the office of rural health, shall make special efforts to identify areas of the state where need is the greatest, notify representatives of those areas about grant opportunities, and encourage them to submit applications.

Subd. 8. [REQUIREMENTS.] The commissioner shall develop a list of requirements for community health centers and a tracking and reporting system to assess benefits realized from the program to ensure that projects are on schedule and effectively utilizing state funds.

The commissioner shall require community health centers established through the grant program to:

(1) abide by all federal and state laws, rules, regulations, and executive orders;

(2) establish policies, procedures, and services equivalent to those required for federally certified rural health clinics or federally qualified health centers. Written policies are required for description of services, medical management, drugs, biologicals and review of policies;

(3) become a Minnesota nonprofit corporation and apply for 501(c)(3) tax-exempt status within six months of accepting state funding. Local governmental or tribal entities are exempt from this requirement;

(4) establish a governing board composed of nine to 25 members who are residents of the area served and representative of the social, economic, linguistic, ethnic, and racial target population. At least 35 percent of the board must represent consumers;

(5) establish corporate bylaws that reflect all functions and responsibilities of the board;

(6) develop an appropriate management and organizational structure with clear lines of authority and responsibility to the board;

(7) provide for adequate patient management and continuity of care on site and from referral sources;

(8) establish quality assurance and risk management programs, policies, and procedures;

(9) develop a strategic staffing plan to acquire an appropriate mix of primary care providers and clinical support staff;

(10) establish billing policies and procedures to maximize patient collections, except where federal regulations or contractual obligations prohibit the use of these measures;

(11) develop and implement policies and procedures, including a sliding scale fee schedule, that assure that no person will be denied services because of inability to pay;

(12) establish an accounting and internal control system in accordance with sound financial management principles;

(13) provide a local match equal to 20 percent of the grant amount;

(14) work cooperatively with the local community and other health care organizations, other grant recipients, and the office of rural health;

(15) obtain an independent annual audit and submit audit results to the office of rural health;

(16) maintain detailed records and, upon request, make these records available to the commissioner for examination; and

(17) pursue supplemental funding sources, when practical, for implementation and initial operating expenses.

Subd. 9. [PRECAUTIONS.] The commissioner may withhold, delay, or cancel grant funding if a grant recipient does not comply with program requirements and objectives.

Subd. 10. [TECHNICAL ASSISTANCE.] The commissioner may provide, contract for, or provide supplemental funding for technical assistance to community health centers in the areas of clinical operations, medical practice management, community development, and program management.

Sec. 35. [144.1492] [PHYSICIAN SUBSTITUTE DEMONSTRATION PROJECT.]

Subdivision 1. [ESTABLISHMENT.] The commissioner of health, through the office of rural health, shall establish and administer a physician substitute (locum tenens and emergency room coverage) demonstration project at up to four rural demonstration sites within the state. The commissioner shall coordinate the administration of the project with the University of Minnesota health system. The commissioner may contract with a nonprofit rural health policy organization to establish, administer, and evaluate the physician substitute program.

Subd. 2. [PROJECT ACTIVITIES.] The project must:

(1) encourage physicians to serve as substitute physicians for the demonstration sites;

(2) provide a central register of physicians interested in serving as physician substitutes at the demonstration sites;

(3) provide a referral service for requests from demonstration sites for physician substitutes; and

(4) provide physician substitute services, at rates that reflect the administrative savings resulting from centralized referral and credentialing.

Subd. 3. [UNIVERSITY OF MINNESOTA HEALTH SYSTEM.] The commissioner shall seek the assistance of the University of Minnesota health system in credentialing persons desiring to serve as physician substitutes. The University of Minnesota health system may employ physician substitutes serving in the demonstration project as temporary clinical faculty and may provide physician substitutes with additional opportunities for professional education and interaction.

Subd. 4. [DEMONSTRATION SITES.] The commissioner shall designate up to four rural communities as demonstration sites for the project. The commissioner shall choose sites based on a community's need for physician substitute services and the willingness of the community to work cooperatively with the commissioner and the University of Minnesota health system and participate in the demonstration project evaluation.

Subd. 5. [EVALUATION.] The commissioner shall evaluate the demonstration project and shall present an evaluation report to the legislature by January 15, 1995. The evaluation must identify any modifications necessary to improve the effectiveness of the project. The evaluation must also include a recommendation on whether the demonstration project should be extended to other areas of the state.

Sec. 36. [144.1493] [STATE RURAL HEALTH NETWORK REFORM INITIATIVE.]

Subdivision 1. [PURPOSE AND MATCHING FUNDS.] The commissioner of health shall apply for federal grant funding under the state rural health network reform initiative, a health care financing administration program to provide grant funds to states to encourage innovations in rural health financing and delivery systems. The commissioner may use state funds appropriated to the department of health for the provision of technical assistance for community integrated service network development as matching funds for the federal grant.

Subd. 2. [USE OF FEDERAL FUNDS.] If the department of health receives federal funding under the state rural health network reform initiative, the department shall use these funds to implement a program to provide technical assistance and grants to rural communities to establish health care networks and to develop and test a rural health network reform model.

Subd. 3. [ELIGIBLE APPLICANTS AND CRITERIA FOR AWARDING OF GRANTS TO RURAL COMMUNITIES.] (a) Funding which the department receives to award grants to rural communities to establish health care networks shall be awarded through a request for proposal process. Planning grant funds may be used for community facilitation and initial network development activities including incorporation as a nonprofit organization or cooperative, assessment of network models, and determination of the best fit for the community. Implementation grant funds can be used to enable incorporated nonprofit organizations and cooperatives to purchase technical services needed for further network development such as legal, actuarial, financial, marketing, and administrative services.

(b) In order to be eligible to apply for a planning or implementation grant under the federally funded health care network reform program, an organization must be located in a rural area of Minnesota excluding the seven-county Twin Cities metropolitan area and the census-defined urbanized areas of Duluth, Rochester, St. Cloud, and Moorhead. The proposed network organization must also meet or plan to meet the criteria for a community integrated service network.

(c) In determining which organizations will receive grants, the commissioner may consider the following factors:

(1) the applicant's description of their plans for health care network development, their need for technical assistance, and other technical assistance resources available to the applicant. The applicant must clearly describe the service area to be served by the network, how the grant funds will be used, what will be accomplished, and the expected results. The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations;

(2) the extent of community support for the applicant and the health care network. The applicant should demonstrate support from private and public health care providers in the service area, local community and government leaders, and the regional coordinating board for the area. Evidence of such support may include commitment of financial support, in-kind services or cash, for development of the network;

(3) the size and demographic characteristics of the population in the service area for the proposed network and the distance of the service area from the nearest metropolitan area; and

(4) the technical assistance resources available to the applicant from nonstate sources and the financial ability of the applicant to purchase technical assistance services with nonstate funds.

Sec. 37. Minnesota Statutes 1992, section 144.581, subdivision 2, is amended to read:

Subd. 2. [USE OF HOSPITAL FUNDS FOR CORPORATE PROJECTS.] In the event that the municipality, political subdivision, state agency, or other governmental entity provides direct financial subsidy to the hospital from tax revenue at the time an undertaking authorized under subdivision 1, clauses (a) to (g), is established or funded, the hospital may not contribute funds to the undertaking for more than three years and thereafter all funds must be repaid, with interest in no more than ten years.

Sec. 38. Minnesota Statutes 1992, section 145.64, subdivision 1, is amended to read:

Subdivision 1. [DATA AND INFORMATION.] All data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery. No person described in section 145.63 shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization. The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional arising out of the matter or matters which are the subject of consideration by the review organization. Information, documents or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness cannot be asked about the witness' testimony before a review organization or opinions formed by the witness as a result of its hearings.

The confidentiality protection and protection from discovery or introduction into evidence provided in this subdivision shall also apply to the governing body of the review organization and shall not be waived as a result of referral of a matter from the review organization to the governing body or consideration by the governing body of decisions, recommendations, or documentation of the review organization.

The governing body of a hospital, community integrated service network, or integrated service network, that is owned or operated by a governmental entity, may close a meeting to discuss decisions, recommendations, deliberations, or documentation of the review organization. A meeting may not be closed except by a majority vote of the governing body in a public meeting. The closed meeting must be tape recorded and the tape must be retained by the governing body for five years.

Sec. 39. Minnesota Statutes 1993 Supplement, section 256.9352, subdivision 3, is amended to read:

Subd. 3. [FINANCIAL MANAGEMENT.] (a) The commissioner shall manage spending for the ~~health right plan~~ MinnesotaCare program in a manner that maintains a minimum reserve equal to five percent of the expected cost of state premium subsidies. The commissioner must make a quarterly assessment of the expected expenditures for the covered services for the remainder of the current fiscal year and for the following two fiscal years. The estimated expenditure shall be compared to an estimate of the revenues that will be deposited in the health care access fund.

Based on this comparison, and after consulting with the chairs of the house ways and means committee and the senate finance committee, and the legislative commission on health care access, the commissioner shall make adjustments as necessary to ensure that expenditures remain within the limits of available revenues. The adjustments the commissioner may use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the ~~health right plan~~ MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the ~~health right plan~~ MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner may further limit enrollment or decrease premium subsidies.

The reserve referred to in this subdivision is appropriated to the commissioner but may only be used upon approval of the commissioner of finance, if estimated costs will exceed the forecasted amount of available revenues after all adjustments authorized under this subdivision have been made.

By February 1, ~~1994~~ 1995, the department of human services and the department of health shall develop a plan to adjust benefit levels, eligibility guidelines, or other steps necessary to ensure that expenditures for the MinnesotaCare program are contained within the two percent ~~provider tax~~ taxes imposed under section 295.52 and the ~~one percent HMO~~ gross premiums tax ~~for the 1996-1997 biennium~~ imposed under section 60A.15, subdivision 1, paragraph (e), for fiscal year 1997. ~~Notwithstanding any law to the contrary, no further enrollment in MinnesotaCare, and no additional hiring of staff for the departments shall take place after June 1, 1994, unless a plan to balance the MinnesotaCare budget for the 1996-1997 biennium has been passed by the 1994 legislature.~~

(b) Notwithstanding paragraph (a), the commissioner shall proceed with the enrollment of single adults and households without children who have gross family incomes that are equal to or less than 125 percent of the federal poverty guidelines, even if the expenditures do not remain within the limits of available revenues through fiscal year 1997, in order to allow the department of human services and the department of health to develop the plan required by paragraph (a).

(c) Notwithstanding any law to the contrary, no further enrollment in MinnesotaCare, and no additional hiring of staff for the department of human services and the department of health shall take place after September 30, 1995, unless a plan to balance the MinnesotaCare budget for the 1996-1997 biennium has been passed by the 1995 legislature.

Sec. 40. Minnesota Statutes 1993 Supplement, section 256.9354, subdivision 5, is amended to read:

Subd. 5. [ADDITION OF SINGLE ADULTS AND HOUSEHOLDS WITH NO CHILDREN.] (a) Beginning ~~July~~ October 1, 1994, "eligible persons" ~~means~~ shall include all ~~families and individuals~~ individuals and households with no children who have gross family incomes that are equal to or less than 125 percent of the federal poverty guidelines and who are not eligible for medical assistance under chapter 256B.

(b) Beginning October 1, 1995, "eligible persons" means all individuals and families who are not eligible for medical assistance under chapter 256B.

(c) ~~These persons~~ All eligible persons under paragraphs (a) and (b) are eligible for coverage through the MinnesotaCare ~~plan~~ program but must pay a premium as determined under sections 256.9357 and 256.9358. Individuals and families whose income is greater than the limits established under section 256.9358 may not enroll in the MinnesotaCare ~~plan~~ program.

Sec. 41. Minnesota Statutes 1992, section 256.9358, subdivision 4, is amended to read:

Subd. 4. [INELIGIBILITY.] ~~An individual or family~~ Families with children whose gross monthly income is above the amount specified in subdivision 3 ~~is~~ are not eligible for the plan. Beginning October 1, 1994, an individual or households with no children whose gross monthly income is greater than $767 for a single individual and $1,025 for a married couple without children are ineligible for the plan. Beginning October 1, 1995, an individual or families whose gross monthly income is above the amount specified in subdivision 3 are not eligible for the plan.

Sec. 42. Minnesota Statutes 1993 Supplement, section 151.21, subdivision 7, is amended to read:

Subd. 7. ~~This section does not apply to prescription drugs dispensed to persons covered by a health plan that covers prescription drugs under a managed care formulary or similar practices.~~ This section does not apply when a pharmacist is dispensing a prescribed drug to persons covered under a managed health care plan that maintains a mandatory or closed drug formulary.

Sec. 43. Minnesota Statutes 1993 Supplement, section 151.21, subdivision 8, is amended to read:

Subd. 8. ~~The following drugs are excluded from this section: coumadin, dilantin, lanoxin, premarin, theophylline, synthroid, tegretol, and phenobarbital.~~ The drug formulary committee established under section 256B.0625, subdivision 13, shall establish a list of drug products that are to be excluded from this section. This list shall be updated on an annual basis and shall be provided to the board for dissemination to pharmacists licensed in the state.

Sec. 44. Minnesota Statutes 1993 Supplement, section 256.9354, is amended by adding a subdivision to read:

Subd. 7. [GENERAL ASSISTANCE MEDICAL CARE.] A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same month, except that a MinnesotaCare enrollee may be eligible for retroactive general assistance medical care according to section 256D.03, subdivision 3, paragraph (b).

Sec. 45. Minnesota Statutes 1993 Supplement, section 256.9363, subdivision 6, is amended to read:

Subd. 6. [COPAYMENTS AND BENEFIT LIMITS.] Enrollees are responsible for all copayments in section 256.9353, subdivision 6, and shall pay copayments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit ~~to the managed care plan or its participating providers~~.

Sec. 46. Minnesota Statutes 1993 Supplement, section 256.9363, subdivision 7, is amended to read:

Subd. 7. [MANAGED CARE PLAN VENDOR REQUIREMENTS.] The following requirements apply to all counties or vendors who contract with the department of human services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256.9353 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee copayments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D; and

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services~~; and~~

~~(9) shall submit to the commissioner claims in the format specified by the commissioner of human services for all hospital services provided to enrollees for the purpose of determining whether enrollees meet medical assistance spend-down requirements and shall provide to the enrollee, upon the enrollee's request, information on the cost of services provided to the enrollee by the managed care plan for the purpose of establishing whether the enrollee has met medical assistance spend-down requirements.~~

Sec. 47. Minnesota Statutes 1993 Supplement, section 256.9363, subdivision 9, is amended to read:

Subd. 9. [RATE SETTING.] Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

Sec. 48. Minnesota Statutes 1993 Supplement, section 256.9657, subdivision 3, is amended to read:

Subd. 3. [HEALTH MAINTENANCE ORGANIZATION; INTEGRATED SERVICE NETWORK SURCHARGE.] (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each integrated service network and community integrated service network licensed by the commissioner under ~~sections 62N.01 to 62N.22~~ chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization, ~~or~~ integrated service network, or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization, integrated service network, or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wrap-around subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization, an integrated service network, or a community integrated service network and the health care financing administration of the federal Department of Health and Human Services, for services to a Medicare beneficiary; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization, integrated service network, or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization, integrated service network, or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

Sec. 49. Minnesota Statutes 1993 Supplement, section 295.50, subdivision 4, is amended to read:

Subd. 4. [HEALTH CARE PROVIDER.] (a) "Health care provider" means:

(1) a person furnishing any or all of the following goods or services directly to a patient or consumer: medical, surgical, optical, visual, dental, hearing, nursing services, drugs, medical supplies, medical appliances, laboratory, diagnostic or therapeutic services, or any goods and services not listed above that qualifies for reimbursement under the medical assistance program provided under chapter 256B;

(2) a staff model health ~~carrier~~ plan company; or

(3) a licensed ambulance service.

(b) Health care provider does not include hospitals, nursing homes licensed under chapter 144A, pharmacies, and surgical centers.

Sec. 50. Minnesota Statutes 1993 Supplement, section 295.50, subdivision 12b, is amended to read:

Subd. 12b. [STAFF MODEL HEALTH ~~CARRIER~~ PLAN COMPANY.] "Staff model health ~~carrier~~ plan company" means a health ~~carrier~~ plan company as defined in section ~~62L.02, subdivision 16~~ 62Q.01, subdivision 4, which employs one or more types of health care provider to deliver health care services to the health ~~carrier's~~ plan company's enrollees.

Sec. 51. [317A.022] [ELECTION BY CERTAIN CHAPTER 318 ASSOCIATIONS.]

Subdivision 1. [GENERAL.] An association described in section 318.02, subdivision 5, may elect to cease to be an association subject to and governed by chapter 318 and to become subject to and governed by this chapter in the same manner and to the extent provided in this chapter as though it were a nonprofit corporation by complying with this section.

Subd. 2. [AMENDED TITLE AND OTHER CONFORMING AMENDMENTS.] The declaration of trust, as defined in section 318.02, subdivision 1, of the association must be amended to identify it as the "articles of an association electing to be treated as a nonprofit corporation." All references in this chapter to "articles" or "articles of incorporation" include the declaration of trust of an electing association. If the declaration of trust includes a provision prohibited by this chapter for inclusion in articles of incorporation, omits a provision required by this chapter to be included in articles of incorporation, or is inconsistent with this chapter, the electing association shall amend its declaration of trust to conform to the requirements of this chapter. The appropriate provisions of the association's declaration of trust or bylaws or chapter 318 control the manner of adoption of the amendments required by this subdivision.

Subd. 3. [METHOD OF ELECTION.] An election by an association under subdivision 2 must be made by resolution approved by the affirmative vote of the trustees of the association and by the affirmative vote of the members or other persons with voting rights in the association. The affirmative vote of both the trustees of the association and of the members or other persons with voting rights, if any, in the association must be of the same proportion that is required for an amendment of the declaration of trust of the association before the election, in each case upon proper notice that a purpose of the meeting is to consider an election by the association to cease to be an association subject to and governed by chapter 318 and to become and be a nonprofit corporation subject to and governed by this chapter. The resolution and the articles of the amendment of the declaration of trust must be filed with the secretary of state and are effective upon filing, or a later date as may be set forth in the filed resolution. Upon the effective date, without any other action or filing by or on behalf of the association, the association automatically is subject to this chapter in the same manner and to the same extent as though it had been formed as a nonprofit corporation pursuant to this chapter. Upon the effective date of the election, the association is not considered to be a new entity, but is considered to be a continuation of the same entity.

Subd. 4. [EFFECTS OF ELECTION.] Upon the effective date of an association's election under subdivision 3, and consistent with the continuation of the association under this chapter:

(1) the organization has the rights, privileges, immunities, powers, and is subject to the duties and liabilities, of a corporation formed under this chapter;

(2) all real or personal property, debts, including debts arising from a subscription for membership and interests belonging to the association, continue to be the real and personal property, and debts of the organization without further action;

(3) an interest in real estate possessed by the association does not revert to the grantor, or otherwise, nor is it in any way impaired by reason of the election, and the personal property of the association does not revert by reason of the election;

(4) except where the will or other instrument provides otherwise, a devise, bequest, gift, or grant contained in a will or other instrument, in a trust or otherwise, made before or after the election has become effective, to or for the association, inures to the organization;

(5) the debts, liabilities, and obligations of the association continue to be the debts, liabilities, and obligations of the organization, just as if the debts, liabilities, and obligations had been incurred or contracted by the organization after the election;

(6) existing claims or a pending action or proceeding by or against the association may be prosecuted to judgment as though the election had not been affected;

(7) the liabilities of the trustees, members, officers, directors, or similar groups or persons, however denominated, of the association, are not affected by the election;

(8) the rights of creditors or liens upon the property of the association are not impaired by the election;

(9) an electing association may merge with one or more nonprofit corporations in accordance with the applicable provisions of this chapter, and either the association or a nonprofit corporation may be the surviving entity in the merger; and

(10) the provisions of the bylaws of the association that are consistent with this chapter remain or become effective and provisions of the bylaws that are inconsistent with this chapter are not effective.

Sec. 52. Minnesota Statutes 1992, section 318.02, is amended by adding a subdivision to read:

Subd. 5. [ELECTION TO BE GOVERNED BY CHAPTER 317A.] An association may cease to be subject to or governed by this chapter by filing an election in the manner described in section 317A.022, to be subject to and governed by chapter 317A in the same manner and to the same extent provided in chapter 317A as though it were a nonprofit corporation if:

(1) it is not formed for a purpose involving pecuniary gain to its members, other than to members that are nonprofit organizations or subdivisions, units, or agencies of the United States or a state or local government; and

(2) it does not pay dividends or other pecuniary remuneration, directly or indirectly, to its members, other than to members that are nonprofit organizations or subdivisions, units, or agencies of the United States or a state or local government.

Sec. 53. [REVISOR INSTRUCTION.]

The revisor of statutes shall change the term "health right" to "MinnesotaCare," "health right plan" to "MinnesotaCare program," and "MinnesotaCare plan" to "MinnesotaCare program," wherever these terms are used in Minnesota Statutes or Minnesota Rules.

Sec. 54. [REPEALER.]

Minnesota Statutes 1992, section 256.362, subdivision 5; Minnesota Statutes 1993 Supplement, sections 62J.04, subdivision 8; 62N.07; 62N.075; 62N.08; 62N.085; and 62N.16, are repealed.

Sec. 55. [EFFECTIVE DATE.]

Sections 2 to 4, 6 to 18, 21 to 33, 36, 38 to 41, and 48 to 52 are effective the day following final enactment. Sections 1, 19, 20, 34, 35, 37, 42 to 47, and 53 are effective July 1, 1994. Section 5 is effective January 1, 1995.

ARTICLE 9

ADMINISTRATIVE SIMPLIFICATION

Section 1. [62J.50] [CITATION AND PURPOSE.]

Subdivision 1. [CITATION.] Sections 62J.50 to 62J.61 may be cited as the Minnesota health care administrative simplification act of 1994.

Subd. 2. [PURPOSE.] The legislature finds that significant savings throughout the health care industry can be accomplished by implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange. The legislature finds that initial steps have been taken at the national level by the federal health care financing administration in its implementation of nationally accepted electronic transaction sets for its medicare program. The legislature further recognizes the work done by the workgroup for electronic data interchange and the American national standards institute and its accredited

standards committee X12, at the national level, and the Minnesota administrative uniformity committee, a statewide, voluntary, public-private group representing payers, hospitals, state programs, physicians, and other health care providers in their work toward administrative simplification in the health care industry.

Sec. 2. [62J.51] [DEFINITIONS.]

Subdivision 1. [SCOPE.] For purposes of sections 62J.50 to 62J.61, the following definitions apply.

Subd. 2. [ANSI.] "ANSI" means the American national standards institute.

Subd. 3. [ASCX12] "ASC X12" means the American national standards institute committee X12.

Subd. 4. [CATEGORY I INDUSTRY PARTICIPANTS.] "Category I industry participants" means the following group purchasers, providers, and other health care organizations doing business in Minnesota including public and private payers: hospitals; self-insured plans and employers with more than 100 employees; clinic laboratories; durable medical equipment suppliers with a volume of at least 50,000 claims or encounters per year; and group practices with 20 or more physicians.

Subd. 5. [CATEGORY II INDUSTRY PARTICIPANTS.] "Category II industry participants" means all group purchasers and providers doing business in Minnesota not classified as category I industry participants.

Subd. 6. [CLAIM PAYMENT/ADVICE TRANSACTION SET (ANSI ASC X12 835).] "Claim payment/advice transaction set (ANSI ASC X12 835)" means the electronic transaction format developed and approved for implementation in October 1991, and used for electronic remittance advice and electronic funds transfer.

Subd. 7. [CLAIM SUBMISSION TRANSACTION SET (ANSI ASC X12 837).] "Claim submission transaction set (ANSI ASC X12 837)" means the electronic transaction format developed and approved for implementation in October 1992, and used to submit all health care claims information.

Subd. 8. [EDI.] "EDI" or "electronic data interchange" means the computer application to computer application exchange of information using nationally accepted standard formats.

Subd. 9. [ELIGIBILITY TRANSACTION SET (ANSI ASC X12 270/271).] "Eligibility transaction set (ANSI ASC X12 270/271)" means the transaction format developed and approved for implementation in February 1993, and used by providers to request and receive coverage information on the member or insured.

Subd. 10. [ENROLLMENT TRANSACTION SET (ANSI ASC X12 834).] "Enrollment transaction set (ANSI ASC X12 834)" means the electronic transaction format developed and approved for implementation in February 1992, and used to transmit enrollment and benefit information from the employer to the payer for the purpose of enrolling in a benefit plan.

Subd. 11. [GROUP PURCHASER.] "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

Subd. 12. [ISO.] "ISO" means the international standardization organization.

Subd. 13. [NCPDP.] "NCPDP" means the national council for prescription drug programs, inc.

Subd. 14. [NCPDP TELECOMMUNICATION STANDARD FORMAT 3.2.] "NCPDP telecommunication standard format 3.2" means the recommended transaction sets for claims transactions adopted by the membership of NCPDP in 1992.

Subd. 15. [NCPDP TAPE BILLING AND PAYMENT FORMAT 2.0.] "NCPDP tape billing and payment format 2.0" means the recommended transaction standards for batch processing claims adopted by the membership of the NCPDP in 1993.

Subd. 16. [PROVIDER.] "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Subd. 17. [UNIFORM BILLING FORM HCFA 1450.] "Uniform billing form HCFA 1450" means the uniform billing form known as the HCFA 1450 or UB92, developed by the national uniform billing committee in 1992 and approved for implementation in October 1993.

Subd. 18. [UNIFORM BILLING FORM HCFA 1500.] "Uniform billing form HCFA 1500" means the 1990 version of the health insurance claim form, HCFA 1500, developed by the uniform claims form task force of the federal health care financing administration.

Subd. 19. [UNIFORM DENTAL BILLING FORM.] "Uniform dental billing form" means the 1990 uniform dental claim form developed by the American dental association.

Subd. 20. [UNIFORM PHARMACY BILLING FORM.] "Uniform pharmacy billing form" means the national council for prescription drug programs/universal claim form (NCPDP/UCF).

Subd. 21. [WEDI.] "WEDI" means the national workgroup for electronic data interchange report issued in October, 1993.

Sec. 3. [62J.52] [ESTABLISHMENT OF UNIFORM BILLING FORMS.]

Subdivision 1. [UNIFORM BILLING FORM HCFA 1450.] (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, and institutionally owned or operated outpatient services rendered by providers in Minnesota, that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form HCFA 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the national uniform billing committee, as adopted and finalized by the Minnesota uniform billing committee.

(c) Services to be billed using the uniform billing form HCFA 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); and institutional owned or operated outpatient services such as hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, including infusion therapy, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, community mental health centers, and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

Subd. 2. [UNIFORM BILLING FORM HCFA 1500.] (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form HCFA 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1500 shall be in accordance with the manual developed by the administrative uniformity committee entitled standards for the use of the HCFA 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form HCFA 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional services, certified registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, and other health care providers such as home health intravenous therapy providers, personal care attendants, day activity centers, waivered services, hospice, and other home health services, and freestanding ambulatory surgical centers.

Subd. 3. [UNIFORM DENTAL BILLING FORM.] (a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the American dental association uniform dental billing form.

(b) The instructions and definitions for the use of the uniform dental billing form shall be in accordance with the manual developed by the administrative uniformity committee dated February 1994, and as amended or further defined by the commissioner.

Subd. 4. [UNIFORM PHARMACY BILLING FORM.] On and after January 1, 1996, all pharmacy services provided by pharmacists in Minnesota that are not currently being billed using an equivalent electronic billing format shall be billed using the NCPDP/universal claim form, except as provided in subdivision 5.

Subd. 5. [STATE AND FEDERAL HEALTH CARE PROGRAMS.] (a) Skilled nursing facilities and ICF-MR services billed to state and federal health care programs administered by the department of human services shall use the form designated by the department of human services.

(b) On and after July 1, 1996, state and federal health care programs administered by the department of human services shall accept the HCFA 1450 for community mental health center services and shall accept the HCFA 1500 for freestanding ambulatory surgical center services.

(c) State and federal health care programs administered by the department of human services shall be authorized to use the forms designated by the department of human services for pharmacy services and for child and teen checkup services.

(d) State and federal health care programs administered by the department of human services shall accept the form designated by the department of human services, and the HCFA 1500 for supplies, medical supplies or durable medical equipment. Health care providers may choose which form to submit.

Sec. 4. [62J.53] [ACCEPTANCE OF UNIFORM BILLING FORMS BY GROUP PURCHASERS.]

On and after January 1, 1996, all category I and II group purchasers in Minnesota shall accept the uniform billing forms prescribed under section 62J.52 as the only nonelectronic billing forms used for payment processing purposes.

Sec. 5. [62J.54] [IDENTIFICATION AND IMPLEMENTATION OF UNIQUE IDENTIFIERS.]

Subdivision 1. [UNIQUE IDENTIFICATION NUMBER FOR HEALTH CARE PROVIDER ORGANIZATIONS.] (a) On and after July 1, 1995, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify health care provider organizations, except as provided in paragraph (d).

(b) Following the recommendation of the workgroup for electronic data interchange, the federal tax identification number assigned to each health care provider organization by the internal revenue service of the department of the treasury shall be used as the unique identification number for health care provider organizations.

(c) The unique health care provider organization identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The state and federal health care programs administered by the department of human services shall use the unique identification number assigned to health care providers for implementation of the medicaid management information system or the unique physician identification number (UPIN) assigned by the health care financing administration.

Subd. 2. [UNIQUE IDENTIFICATION NUMBER FOR INDIVIDUAL HEALTH CARE PROVIDERS.] (a) On and after July 1, 1995, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify an individual health care provider, except as provided in paragraph (d).

(b) The Unique Identification Number (UPIN) assigned by the health care financing administration shall be used as the unique identification number for individual health care providers. Providers who do not currently have a UPIN number shall request one from the health care financing administration.

(c) The unique individual health care provider identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The state and federal health care programs administered by the department of human services shall use the unique identification number assigned to health care providers for implementation of the medicaid management information system or the unique physician identification number (UPIN) assigned by the health care financing administration.

Subd. 3. [UNIQUE IDENTIFICATION NUMBER FOR GROUP PURCHASERS.] (a) On and after July 1, 1995, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers.

(b) The federal tax identification number assigned to each group purchaser by the internal revenue service of the department of the treasury shall be used as the unique identification number for group purchasers. This paragraph applies until the codes described in paragraph (c) are available and feasible to use, as determined by the commissioner.

(c) A two-part code, consisting of 11 characters and modeled after the national association of insurance commissioners company code shall be assigned to each group purchaser and used as the unique identification number for group purchasers. The first six characters, or prefix, shall contain the numeric code, or company code, assigned by the national association of insurance commissioners. The last five characters, or suffix, which is optional, shall contain further codes that will enable group purchasers to further route electronic transaction in their internal systems.

(d) The unique group purchaser identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

Subd. 4. [UNIQUE PATIENT IDENTIFICATION NUMBER.] (a) On and after July 1, 1995, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (e).

(b) Following the recommendation of the workgroup for electronic data interchange, the social security number of the patient shall be used as the unique patient identification number.

(c) The unique patient identification number shall be used by group purchasers and health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The commissioner shall develop an alternate numbering system for patients who do not have or refuse to provide a social security number. This provision does not require that patients provide their social security numbers and does not require group purchasers or providers to demand that patients provide their social security numbers.

(e) The state and federal health care programs administered by the department of human services shall use the unique person master index (PMI) identification number assigned to clients participating in programs administered by the department of human services.

Sec. 6. [62J.55] [PRIVACY OF UNIQUE IDENTIFIERS.]

(a) When the unique identifiers specified in section 62J.54 are used for data collection purposes, the identifiers must be encrypted, as required in section 62J.30, subdivision 6. Encryption must follow encryption standards set by the national bureau of standards and approved by the American national standards institute as ANSIX3. 92-1982/R 1987 to protect the confidentiality of the data. Social security numbers must not be maintained in unencrypted form in the database, and the data must never be released in a form that would allow for the identification of individuals. The encryption algorithm and hardware used must not use clipper chip technology.

(b) Providers and group purchasers shall treat the social security number as confidential, private data and shall maintain strict confidentiality of medical records and data files. Social security numbers must not be used to link with non-health-related data under any circumstances.

Sec. 7. [62J.56] [IMPLEMENTATION OF ELECTRONIC DATA INTERCHANGE STANDARDS.]

Subdivision 1. [GENERAL PROVISIONS.] (a) The legislature finds that there is a need to advance the use of electronic methods of data interchange among all health care participants in the state in order to achieve significant administrative cost savings. The legislature also finds that in order to advance the use of health care electronic data interchange in a cost-effective manner, the state needs to implement electronic data interchange standards that are

nationally accepted, widely recognized, and available for immediate use. The legislature intends to set forth a plan for a systematic phase-in of uniform health care electronic data interchange standards in all segments of the health care industry.

(b) The commissioner of health, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, shall administer the implementation of and monitor compliance with, electronic data interchange standards of health care participants, according to the plan provided in this section.

(c) The commissioner may grant exemptions to category I and II industry participants from the requirements to implement some or all of the provisions in this section if the commissioner determines that the cost of compliance would place the organization in financial distress, or if the commissioner determines that appropriate technology is not available to the organization.

Subd. 2. [IDENTIFICATION OF CORE TRANSACTION SETS.] (a) All category I and II industry participants in Minnesota shall comply with the standards developed by the ANSI ASC X12 for the following core transaction sets, according to the implementation plan outlined for each transaction set.

(1) ANSI ASC X12 835 health care claim payment/advice transaction set.

(2) ANSI ASC X12 837 health care claim transaction set.

(3) ANSI ASC X12 834 health care enrollment transaction set.

(4) ANSI ASC X12 270/271 health care eligibility transaction set

(b) The commissioner, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, and in coordination with federal efforts, may approve the use of new ASC X12 standards as they become available, or other nationally recognized standards, where appropriate ASC X12 standards are not available for use. These alternative standards may be used during a transition period while ASC X12 standards are developed.

Subd. 3. [IMPLEMENTATION GUIDES.] (a) The commissioner, with the advice of the Minnesota administrative uniformity committee, and the Minnesota Center for Health Care Electronic Data Interchange shall review and recommend the use of guides to implement the core transaction sets. Implementation guides must contain the background and technical information required to allow health care participants to implement the transaction set in the most cost-effective way.

(b) The commissioner shall promote the development of implementation guides among health care participants for those business transaction types for which implementation guides are not available, to allow providers and group purchasers to implement electronic data interchange. In promoting the development of these implementation guides, the commissioner shall review the work done by the American hospital association through the national uniform billing committee and its state representative organization; the american medical association through the uniform claim task force; the american dental association; the national council of prescription drug programs; and the workgroup for electronic data interchange.

Sec. 8. [62J.57] [MINNESOTA CENTER FOR HEALTH CARE ELECTRONIC DATA INTERCHANGE.]

(a) It is the intention of the legislature to support, to the extent of funds appropriated for that purpose, the creation of the Minnesota center for health care electronic data interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers, and government programs to advance the use of health care electronic data interchange in the state. The center shall attempt to obtain private sector funding to supplement legislative appropriations, and shall become self-supporting by the end of the second year.

(b) The Minnesota center for health care electronic data interchange shall facilitate the statewide implementation of electronic data interchange standards in the health care industry by:

(1) Coordinating and ensuring the availability of quality electronic data interchange education and training in the state;

(2) Developing an extensive, cohesive health care electronic data interchange education curriculum;

(3) Developing a communications and marketing plan to publicize electronic data interchange education activities, and the products and services available to support the implementation of electronic data interchange in the state;

(4) Administering a resource center that will serve as a clearinghouse for information relative to electronic data interchange, including the development and maintenance of a health care constituents data base, health care directory and resource library, and a health care communications network through the use of electronic bulletin board services and other network communications applications; and

(5) Providing technical assistance in the development of implementation guides, and in other issues including legislative, legal, and confidentiality requirements.

Sec. 9. [62J.58] [IMPLEMENTATION OF STANDARD TRANSACTION SETS.]

Subdivision 1. [CLAIMS PAYMENT.] (a) By July 1, 1995, all category I industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version 3030) for electronic transfer of payment information.

(b) By July 1, 1996, all category II industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version 3030) for electronic submission of payment information to health care providers.

Subd. 2. [CLAIMS SUBMISSION.] Beginning July 1, 1995, all category I industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 837 health care claim transaction set (draft standard for trial use version 3030) for the electronic transfer of health care claim information. Category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, this transaction set, beginning July 1, 1996.

Subd. 3. [ENROLLMENT INFORMATION.] Beginning January 1, 1996, all category I industry participants, excluding pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 834 health care enrollment transaction set (draft standard for trial use version 3030) for the electronic transfer of enrollment and health benefit information. Category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, this transaction set, beginning January 1, 1997.

Subd. 4. [ELIGIBILITY INFORMATION.] By January 1, 1996, all category I industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 270/271 health care eligibility transaction set (draft standard for trial use version 3030) for the electronic transfer of health benefit eligibility information. Category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, this transaction set, beginning January 1, 1997.

Subd. 5. [APPLICABILITY.] This section does not require a group purchaser, health care provider, or employer to use electronic data interchange or to have the capability to do so. This section applies only to the extent that a group purchaser, health care provider, or employer chooses to use electronic data interchange.

Sec. 10. [62J.59] [IMPLEMENTATION OF NCPDP TELECOMMUNICATIONS STANDARD FOR PHARMACY CLAIMS.]

(a) Beginning January 1996, all category I and II pharmacists licensed in this state shall accept the NCPDP telecommunication standard format 3.2 or the NCPDP tape billing and payment format 2.0 for the electronic submission of claims as appropriate.

(b) Beginning January 1996, all category I and category II group purchasers in this state shall use the NCPDP telecommunication standard format 3.2 or NCPDP tape billing and payment format 2.0 for electronic submission of payment information to pharmacists.

Sec. 11. [62J.60] [STANDARDS FOR THE MINNESOTA UNIFORM HEALTH CARE IDENTIFICATION CARD.]

Subdivision 1. [MINNESOTA HEALTH CARE IDENTIFICATION CARD.] All individuals with health care coverage shall be issued health care identification cards by group purchasers as of January 1, 1998. The health care identification cards shall comply with the standards prescribed in this section.

Subd. 2. [GENERAL CHARACTERISTICS.] (a) The Minnesota 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.

(b) The Minnesota health care identification card must have an essential information window in the front side with the following data elements left justified in the following top to bottom sequence: issuer name, issuer number, identification number, 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. The card issuer may decide the location of the standardized label relative to the data element.

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 health care identification card:

(1) Issuer name or logo, which is the name or logo that identifies the card issuer. The issuer name or logo may be the card's front background. No standard label is required for this data element;

(2) Issuer number, which is the unique card issuer number consisting of a base number assigned by a registry process followed by a suffix number assigned by the card issuer. The use of this element is mandatory within one year of the establishment of a process for this identifier. The standardized label for this element is "Issuer";

(3) 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";

(4) 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";

(5) Account number(s), which is any other number, such as a group number, if required for part of the identification or claims process. The standardized label for this data element is "Account";

(6) Care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. 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";

(8) Employer name, which is the name of the employer of the primary beneficiary; and

(9) Union local name and number.

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

(1) Claims submission name(s) and address(es), which are the name(s) and address(es) 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 number(s) and name(s); which are the telephone number(s) and name(s) of the following contact(s) with a standardized label describing the service function as applicable:

(i) eligibility information;

(ii) utilization review;

(iii) precertification; and

(iv) customer services.

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

Subd. 4. [MACHINE READABLE DATA CONTENT.] The Minnesota 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. The machine readable record format must conform to the following record length and format standards.

Sec. 12. [62J.61] [RULEMAKING; IMPLEMENTATION.]

The commissioner of health is exempt from rulemaking in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.59. The commissioner shall publish proposed rules in the State Register. Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish the final rules in the State Register 30 days before they are to take effect. The commissioner may use emergency and permanent rulemaking to implement the remainder of this article. The commissioner shall not adopt any rules requiring patients to provide their social security numbers unless and until federal laws are modified to allow or require such action, nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter.

Sec. 13. [COMMISSIONER; CONTINUED SIMPLIFICATION.] The commissioner of health shall continue to develop additional standard billing and administrative procedure simplification. These may include reduction or elimination of payer-required attachments to claims, standard formularies, standard format for direct patient billing, and increasing standardization of claims forms and EDI formats.

Sec. 14. [EVALUATIONS.]

Subdivision 1. [UNIQUE EMPLOYER IDENTIFICATION NUMBER.] The commissioner of health shall evaluate the need for the development and implementation of unique employer identification numbers to identify employers or entities that provide health care coverage.

Subd. 2. [UNIQUE "ISSUER" IDENTIFICATION NUMBER.] The commissioner of health shall evaluate the need for the development and implementation of unique identification numbers to identify issuers of health care identification cards.

Sec. 15. [EFFECTIVE DATE.]

Sections 1 to 14 are effective the day following final enactment.

ARTICLE 10

INSURANCE REFORM

Section 1. Minnesota Statutes 1993 Supplement, section 43A.317, is amended by adding a subdivision to read:

Subd. 12. [STATUS OF AGENTS.] Notwithstanding section 60K.03, subdivision 5, and 72A.07, the program may use, and pay referral fees, commissions, or other compensation to, agents licensed as life and health agents under chapter 60K or licensed under section 62C.17, regardless of whether the agents are appointed to represent the particular health carriers, integrated service networks, or community integrated service networks that provide the coverage available through the program. When acting under this subdivision, an agent is not an agent of the health carrier, integrated service network, or community integrated service network, with respect to that transaction.

Sec. 2. Minnesota Statutes 1993 Supplement, section 60K.14, subdivision 7, is amended to read:

Subd. 7. [DISCLOSURE OF COMMISSIONS.] Before selling~~, or offering to sell,~~ any ~~health insurance or a~~ health plan as defined in section 62A.011, subdivision 3, an agent shall disclose in writing to the prospective purchaser the amount of any commission or other compensation the agent 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.

Sec. 3. Minnesota Statutes 1993 Supplement, section 62A.011, subdivision 3, is amended to read:

Subd. 3. [HEALTH PLAN.] "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense-incurred basis;

(5) credit accident and health insurance as defined in section 62B.02;

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

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) a long-term care policy as defined in section 62A.46;

(10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended ~~through December 31, 1991~~;

(11) workers' compensation insurance; or

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan.

Sec. 4. Minnesota Statutes 1992, section 62A.303, is amended to read:

62A.303 [PROHIBITION; SEVERING OF GROUPS.]

Section 62L.12, subdivisions ~~1, 2,~~ 3~~,~~ and 4, apply to all employer group health plans, as defined in section 62A.011, regardless of the size of the group.

Sec. 5. [62A.305] [USE OF GENDER PROHIBITED.]

Subdivision 1. [APPLICABILITY.] This section applies to all health plans as defined in section 62A.011 offered, sold, issued, or renewed, by a health carrier on or after January 1, 1995.

Subd. 2. [PROHIBITION ON USE OF GENDER.] No health plan described in subdivision 1 shall determine the premium rate or any other underwriting decision, including initial issuance, through a method that is in any way based upon the gender of any person covered or to be covered under the health plan. This subdivision prohibits use of marital status or generalized differences in expected costs between employees and spouses or between principal insureds and their spouses.

Sec. 6. Minnesota Statutes 1993 Supplement, section 62A.31, subdivision 1h, is amended to read:

Subd. 1h. [LIMITATIONS ON DENIALS, CONDITIONS, AND PRICING OF COVERAGE.] No issuer of Medicare supplement policies, including policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395,

et seq., in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any Medicare supplement insurance policy form available for sale in this state, nor may it discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such insurance is submitted during the six-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B. This paragraph applies regardless of whether the individual has attained the age of 65 years. If an individual who is enrolled in Medicare Part B due to disability status is involuntarily disenrolled due to loss of disability status, the individual is eligible for the six-month enrollment period provided under this subdivision if the individual later becomes eligible for and enrolls again in Medicare Part B.

Sec. 7. Minnesota Statutes 1993 Supplement, section 62A.36, subdivision 1, is amended to read:

Subdivision 1. [LOSS RATIO STANDARDS.] (a) For purposes of this section, "Medicare supplement policy or certificate" has the meaning given in section 62A.31, subdivision 3, but also includes a policy, contract, or certificate issued under a contract under section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

(1) at least 75 percent of the aggregate amount of premiums earned in the case of group policies, and

(2) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. An insurer shall demonstrate that the third year loss ratio is greater than or equal to the applicable percentage. The applicable percentage for group policies or contracts shall increase by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for individual policies or contracts shall increase by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1, 2000.

All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy or certificate shall equal or exceed the appropriate loss ratio standards.

(b) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the National Association of Insurance Commissioners Medicare Supplement Refund Calculating form, for each type of Medicare supplement benefit plan.

If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation must be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury bills. A refund or credit against premiums due shall be made by September 30 following the experience year on which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy or certificate duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(1) a premium adjustment that is necessary to produce an expected loss ratio under the policy or certificate that will conform with minimum loss ratio standards for Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy or certificate other than the adjustments described herein shall be made with respect to a policy or certificate at any time other than on its renewal date or anniversary date;

(2) if an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits considered necessary to achieve the loss ratio required by this section;

(3) any appropriate riders, endorsements, or policy or certificate forms needed to accomplish the Medicare supplement insurance policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy or certificate forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(d) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of a refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner considered appropriate by the commissioner.

(e) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with, and approved by, the commissioner according to the filing requirements and procedures prescribed by the commissioner.

Sec. 8. Minnesota Statutes 1993 Supplement, section 62A.65, subdivision 2, is amended to read:

Subd. 2. [GUARANTEED RENEWAL.] No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health plan provides that the plan is guaranteed renewable at a premium rate that does not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the health plan to the person. The premium rate upon renewal must also otherwise comply with this section. A health carrier must not refuse to renew an individual health plan ~~may be subject to refusal to renew only under the conditions provided in chapter 62L for health benefit plans~~ prior to enrollment in Medicare Parts A and B, except for nonpayment of premiums, fraud, or misrepresentation.

Sec. 9. Minnesota Statutes 1993 Supplement, section 62A.65, subdivision 3, is amended to read:

Subd. 3. [PREMIUM RATE RESTRICTIONS.] No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the ~~rating and premium restrictions provided under chapter 62L, except that the minimum loss ratio applicable to an individual health plan is as provided in section 62A.021. All rating and premium restrictions of chapter 62L apply to the individual market, unless clearly inapplicable to the individual market.~~ following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and

(4) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

Sec. 10. Minnesota Statutes 1993 Supplement, section 62A.65, subdivision 4, is amended to read:

Subd. 4. [GENDER RATING PROHIBITED.] No individual health plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, ~~on~~ through a method that is in any way based upon the gender of any person covered or to be covered under the health plan. This subdivision prohibits the use of marital status or generalized differences in expected costs between principal insureds and their spouses.

Sec. 11. Minnesota Statutes 1993 Supplement, section 62A.65, subdivision 5, is amended to read:

Subd. 5. [PORTABILITY OF COVERAGE.] (a) No individual health plan may be offered, sold, issued, or with respect to children age 18 or under renewed, to a Minnesota resident that contains a preexisting condition limitation or exclusion or exclusionary rider, unless the limitation or exclusion ~~would be~~ is permitted under ~~chapter 62L~~ this subdivision, provided that, except for children age 18 or under, underwriting restrictions may be retained on individual contracts that are issued without evidence of insurability as a replacement for prior individual coverage that was sold before May 17, 1993. The individual may be ~~treated as a late entrant, as defined in chapter 62L~~ subjected to an 18-month preexisting condition limitation, unless the individual has maintained continuous coverage as defined in ~~chapter 62L~~ section 62L.02. The individual must not be subjected to an exclusionary rider. An individual who has maintained continuous coverage may be subjected to a one-time preexisting condition limitation ~~as permitted under chapter 62L for persons who are not late entrants,~~ of up to 12 months, with credit for time covered

under qualifying coverage as defined in section 62L.02, at the time that the individual first is covered under an individual health plan by any health carrier. The individual must not be subjected to an exclusionary rider. Thereafter, the individual must not be subject to any preexisting condition limitation or exclusion or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health ~~benefit~~ plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in ~~chapter 62L~~ section 62L.02. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan and must not contain any preexisting condition limitation or exclusion or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed 90 percent of the premium charged for comparable individual coverage by the Minnesota comprehensive health association, and the premium rate must be less than that amount if necessary to otherwise comply with this section. An individual health plan offered under this paragraph to a person satisfies the health carrier's obligation to offer conversion coverage under section 62E.16, with respect to that person. Section 72A.20, subdivision 28, applies to this paragraph.

Sec. 12. Minnesota Statutes 1993 Supplement, section 62A.65, is amended by adding a subdivision to read:

Subd. 7. [SHORT TERM COVERAGE.] (a) For purposes of this section, "short term coverage" means an individual health plan that:

(1) is issued to provide coverage for a period of 185 days or less, except that the health plan may permit coverage to continue until the end of a period of hospitalization for a condition for which the covered person was hospitalized on the day that coverage would otherwise have ended;

(2) is nonrenewable, provided that the health carrier may provide coverage for one or more subsequent periods that satisfy clause (1), if the total of the periods of coverage do not exceed a total of 185 days out of any 365 day period, plus any additional days covered as a result of hospitalization on the day that a period of coverage would otherwise have ended;

(3) does not cover any preexisting conditions, including ones that originated during a previous identical policy or contract with the same health carrier where coverage was continuous between the previous and the current policy or contract; and

(4) is available with an immediate effective date without underwriting upon receipt of a completed application indicating eligibility under the health carrier's eligibility requirements, provided that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(b) Short term coverage is not subject to subdivisions 2 and 5. Short term coverage may exclude as a preexisting condition any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the coverage, but dependent children born or placed for adoption during the policy period must not be subject to this provision.

(c) Notwithstanding subdivision 3, and section 62A.021, a health carrier may combine short term coverage with its most commonly sold individual qualified plan as defined in section 62E.02, other than short term coverage, for purposes of complying with the loss ratio requirement.

(d) The 185 day coverage limitation provided in paragraph (a), applies to the total number of days of short term coverage that covers a person, regardless of the number of policies, contracts, or health carriers that provide the coverage. A written application for short term coverage must ask the applicant whether the applicant has been covered by short term coverage by any health carrier within the 365 days immediately preceding the effective date of the coverage being applied for. Short term coverage issued in violation of the 185 day limitation is valid until the end of its term, and does not lose its status as short term coverage, in spite of the violation. A health carrier that knowingly issues short term coverage in violation of the 185 day limitation is subject to the administrative penalties otherwise available to the commissioner of commerce or the commissioner of health, as appropriate.

(e) Time spent under short term coverage counts as time spent under a preexisting condition limitation for purposes of group or individual health plans, other than short term coverage, subsequently issued to that person, or to cover that person, by any health carrier, if the person maintains continuous coverage as defined in section 62L.02. Short term coverage is a health plan and is qualifying coverage as defined in section 62L.02. Notwithstanding any other law to the contrary, a health carrier is not required under any circumstances to provide a person covered by short-term coverage the right to obtain coverage on a guaranteed issue basis under another health plan offered by the health carrier, as a result of the person's enrollment in short-term coverage.

Sec. 13. Minnesota Statutes 1993 Supplement, section 62A.65, is amended by adding a subdivision to read:

Subd. 8. [CESSATION OF INDIVIDUAL BUSINESS.] Notwithstanding the provisions of subdivisions 1 to 7, a health carrier may elect to cease doing business in the individual market if it complies with the requirements of this subdivision. A health carrier electing to cease doing business in the individual market shall notify the commissioner 180 days prior to the effective date of the cessation. The cessation of business does not include the failure of a health carrier to offer or issue new business in the individual market or continue an existing product line, provided that a health carrier does not terminate, cancel, or fail to renew its current individual business or other product lines. A health carrier electing to cease doing business in the individual market shall provide 120 days' written notice to each policyholder covered by a health plan issued by the health carrier. A health carrier that ceases to write new business in the individual market shall continue to be governed by this section with respect to continuing individual business conducted by the carrier. A health carrier that ceases to do business in the individual market after July 1, 1994, is prohibited from writing new business in the individual market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the individual market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the individual market in that same service area.

Sec. 14. Minnesota Statutes 1993 Supplement, section 62D.12, subdivision 17, is amended to read:

Subd. 17. [DISCLOSURE OF COMMISSIONS.] Any person receiving commissions for the sale of coverage or enrollment in a health plan, as defined in section 62A.011, offered by a health maintenance organization shall, before selling ~~or offering to sell~~ coverage or enrollment, 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.

Sec. 15. Minnesota Statutes 1992, section 62E.141, is amended to read:

62E.141 [INCLUSION IN EMPLOYER-SPONSORED PLAN.]

No employee, or dependent of an employee, of an employer ~~who~~ that offers a health ~~benefit~~ plan, under which the employee or dependent is eligible ~~to enroll under chapter 62L~~ for coverage, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation or exclusion or exclusionary rider under the employer's health ~~benefit~~ plan. This section does not apply to persons enrolled in the comprehensive health association as of June 30, 1993. With respect to persons eligible to enroll in the health plan of an employer that has more than 29 current employees, as defined in section 62L.02, this section does not apply to persons enrolled in the comprehensive health association as of December 31, 1994.

Sec. 16. Minnesota Statutes 1992, section 62E.16, is amended to read:

62E.16 [POLICY CONVERSION RIGHTS.]

Every program of self-insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state, shall include, in addition to the provisions required by section 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions if the individual insured leaves the group regardless of the reason for leaving the group or if an employer member of a group ceases to remit payment so as to terminate coverage for its employees, or upon cancellation or termination of the coverage for the group except where uninterrupted and continuous group coverage is otherwise provided to the group. If the health maintenance organization has canceled coverage for the group because of a loss of providers in a service area, the health maintenance organization shall arrange for other health maintenance or

indemnity conversion options that shall be offered to enrollees without the addition of underwriting restrictions. The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. The person may exercise this right to conversion within 30 days of leaving the group or within 30 days following receipt of due notice of cancellation or termination of coverage of the group or of the employer member of the group and upon payment of premiums from the date of termination or cancellation. Due notice of cancellation or termination of coverage for a group or of the employer member of the group shall be provided to each employee having coverage in the group by the insurer, self-insurer or health maintenance organization canceling or terminating the coverage except where reasonable evidence indicates that uninterrupted and continuous group coverage is otherwise provided to the group. Every employer having a policy of group accident and health insurance, group subscriber or contract of coverage by a health maintenance organization shall, upon request, provide the insurer or health maintenance organization a list of the names and addresses of covered employees. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue coverage under the same or a different contract without the addition of underwriting restrictions until the individual would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived. An individual conversion contract issued by a health maintenance organization shall not be deemed to be an individual enrollment contract for the purposes of section 62D.10. An individual health plan offered under section 62A.65, subdivision 5, paragraph (b), to a person satisfies the health carrier's obligation to offer conversion coverage under this section with respect to that person.

Sec. 17. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 8, is amended to read:

Subd. 8. [COMMISSIONER.] "Commissioner" means the commissioner of commerce for health carriers subject to the jurisdiction of the department of commerce or the commissioner of health for health carriers subject to the jurisdiction of the department of health, or the relevant commissioner's designated representative. For purposes of sections 62L.13 to 62L.22, "commissioner" means the commissioner of commerce or that commissioner's designated representative.

Sec. 18. Minnesota Statutes 1992, section 62L.02, subdivision 9, is amended to read:

Subd. 9. [CONTINUOUS COVERAGE.] "Continuous coverage" means the maintenance of continuous and uninterrupted qualifying ~~prior~~ coverage ~~by an eligible employee or dependent~~. An ~~eligible employee or dependent~~ individual is considered to have maintained continuous coverage if the individual requests enrollment in ~~a health benefit plan~~ qualifying coverage within 30 days of termination of ~~the~~ qualifying ~~prior~~ coverage.

Sec. 19. Minnesota Statutes 1992, section 62L.02, is amended by adding a subdivision to read:

Subd. 9a. [CURRENT EMPLOYEE.] "Current employee" means an employee, as defined in this section, other than a retiree or handicapped former employee.

Sec. 20. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 11, is amended to read:

Subd. 11. [DEPENDENT.] "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 19 years, unmarried child under the age of 25 years who is a full-time student as defined in section 62A.301 ~~and financially dependent upon the eligible employee, or~~, dependent child of any age who is handicapped and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child may include a child for whom the employee or the employee's spouse has been appointed legal guardian.

Sec. 21. Minnesota Statutes 1992, section 62L.02, subdivision 13, is amended to read:

Subd. 13. [ELIGIBLE EMPLOYEE.] "Eligible employee" means an ~~individual employed by a small employer for at least 20 hours per week and~~ employee who has satisfied all employer participation and eligibility requirements~~, including, but not limited to, the satisfactory completion of a probationary period of not less than 30 days but no more than 90 days. The term includes A sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include employees who work on a temporary, seasonal, or substitute basis~~.

Sec. 22. Minnesota Statutes 1992, section 62L.02, is amended by adding a subdivision to read:

Subd. 13a. [EMPLOYEE.] "Employee" means an individual employed for at least 20 hours per week and includes a sole proprietor or a partner of a partnership, if the sole proprietor or partner is included under a health benefit plan of the employer, but does not include individuals who work on a temporary, seasonal, or substitute basis. "Employee" also includes a retiree or a handicapped former employee required to be covered under sections 62A.147 and 62A.148.

Sec. 23. Minnesota Statutes 1992, section 62L.02, is amended by adding a subdivision to read:

Subd. 14a. [GUARANTEED ISSUE.] "Guaranteed issue" means that a health carrier shall not decline an application by a small employer for any health benefit plan offered by that health carrier and shall not decline to cover under a health benefit plan any eligible employee or eligible dependent, including persons who become eligible employees or eligible dependents after initial issuance of the health benefit plan, subject to the health carrier's right to impose preexisting condition limitations permitted under this chapter.

Sec. 24. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 15, is amended to read:

Subd. 15. [HEALTH BENEFIT PLAN.] "Health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a health carrier to a small employer for the coverage of medical and hospital benefits. Health benefit plan includes a small employer plan. Health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense-incurred basis;

(5) credit accident and health insurance as defined in section 62B.02;

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

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) a long-term care policy as defined in section 62A.46;

(10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended ~~through December 31, 1991~~;

(11) workers' compensation insurance; or

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health benefit plan.

For the purpose of this chapter, a health benefit plan issued to eligible employees of a small employer who meets the participation requirements of section 62L.03, subdivision 3, is considered to have been issued to a small employer. A health benefit plan issued on behalf of a health carrier is considered to be issued by the health carrier.

Sec. 25. Minnesota Statutes 1992, section 62L.02, subdivision 16, is amended to read:

Subd. 16. [HEALTH CARRIER.] "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; and a multiple employer welfare arrangement, as defined in United States Code, title 29, section 1002(40), as amended ~~through December 31, 1991~~. For purposes of sections

62L.01 to 62L.12, but not for purposes of sections 62L.13 to 62L.22, "health carrier" includes a community integrated service network or integrated service network licensed under chapter 62N. Any use of this definition in another chapter by reference does not include a community integrated service network or integrated service network, unless otherwise specified. For the purpose of this chapter, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one health carrier, except that any insurance company or health service plan corporation that is an affiliate of a health maintenance organization located in Minnesota, or any health maintenance organization located in Minnesota that is an affiliate of an insurance company or health service plan corporation, or any health maintenance organization that is an affiliate of another health maintenance organization in Minnesota, may treat the health maintenance organization as a separate health carrier.

Sec. 26. Minnesota Statutes 1992, section 62L.02, subdivision 17, is amended to read:

Subd. 17. [HEALTH PLAN.] "Health plan" means a health ~~benefit~~ plan ~~issued by a health carrier, except that it may be issued:~~

~~(1) to a small employer;~~

~~(2) to an employer who does not satisfy the definition of a small employer as defined under subdivision 26; or~~

~~(3) to an individual purchasing an individual or conversion policy of health care coverage issued by a health carrier~~ as defined in section 62A.011 and includes individual and group coverage regardless of the size of the group, unless otherwise specified.

Sec. 27. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 19, is amended to read:

Subd. 19. [LATE ENTRANT.] "Late entrant" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period applicable to the employee or dependent under the terms of the health benefit plan, provided that the initial enrollment period must be a period of at least 30 days. However, an eligible employee or dependent must not be considered a late entrant if:

(1) the individual was covered under qualifying ~~existing~~ coverage at the time the individual was eligible to enroll in the health benefit plan, declined enrollment on that basis, and presents to the health carrier a certificate of termination of the qualifying ~~prior~~ coverage, due to loss of eligibility for that coverage, provided that the individual maintains continuous coverage. For purposes of this clause, ~~eligibility for prior coverage does not include eligibility for~~ an individual is not a late entrant if the individual elects coverage under the health benefit plan rather than accepting continuation coverage ~~required~~ for which the individual is eligible under state or federal law with respect to the individual's previous qualifying coverage;

(2) the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law Number 99-272, as amended, and any state continuation laws applicable to the employer or health carrier, provided that the individual maintains continuous coverage;

(3) the individual is a new spouse of an eligible employee, provided that enrollment is requested within 30 days of becoming legally married;

(4) the individual is a new dependent child of an eligible employee, provided that enrollment is requested within 30 days of becoming a dependent;

(5) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(6) a court has ordered that coverage be provided for a former spouse or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

Sec. 28. Minnesota Statutes 1992, section 62L.02, subdivision 24, is amended to read:

Subd. 24. [QUALIFYING ~~PRIOR~~ COVERAGE ~~OR QUALIFYING EXISTING COVERAGE~~.] "Qualifying ~~prior~~ coverage" ~~or "qualifying existing coverage"~~ means health benefits or health coverage provided under:

(1) a health plan, as defined in this section;

(2) Medicare;

(3) medical assistance under chapter 256B;

(4) general assistance medical care under chapter 256D;

(5) MCHA;

(6) a self-insured health plan;

(7) the ~~health right~~ MinnesotaCare ~~plan~~ program established under section 256.9352, when the plan includes inpatient hospital services as provided in section 256.9353;

(8) a plan provided under section 43A.316, 43A.317, or 471.617; or

(9) a plan similar to any of the above plans provided in this state or in another state as determined by the commissioner.

Sec. 29. Minnesota Statutes 1993 Supplement, section 62L.02, subdivision 26, is amended to read:

Subd. 26. [SMALL EMPLOYER.] (a) "Small employer" means a person, firm, corporation, partnership, association, or other entity actively engaged in business ~~who~~, including a political subdivision of the state, that, on at least 50 percent of its working days during the preceding ~~calendar year~~ 12 months, employed no fewer than two nor more than 29 ~~eligible~~, or after June 30, 1995, more than 49, current employees, the majority of whom were employed in this state. A political subdivision of the state is not a small employer and is not subject to this chapter when it provides health coverage to its employees, officers, and retirees, and their dependents, by participation in group purchasing of health plan coverage by or through an association of political subdivisions or by or through an educational cooperative service unit created under section 123.58 or by participating in a joint self-insurance pool authorized under section 471.617, subdivision 2. If an employer has only two eligible employees and one is the spouse, child, sibling, parent, or grandparent of the other, the employer must be a Minnesota domiciled employer and have paid social security or self-employment tax on behalf of both eligible employees. If an employer has only one eligible employee who has not waived coverage, the sale of a health plan to or for that eligible employee is not a sale to a small employer and is not subject to this chapter and may be treated as the sale of an individual health plan. A small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than two current employees. Entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer for purposes of determining the number of ~~eligible~~ current employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan.

(b) Where an association, described in section 62A.10, subdivision 1, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association shall be considered to be a small employer, with respect to those employers in the association that employ no fewer than two nor more than 29 ~~eligible~~, or after June 30, 1995, more than 49, current employees, even though the association provides coverage to its members that do not qualify as small employers. An association in existence prior to July 1, 1993, is exempt from this chapter with respect to small employers that are members as of that date. However, in providing coverage to new ~~groups~~ employers after July 1, 1993, the existing association must comply with all requirements of this chapter. Existing associations must register with the commissioner of commerce prior to July 1, 1993. With respect to small employers having not fewer than 30 nor more than 49 current employees, the July 1, 1993 date in this paragraph becomes July 1, 1995, and the reference to "after" that date becomes "on or after."

(c) If an employer has employees covered under a trust ~~established~~ specified in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq., as amended, or employees whose health coverage is determined by a collective bargaining agreement and, as a result of the collective bargaining agreement, is purchased separately from the health plan provided to other employees, those employees are excluded in determining whether the employer qualifies as a small employer. Those employees are considered to be a separate small employer if they constitute a group that would qualify as a small employer in the absence of the employees who are not subject to the collective bargaining agreement.

Sec. 30. Minnesota Statutes 1992, section 62L.03, subdivision 1, is amended to read:

Subdivision 1. [GUARANTEED ISSUE AND REISSUE.] Every health carrier shall, as a condition of authority to transact business in this state in the small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans, on a guaranteed issue basis, to any small employer that meets the participation and contribution requirements of subdivision 3, as provided in this chapter. This requirement does not apply to a health benefit plan designed for a small employer to comply with a collective bargaining agreement, provided that the health benefit plan otherwise complies with this chapter and is not offered to other small employers, except for other small employers that need it for the same reason. Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers. A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

Sec. 31. Minnesota Statutes 1993 Supplement, section 62L.03, subdivision 3, is amended to read:

Subd. 3. [MINIMUM PARTICIPATION AND CONTRIBUTION.] (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan and that contributes at least 50 percent toward the cost of coverage of eligible employees must be guaranteed coverage on a guaranteed issue basis from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier ~~may~~ must not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to: (1) coverage under another group health plan; (2) coverage under Medicare parts A and B; or (3) coverage under MCHA permitted under section 62E.141.

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual ~~coverage~~ health plans, or a health benefit plan which~~, except for guaranteed issue,~~ must fully comply with this chapter. A health carrier that provides ~~group coverage~~ a health benefit plan to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer an individual ~~coverage~~ health plan, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers ~~coverage~~ the individual health plan, on a guaranteed issue basis, to all other employees of the same employer.

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer.

Sec. 32. Minnesota Statutes 1993 Supplement, section 62L.03, subdivision 4, is amended to read:

Subd. 4. [UNDERWRITING RESTRICTIONS.] Health carriers may apply underwriting restrictions to coverage for health benefit plans for small employers, including any preexisting condition limitations, only as expressly permitted under this chapter. For purposes of this ~~subdivision~~ section, "underwriting restrictions" means any refusal of the health carrier to issue or renew coverage, any premium rate higher than the lowest rate charged by the health carrier for the same coverage, ~~or~~ any preexisting condition limitation or exclusion, or any exclusionary rider. Health carriers may collect information relating to the case characteristics and demographic composition of small employers, as well as health status and health history information about employees, and dependents of employees, of small employers. Except as otherwise authorized for late entrants, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the effective date of coverage of an eligible employee or dependent, but exclusionary riders must not be used. When calculating a preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying prior coverage, provided that the individual maintains continuous coverage. Late entrants may be subject to a preexisting condition limitation not to exceed 18 months from the effective date of coverage of the late entrant, but must not be subject to any exclusionary rider or exclusion. ~~Late entrants may also be excluded from coverage for a period not to exceed 18 months, provided that if a health carrier imposes an exclusion from coverage and a preexisting condition limitation, the combined time period for both the coverage exclusion and preexisting condition limitation must not exceed 18 months.~~ A health carrier shall, at the time of first issuance or renewal of a health benefit plan on or after July 1, 1993, credit against any preexisting condition limitation or exclusion permitted under this section, the time period prior to July 1, 1993, during which an eligible employee or dependent was covered by qualifying ~~existing~~ coverage ~~or qualifying prior coverage~~, if the person has maintained continuous coverage.

Sec. 33. Minnesota Statutes 1993 Supplement, section 62L.03, subdivision 5, is amended to read:

Subd. 5. [CANCELLATIONS AND FAILURES TO RENEW.] (a) No health carrier shall cancel, decline to issue, or fail to renew a health benefit plan as a result of the claim experience or health status of the persons covered or to be covered by the health benefit plan. A health carrier may cancel or fail to renew a health benefit plan:

(1) for nonpayment of the required premium;

(2) for fraud or misrepresentation by the small employer, or, with respect to coverage of an individual eligible employee or dependent, fraud or misrepresentation by the eligible employee or dependent, with respect to eligibility for coverage or any other material fact;

(3) if eligible employee participation during the preceding calendar year declines to less than 75 percent, subject to the waiver of coverage provision in subdivision 3;

(4) if the employer fails to comply with the minimum contribution percentage ~~legally~~ required ~~by the health carrier~~ under subdivision 3;

(5) if the health carrier ceases to do business in the small employer market under section 62L.09; ~~or~~

(6) if a failure to renew is based upon the health carrier's decision to discontinue the health benefit plan form previously issued to the small employer, but only if the health carrier permits each small employer covered under the prior form to switch to its choice of any other health benefit plan offered by the health carrier, without any underwriting restrictions that would not have been permitted for renewal purposes; or

(7) for any other reasons or grounds expressly permitted by the respective licensing laws and regulations governing a health carrier, including, but not limited to, service area restrictions imposed on health maintenance organizations under section 62D.03, subdivision 4, paragraph (m), to the extent that these grounds are not expressly inconsistent with this chapter.

(b) A health carrier need not renew a health benefit plan, and shall not renew a small employer plan, if an employer ceases to qualify as a small employer as defined in section 62L.02. If a health benefit plan, other than a small employer plan, provides terms of renewal that do not exclude an employer that is no longer a small employer, the health benefit plan may be renewed according to its own terms. If a health carrier issues or renews a health plan to an employer that is no longer a small employer, without interruption of coverage, the health plan is subject to section 60A.082.

Sec. 34. Minnesota Statutes 1993 Supplement, section 62L.04, subdivision 1, is amended to read:

Subdivision 1. [APPLICABILITY OF CHAPTER REQUIREMENTS.] (a) Beginning July 1, 1993, health carriers participating in the small employer market must offer and make available on a guaranteed issue basis any health benefit plan that they offer, including both of the small employer plans provided in section 62L.05, to all small employers ~~who~~ that satisfy the small employer participation and contribution requirements specified in this chapter. Compliance with these requirements is required as of the first renewal date of any small employer group occurring after July 1, 1993. For new small employer business, compliance is required as of the first date of offering occurring after July 1, 1993.

(b) Compliance with these requirements is required as of the first renewal date occurring after July 1, 1994, with respect to employees of a small employer who had been issued individual coverage prior to July 1, 1993, administered by the health carrier on a group basis. Notwithstanding any other law to the contrary, the health carrier shall offer to terminate any individual coverage for employees of small employers who satisfy the small employer participation and contribution requirements specified in section 62L.03 and offer to replace it with a health benefit plan. If the employer elects not to purchase a health benefit plan, the health carrier must offer all covered employees and dependents the option of maintaining their current coverage, administered on an individual basis, or replacement individual coverage. Small employer and replacement individual coverage provided under this subdivision must be without application of underwriting restrictions, provided continuous coverage is maintained.

(c) With respect to small employers having no fewer than 30 nor more than 49 current employees, all dates in this subdivision become July 1, 1995, and any reference to "after" a date becomes "on or after" July 1, 1995.

Sec. 35. Minnesota Statutes 1992, section 62L.05, subdivision 1, is amended to read:

Subdivision 1. [TWO SMALL EMPLOYER PLANS.] Each health carrier in the small employer market must make available, on a guaranteed issue basis, to any small employer that satisfies the contribution and participation requirements of section 62L.03, subdivision 3, both of the small employer plans described in subdivisions 2 and 3. Under subdivisions 2 and 3, coinsurance and deductibles do not apply to child health supervision services and prenatal services, as defined by section 62A.047. The maximum out-of-pocket costs for covered services must be $3,000 per individual and $6,000 per family per year. The maximum lifetime benefit must be $500,000. ~~The out-of-pocket cost limits and the deductible amounts provided in subdivision 2 must be adjusted on July 1 every two years, based upon changes in the consumer price index, as of the end of the previous calendar year, as determined by the commissioner of commerce. Adjustments must be in increments of $50 and must not be made unless at least that amount of adjustment is required.~~

Sec. 36. Minnesota Statutes 1992, section 62L.05, subdivision 5, is amended to read:

Subd. 5. [PLAN VARIATIONS.] (a) No health carrier shall offer to a small employer a health benefit plan that differs from the two small employer plans described in subdivisions 1 to 4, unless the health benefit plan complies with all provisions of chapters 62A, 62C, 62D, 62E, 62H, 62N, and 64B that otherwise apply to the health carrier, except as expressly permitted by paragraph (b).

(b) As an exception to paragraph (a), a health benefit plan is deemed to be a small employer plan and to be in compliance with paragraph (a) if it differs from one of the two small employer plans described in subdivisions 1 to 4 only by providing benefits in addition to those described in subdivision 4, provided that the health ~~care~~ benefit plan has an actuarial value that exceeds the actuarial value of the benefits described in subdivision 4 by no more than two percent. "Benefits in addition" means additional units of a benefit listed in subdivision 4 or one or more benefits not listed in subdivision 4.

Sec. 37. Minnesota Statutes 1992, section 62L.05, subdivision 8, is amended to read:

Subd. 8. [CONTINUATION COVERAGE.] Small employer plans must include the continuation of coverage provisions required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law Number 99-272, as amended ~~through December 31, 1991~~, and by state law.

Sec. 38. Minnesota Statutes 1992, section 62L.08, subdivision 2, is amended to read:

Subd. 2. [GENERAL PREMIUM VARIATIONS.] Beginning July 1, 1993, each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, industry of the employer, and duration of coverage from the date of issue. For purposes of this subdivision, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined to be actuarially valid and approved by the commissioner. Variations permitted under this subdivision must not be based upon age or applied differently at different ages. This subdivision does not prohibit use of a constant percentage adjustment for factors permitted to be used under this subdivision.

Sec. 39. Minnesota Statutes 1993 Supplement, section 62L.08, subdivision 4, is amended to read:

Subd. 4. [GEOGRAPHIC PREMIUM VARIATIONS.] A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. A health carrier may also request approval to establish one or more additional geographic ~~region~~ regions and ~~a~~ one or more separate index ~~rate~~ rates for premiums for employees working and residing outside of Minnesota~~, and that index rate must not be more than 30 percent higher than the next highest index rate~~. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) if one geographic region is rural, the index rate for the rural region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area;

(4) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

Sec. 40. Minnesota Statutes 1992, section 62L.08, subdivision 5, is amended to read:

Subd. 5. [GENDER-BASED RATES PROHIBITED.] Beginning July 1, 1993, no health carrier may determine premium rates through a method that is in any way based upon the gender of eligible employees or dependents. Rates must not in any way reflect marital status or generalized differences in expected costs between employees and spouses.

Sec. 41. Minnesota Statutes 1992, section 62L.08, subdivision 6, is amended to read:

Subd. 6. [RATE CELLS PERMITTED.] Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based on the number of adults and children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect marital status or differences in expected costs between employees and spouses.

Sec. 42. Minnesota Statutes 1992, section 62L.08, subdivision 7, is amended to read:

Subd. 7. [INDEX AND PREMIUM RATE DEVELOPMENT.] (a) In developing its index rates and premiums, a health carrier may take into account only the following factors:

(1) actuarially valid differences in benefit designs of health benefit plans;

(2) actuarially valid differences in the rating factors permitted in subdivisions 2 and 3;

(3) actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4.

(b) All premium variations permitted under this section must be based upon actuarially valid differences in expected cost to the health carrier of providing coverage. The variation must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All premium variations are subject to approval by the commissioner.

Sec. 43. Minnesota Statutes 1993 Supplement, section 62L.08, subdivision 8, is amended to read:

Subd. 8. [FILING REQUIREMENT.] No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates. The rates shall not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. For premium rates proposed to go into effect between July 1, 1993 and December 31, 1993, the pertinent growth rate is the growth rate applied under section 62J.04, subdivision 1, paragraph (b), to calendar year 1994. ~~As provided in section 62A.65, subdivision 3, this subdivision applies to the individual market, as well as to the small employer market.~~

Sec. 44. Minnesota Statutes 1992, section 62L.12, is amended to read:

62L.12 [PROHIBITED PRACTICES.]

Subdivision 1. [PROHIBITION ON ISSUANCE OF INDIVIDUAL POLICIES.] A health carrier operating in the small employer market shall not knowingly offer, issue, or renew an individual ~~policy, subscriber contract, or certificate~~ health plan to an eligible employee ~~or dependent~~ of a small employer that meets the minimum participation and contribution requirements ~~defined in~~ under section 62L.03, subdivision 3, except as authorized under subdivision 2.

Subd. 2. [EXCEPTIONS.] (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees and dependents.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees and dependents as required.

(e) A health carrier may sell, issue, or renew individual ~~coverage~~ health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group ~~coverage~~ health plan or due to the person's need for health care services not covered under the employer's ~~group policy~~ group health plan.

(f) A health carrier may sell, issue, or renew an individual ~~policy, with the prior consent of the commissioner,~~ health plan, if the individual has elected to buy the individual ~~coverage~~ health plan not as part of a general plan to substitute individual ~~coverage~~ health plans for a group ~~coverage~~ health plan nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

(h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.31 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et. seq., as amended.

(i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

Subd. 3. [AGENT'S LICENSURE.] An agent licensed under chapter ~~60A~~ 60K or section 62C.17 who knowingly and willfully breaks apart a small group for the purpose of selling individual ~~policies~~ health plans to eligible employees and dependents of a small employer that meets the participation and contribution requirements of section 62L.03, subdivision 3, is guilty of an unfair trade practice and subject to disciplinary action, including the revocation or suspension of license, under section ~~60A.17, subdivision 6c,~~ 60K.11 or 62C.17. The action must be by order and subject to the notice, hearing, and appeal procedures specified in section ~~60A.17, subdivision 6d~~ 60K.11. The action of the commissioner is subject to judicial review as provided under chapter 14.

Subd. 4. [EMPLOYER PROHIBITION.] A small employer shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another health carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.

Subd. 5. [SALE OF OTHER PRODUCTS.] A health carrier shall not condition the offer, sale, issuance, or renewal of a health benefit plan on the purchase by a small employer of other insurance products offered by the health carrier or a subsidiary or affiliate of the health carrier, including, but not limited to, life, disability, property, and general liability insurance. This prohibition does not apply to insurance products offered as a supplement to a health maintenance organization plan, including, but not limited to, supplemental benefit plans under section 62D.05, subdivision 6.

Sec. 45. Minnesota Statutes 1992, section 62L.21, subdivision 2, is amended to read:

Subd. 2. [ADJUSTMENT OF PREMIUM RATES.] The board of directors shall establish operating rules to allocate adjustments to the reinsurance premium charge of no more than minus 25 percent of the monthly reinsurance premium for health carriers that can demonstrate administrative efficiencies and cost-effective handling of equivalent risks. The adjustment must be made ~~annually on a retrospective basis~~ monthly, unless the board provides for a different interval in its operating rules. The operating rules must establish objective and measurable criteria which must be met by a health carrier in order to be eligible for an adjustment. These criteria must include consideration of efficiency attributable to case management, but not consideration of such factors as provider discounts.

Sec. 46. [REPEALER.]

(a) Minnesota Statutes 1992, sections 62E.51, 62E.52, 62E.53, 62E.531, 62E.54, and 62E.55 are repealed.

(b) Minnesota Statutes 1992, section 62A.02, subdivision 5, is repealed.

Sec. 47. [REVISOR INSTRUCTIONS.]

(a) The revisor of statutes shall change the name of the private employers insurance program established in Minnesota Statutes, section 43A.317 to the Minnesota employees insurance program, and the private employers insurance trust fund to the Minnesota employees insurance trust fund, wherever either term occurs in Minnesota Statutes or Minnesota Rules.

(b) The revisor of statutes shall renumber Minnesota Statutes 1992, section 62L.23, as section 62L.08, subdivision 11 and shall change all references to that section in Minnesota Statutes or Minnesota Rules accordingly.

Sec. 48. [EFFECTIVE DATES.]

Sections 1, 3 to 5, 8, 10, 12, 17 to 28, 30, 31, 33 to 42, and 44 to 47 are effective the day following final enactment. Sections 2, 6, 7, 13, 14, and 29 are effective July 1, 1994. Sections 9, 11, 15, 16, 23, 32, and 43 are effective January 1, 1995.

ARTICLE 11

HEALTH CARE COOPERATIVES

Section 1. Minnesota Statutes 1993 Supplement, section 62N.06, subdivision 1, is amended to read:

Subdivision 1. [AUTHORIZED ENTITIES.] (a) An integrated service network may be organized as a separate nonprofit corporation under chapter 317A or as a cooperative under chapter 308A or 308B.

(b) A nonprofit health carrier, as defined in section 62A.011, may establish and operate one or more integrated service networks without forming a separate corporation or cooperative, but only if all of the following conditions are met:

(i) a contract between the health carrier and a health care provider, for a term of less than seven years, that was executed before June 1, 1993, does not bind the health carrier or provider as applied to integrated service network services, except with the mutual consent of the health carrier and provider entered into on or after June 1, 1993. This clause does not apply to contracts between a health carrier and its salaried employees;

(ii) the health carrier shall not apply toward the net worth, working capital, or deposit requirements of this chapter any assets used to satisfy net worth, working capital, deposit, or other financial requirements under any other chapter of Minnesota law;

(iii) the health carrier shall not include in its premiums for health coverage provided under any other chapter of Minnesota law, an assessment or surcharge relating to net worth, working capital, or deposit requirements imposed upon the integrated service network under this chapter; and

(iv) the health carrier shall not include in its premiums for integrated service network coverage under this chapter an assessment or surcharge relating to net worth working capital or deposit requirements imposed upon health coverage offered under any other chapter of Minnesota law.

Sec. 2. Minnesota Statutes 1993 Supplement, section 80A.15, subdivision 2, is amended to read:

Subd. 2. The following transactions are exempted from sections 80A.08 and 80A.16:

(a) Any sales, whether or not effected through a broker-dealer, provided that no person shall make more than ten sales of securities of the same issuer pursuant to this exemption during any period of 12 consecutive months; provided further, that in the case of sales by an issuer, except sales of securities registered under the Securities Act of 1933 or exempted by section 3(b) of that act, (1) the seller reasonably believes that all buyers are purchasing for investment, and (2) the securities are not advertised for sale to the general public in newspapers or other publications of general circulation or otherwise, or by radio, television, electronic means or similar communications media, or through a program of general solicitation by means of mail or telephone.

(b) Any nonissuer distribution of an outstanding security if (1) either Moody's, Fitch's, or Standard & Poor's Securities Manuals, or other recognized manuals approved by the commissioner contains the names of the issuer's officers and directors, a balance sheet of the issuer as of a date not more than 18 months prior to the date of the sale, and a profit and loss statement for the fiscal year preceding the date of the balance sheet, and (2) the issuer or its predecessor has been in active, continuous business operation for the five-year period next preceding the date of sale, and (3) if the security has a fixed maturity or fixed interest or dividend provision, the issuer has not, within the three preceding fiscal years, defaulted in payment of principal, interest, or dividends on the securities.

(c) The execution of any orders by a licensed broker-dealer for the purchase or sale of any security, pursuant to an unsolicited offer to purchase or sell; provided that the broker-dealer acts as agent for the purchaser or seller, and has no direct material interest in the sale or distribution of the security, receives no commission, profit, or other compensation from any source other than the purchaser and seller and delivers to the purchaser and seller written confirmation of the transaction which clearly itemizes the commission, or other compensation.

(d) Any nonissuer sale of notes or bonds secured by a mortgage lien if the entire mortgage, together with all notes or bonds secured thereby, is sold to a single purchaser at a single sale.

(e) Any judicial sale, exchange, or issuance of securities made pursuant to an order of a court of competent jurisdiction.

(f) The sale, by a pledge holder, of a security pledged in good faith as collateral for a bona fide debt.

(g) Any offer or sale to a bank, savings institution, trust company, insurance company, investment company as defined in the Investment Company Act of 1940, pension or profit sharing trust, or other financial institution or institutional buyer, or to a broker-dealer, whether the purchaser is acting for itself or in some fiduciary capacity.

(h) Any sales by an issuer to the number of persons that shall not exceed 25 persons in this state, or 35 persons if the sales are made in compliance with Regulation D promulgated by the Securities and Exchange Commission, Code of Federal Regulations, title 17, sections 230.501 to 230.506, (other than those designated in paragraph (a) or (g)), whether or not any of the purchasers is then present in this state, if (1) the issuer reasonably believes that all of the buyers in this state (other than those designated in clause (g)) are purchasing for investment, and (2) no commission or other remuneration is paid or given directly or indirectly for soliciting any prospective buyer in this state (other than those designated in clause (g)), except reasonable and customary commissions paid by the issuer to a broker-dealer licensed under this chapter, and (3) the issuer has, ten days prior to any sale pursuant to this paragraph, supplied the commissioner with a statement of issuer on forms prescribed by the commissioner, containing the following information: (i) the name and address of the issuer, and the date and state of its organization; (ii) the number of units, price per unit, and a description of the securities to be sold; (iii) the amount of commissions to be paid and the persons to whom they will be paid; (iv) the names of all officers, directors and persons owning five percent or more of the equity of the issuer; (v) a brief description of the intended use of proceeds; (vi) a description of all sales of securities made by the issuer within the six-month period next preceding the date of filing; and (vii)

a copy of the investment letter, if any, intended to be used in connection with any sale. Sales that are made more than six months before the start of an offering made pursuant to this exemption or are made more than six months after completion of an offering made pursuant to this exemption will not be considered part of the offering, so long as during those six-month periods there are no sales of unregistered securities (other than those made pursuant to paragraph (a) or (g)) by or for the issuer that are of the same or similar class as those sold under this exemption. The commissioner may by rule or order as to any security or transaction or any type of security or transaction, withdraw or further condition this exemption, or increase the number of offers and sales permitted, or waive the conditions in clause (1), (2), or (3) with or without the substitution of a limitation or remuneration.

(i) Any offer (but not a sale) of a security for which a registration statement has been filed under sections 80A.01 to 80A.31, if no stop order or refusal order is in effect and no public proceeding or examination looking toward an order is pending; and any offer of a security if the sale of the security is or would be exempt under this section. The commissioner may by rule exempt offers (but not sales) of securities for which a registration statement has been filed as the commissioner deems appropriate, consistent with the purposes of sections 80A.01 to 80A.31.

(j) The offer and sale by a cooperative association organized under chapter 308A or 308B, of its securities when the securities are offered and sold only to its members, or when the purchase of the securities is necessary or incidental to establishing membership in such association, or when such securities are issued as patronage dividends.

(l) The issuance and delivery of any securities of one corporation to another corporation or its security holders in connection with a merger, exchange of shares, or transfer of assets whereby the approval of stockholders of the other corporation is required to be obtained, provided, that the commissioner has been furnished with a general description of the transaction and with other information as the commissioner by rule prescribes not less than ten days prior to the issuance and delivery.

(m) Any transaction between the issuer or other person on whose behalf the offering is made and an underwriter or among underwriters.

(n) The distribution by a corporation of its or other securities to its own security holders as a stock dividend or as a dividend from earnings or surplus or as a liquidating distribution; or upon conversion of an outstanding convertible security; or pursuant to a stock split or reverse stock split.

(o) Any offer or sale of securities by an affiliate of the issuer thereof if: (1) a registration statement is in effect with respect to securities of the same class of the issuer and (2) the offer or sale has been exempted from registration by rule or order of the commissioner.

(p) Any transaction pursuant to an offer to existing security holders of the issuer, including persons who at the time of the transaction are holders of convertible securities, nontransferable warrants, or transferable warrants exercisable within not more than 90 days of their issuance, if: (1) no commission or other remuneration (other than a standby commission) is paid or given directly or indirectly for soliciting any security holder in this state; and (2) the commissioner has been furnished with a general description of the transaction and with other information as the commissioner may by rule prescribe no less than ten days prior to the transaction.

(q) Any nonissuer sales of any security, including a revenue obligation, issued by the state of Minnesota or any of its political or governmental subdivisions, municipalities, governmental agencies, or instrumentalities.

Sec. 3. Minnesota Statutes 1992, section 290.092, subdivision 2, is amended to read:

Subd. 2. [EXEMPTIONS.] Corporations subject to tax under sections 290.05, subdivision 3; or 60A.15, subdivision 1, and 290.35; real estate investment trusts; regulated investment companies as defined in section 851(a) of the Internal Revenue Code of 1986 or funds of regulated investment companies as defined in section 851(h) of the Internal Revenue Code of 1986, as amended through December 31, 1991; cooperatives taxable under subchapter T of the Internal Revenue Code of 1986 or organized under chapter 308A or 308B or a similar law of another state; and entities having a valid election in effect under section 1362 or 860D(b) of the Internal Revenue Code of 1986, as amended through December 31, 1991, are not subject to the tax imposed in subdivision 1 or 5.

Sec. 4. [308B.01] [STATEMENT OF LEGISLATIVE PURPOSE AND INTENT.]

The legislature finds that the goals of containing health care costs, improving the quality of health care, and increasing the access of Minnesota citizens to health care services reflected under chapters 62J and 62N may be further enhanced through the promotion of health care cooperatives. The legislature further finds that locally based and

controlled efforts among health care providers, local businesses, units of local government, and health care consumers, can promote the attainment of the legislature's goals of health care reform, and takes notice of the long history of successful operations of cooperative organizations in this state. Therefore, in order to encourage cooperative efforts which are consistent with the goals of health care reform, including efforts among health care providers as sellers of health care services and efforts of consumers as buyers of health care services and health plan coverage, and to encourage the formation of and increase the competition among health plans in Minnesota, the legislature enacts the Minnesota health care cooperative act.

Sec. 5. [308B.02] [CITATION.]

This chapter may be cited as the "Minnesota health care cooperative act."

Sec. 6. [308B.03] [APPLICABILITY OF OTHER LAWS.]

Subdivision 1. [MINNESOTA COOPERATIVE LAW.] A health care cooperative organizing under this chapter is subject to chapter 308A unless otherwise provided in this chapter. After incorporation, a health care cooperative shall enjoy the powers and privileges and shall be subject to the duties and liabilities of other cooperatives organized under chapter 308A, to the extent applicable and except as limited or enlarged by this chapter. If any provision of this chapter conflicts with a provision of chapter 308A, the provision of this chapter takes precedence.

Subd. 2. [HEALTH PLAN LICENSURE AND OPERATION.] A health care network cooperative organized under this chapter must be licensed as a health maintenance organization licensed under chapter 62D, a nonprofit health service plan corporation licensed under chapter 62C, or a community integrated service network or an integrated service network licensed under chapter 62N, at the election of the health care network cooperative. The health care network cooperative shall be subject to the duties and liabilities of health plans licensed pursuant to the chapter under which the cooperative elects to be licensed, to the extent applicable and except as limited or enlarged by this chapter. If any provision of any chapter under which the cooperative elects to be licensed conflicts with the provisions of this chapter, the provisions of this chapter take precedence.

Subd. 3. [HEALTH PROVIDER COOPERATIVES.] A health provider cooperative organized under this chapter shall not be considered a mutual insurance company under chapter 60A, a health maintenance organization under chapter 62D, a nonprofit health services corporation under chapter 62C, or a community integrated service network or an integrated service network under chapter 62N. A health provider network shall not be considered to violate any limitations on the corporate practice of medicine. Health care service contracts under section 308B.06 shall not be considered to violate section 62J.23.

Sec. 7. [308B.04] [DEFINITIONS.]

Subdivision 1. [SCOPE.] For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. [HEALTH CARE COOPERATIVE.] "Health care cooperative" means a health care network cooperative or a health provider cooperative.

Subd. 3. [HEALTH CARE NETWORK COOPERATIVE.] "Health care network cooperative" means a corporation organized under this chapter and licensed in accordance with section 308B.03, subdivision 2. A health care network cooperative shall not have more than 50,000 enrollees, unless exceeding the enrollment limit is necessary to comply with guaranteed issue or guaranteed renewal requirements of chapter 62L or section 62A.65.

Subd. 4. [HEALTH PROVIDER COOPERATIVE.] "Health provider cooperative" means a corporation organized under this chapter and operated on a cooperative plan to market health care services to purchasers of those services.

Subd. 5. [MEMBER.] "Member" means:

(1) in the case of a health care network cooperative, the policyholder; if the policyholder is an individual enrollee, the individual enrollee is the member; if the policyholder is an employer or other group type, entity, or association, the group policyholder is the member;

(2) in the case of a health provider cooperative, the licensed health care provider, professional corporation, partnership, hospital, or other licensed institution, as provided in the cooperative's articles or bylaws.

Subd. 6. [COMMISSIONER.] Unless otherwise specified, "commissioner" means the commissioner of health for a health care network cooperative licensed under chapter 62D or 62N and the commissioner of commerce for a health care network cooperative licensed under chapter 62C.

Subd. 7. [HEALTH CARRIER.] "Health carrier" has the meaning provided in section 62A.011.

Subd. 8. [HEALTH CARE PROVIDING ENTITY.] "Health care providing entity" means a participating entity that provides health care to enrollees of a health care cooperative.

Sec. 8. [308B.05] [POWERS.]

In addition to the powers enumerated under section 308A.201, a health care cooperative shall have all of the powers granted a nonprofit corporation under section 317A.161, except to the extent expressly inconsistent with the provisions of chapter 308A.

Sec. 9. [308B.06] [HEALTH CARE SERVICE CONTRACTS.]

Subdivision 1. [PROVIDER CONTRACTS.] A health provider cooperative and its licensed members may execute marketing and service contracts requiring the provider members to provide some or all of their health care services through the provider cooperative to the enrollees, members, subscribers, or insureds, of a health care network cooperative, community integrated service network, integrated service network, nonprofit health service plan, health maintenance organization, accident and health insurance company, or any other purchaser, including the state of Minnesota and its agencies, instruments, or units of local government. Each purchasing entity is authorized to execute contracts for the purchase of health care services from a health provider cooperative in accordance with this section. Any contract between a provider cooperative and a purchaser must provide for payment by the purchaser to the health provider cooperative on a substantially capitated or similar risk-sharing basis. Each contract between a provider cooperative and a purchaser shall be filed by the provider network cooperative with the commissioner of health and is subject to the provisions of section 62D.19.

Subd. 2. [NO NETWORK LIMITATION.] A health care network cooperative may contract with any health provider cooperative and may contract with any other licensed health care provider to provide health care services for its enrollees.

Sec. 10. [308B.07] [AMENDMENT OF ARTICLES.]

The articles of a health care cooperative incorporated under this chapter shall be amended as provided in section 317A.131.

Sec. 11. [308B.08] [AMENDMENT OF BYLAWS.]

The bylaws of a health care cooperative incorporated under this chapter shall be amended as provided in section 317A.181.

Sec. 12. [308B.09] [VOTING.]

Subdivision 1. [ELECTION OF DIRECTORS.] Directors of health care cooperatives shall be elected in the manner provided in section 308A.311 with the exception of subdivision 4 of that section. Any requirements applicable to directors under chapters 60A and 62A, 62C, 62D, or 62N do not apply.

Subd. 2. [VOTE BY MAIL.] (a) A member may vote by mail for a director unless mail voting is prohibited for election of directors by the articles or bylaws.

(b) The ballot must be in a form prescribed by the board.

(c) The member shall mark the ballot for the candidate chosen and mail the ballot to the cooperative in a sealed plain envelope inside another envelope bearing the member's name.

(d) If the ballot of the member is received by the cooperative on or before the date of the regular members' meeting, the ballot must be accepted and counted as the vote of the absent member.

Subd. 3. [VOTING GENERALLY.] The requirements and procedures for membership voting for each health care cooperative shall be as provided in the bylaws.

Sec. 13. [308B.10] [GOVERNMENTAL PARTICIPATION.]

The state of Minnesota, or any agency, instrumentality, or unit of local government, may be a member of a health care cooperative. Any governmental hospital authorized, organized, or operated under chapters 158, 250, 376, and 397, or under sections 246A.01 to 246A.27, 412.221, 447.05 to 447.13, or 471.50, or under any special law authorizing or establishing a hospital or hospital district, may be a member of a health care provider cooperative.

Sec. 14. [308B.11] [RELICENSURE.]

(a) A health care network cooperative licensed under chapter 62C or 62D may relinquish that license and be granted a new license as a community integrated service network or an integrated service network under chapter 62N in accordance with this section, provided that the cooperative meets all requirements for licensure as a network under chapter 62N, to the extent not expressly inconsistent with the provisions of chapters 308A and 308B.

(b) The relicensure shall be effective at the time specified in the plan of relicensure, which must not be earlier than the date upon which the previous license is surrendered.

(c) Upon the relicensure of the cooperative as a community integrated service network or an integrated service network:

(1) all existing group and individual enrollee benefit contracts in force on the effective date of the relicensure shall continue in effect and with the same terms and conditions, notwithstanding the cooperative's new licensure as a network, until the date of each contract's next renewal or amendment, but no later than one year from the date of the relicensure. At this time, each benefit contract then in force must be amended to comply with all statutory and regulatory requirements for network benefit contracts as of that date; and

(2) all contracts between the cooperative and any health care providing entity, including a health care provider cooperative, in force on the effective date of relicensure shall remain in effect under the cooperative's new licensure as a network until the date of the next renewal or amendment of that contract, but no later than one year from the date of relicensure.

(d) Except as otherwise provided in this section, nothing in the relicensure of a health care network cooperative shall in any way affect its corporate existence or any of its contracts, rights, privileges, immunities, powers or franchises, debts, duties or other obligations or liabilities.

ARTICLE 12

RURAL HEALTH INITIATIVES

Section 1. Minnesota Statutes 1993 Supplement, section 62N.23, is amended to read:

62N.23 [TECHNICAL ASSISTANCE; LOANS.]

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

The technical assistance program shall offer seminars on the establishment and operation of 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 an integrated service network. The guide must provide basic instructions for parties wishing to establish an 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 an integrated service network.

(b) The commissioner~~, in consultation with the commission, shall provide recommendations for the creation of a loan program that would provide loans or grants to entities forming integrated service networks or to networks less than one year old. The commissioner shall propose criteria for the loan program.~~ shall grant loans for organizational

and start-up expenses to entities forming community integrated service networks or 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 and is exempt from rulemaking in doing so.

Sec. 2. Minnesota Statutes 1993 Supplement, section 144.1464, is amended to read:

144.1464 [SUMMER HEALTH CARE INTERNS.]

Subdivision 1. [SUMMER INTERNSHIPS.] The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants to hospitals and clinics to establish a secondary and post-secondary summer health care intern program. The purpose of the program is to expose interested ~~high school~~ secondary and post-secondary pupils to various careers within the health care profession.

Subd. 2. [CRITERIA.] (a) The commissioner, through the organization under contract, shall award grants to hospitals and clinics that agree to:

(1) provide secondary and post-secondary summer health care interns with formal exposure to the health care profession;

(2) provide an orientation for the secondary and post-secondary summer health care interns;

(3) pay one-half the costs of employing ~~a~~ the secondary and post-secondary summer health care intern, based on an overall hourly wage that is at least the minimum wage but does not exceed $6 an hour; and

(4) interview and hire secondary and post-secondary pupils for a minimum of six weeks and a maximum of 12 weeks.

(b) In order to be eligible to be hired as a secondary summer health intern by a hospital or clinic, a pupil must:

(1) intend to complete high school graduation requirements and be between the junior and senior year of high school;

(2) be from a school district in proximity to the facility; and

(3) provide the facility with a letter of recommendation from a health occupations or science educator.

(c) In order to be eligible to be hired as a post-secondary summer health care intern by a hospital or clinic, a pupil must:

(1) intend to complete a two-year or four-year degree program and be planning on enrolling in or be enrolled in that degree program;

(2) be from a school district or attend an educational institution in proximity to the facility; and

(3) provide the facility with a letter of recommendation from a health occupations or science educator.

(d) Hospitals and clinics awarded grants may employ pupils as secondary and post-secondary summer health care interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period before disbursement of state grant money, with money designated as the facility's 50 percent contribution towards internship costs.

Subd. 3. [GRANTS.] The commissioner, through the organization under contract, shall award separate grants to hospitals and clinics meeting the requirements of subdivision 2. The grants must be used to pay one-half of the costs of employing ~~a pupil~~ secondary and post-secondary pupils in a hospital or clinic during the course of the program. No more than five pupils may be selected from any ~~one high school~~ secondary or post-secondary institution to participate in the program and no more than one-half of the number of pupils selected may be from the seven-county metropolitan area.

Subd. 4. [CONTRACT.] The commissioner shall contract with a statewide, nonprofit organization representing facilities at which secondary and post-secondary summer health care interns will serve, to administer the grant program established by this section. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program, in the form and at the times specified by the commissioner.

Sec. 3. [144.1471] [EMERGENCY ROOM COVERAGE GRANT PROGRAM.]

Subdivision 1. [GRANT AWARDS.] The commissioner shall establish a grant program to improve access to quality and efficient emergency medical care. The commissioner shall award grants to small, rural hospitals that:

(1) agree to utilize the grant to maintain and keep open an emergency room, 24 hours a day, seven days a week; and

(2) meet the criteria in subdivision 2.

Subd. 2. [CRITERIA.] In order to be eligible for a grant, a hospital must:

(1) be a licensed acute-care hospital operating in the state;

(2) not be financially able to keep its emergency room open 24 hours a day, seven days a week;

(3) have fewer than three medical doctors on staff; and

(4) have fewer than 50 licensed hospital beds.

Sec. 4. [RURAL MEDICAL SCHOOL PLANNING GRANT.]

The higher education coordinating board shall award a planning grant to a post-secondary institution located in St. Louis county to expand its currently existing two-year medical school program to a four-year medical school program. The newly established four-year medical school program must focus on the training of primary care physicians who are likely to practice in rural areas of the state. If the board of regents of the University of Minnesota accepts the funding appropriated for the planning grant, it shall comply with the duties for which the appropriation is made.

Sec. 5. [PHYSICAL THERAPIST DEGREE PROGRAM.]

The higher education coordinating board shall study the need for the expansion of certified physical therapists degree programs at post-secondary institutions located in the northwestern and southwestern parts of the state of Minnesota. The higher education coordinating board shall also explore the option of telecommunications to provide greater access to physical therapist programs. The higher education coordinating board shall present recommendations to the legislature by January 15, 1995.

ARTICLE 13

FINANCING

Section 1. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

Subd. 2a. [DELIVERED OUTSIDE OF MINNESOTA.] "Delivered outside of Minnesota" means property which the seller delivers to a common carrier for delivery outside Minnesota, places in the United States mail or parcel post directed to the purchaser outside Minnesota, or delivers to the purchaser outside Minnesota by means of the seller's own delivery vehicles, and which is not later returned to a point within Minnesota, except in the course of interstate commerce.

Sec. 2. Minnesota Statutes 1993 Supplement, section 295.50, subdivision 3, is amended to read:

Subd. 3. [GROSS REVENUES.] "Gross revenues" are total amounts received in money or otherwise by:

(1) a resident hospital for patient services;

(2) a resident surgical center for patient services;

(3) a nonresident hospital for patient services provided to patients domiciled in Minnesota;

(4) a nonresident surgical center for patient services provided to patients domiciled in Minnesota;

(5) a resident health care provider, other than a staff model health carrier, for patient services;

(6) a nonresident health care provider for patient services provided to an individual domiciled in Minnesota;

(7) a wholesale drug distributor for sale or distribution of ~~prescription~~ legend drugs that are delivered: (i) to a Minnesota resident by a wholesale drug distributor who is a nonresident pharmacy directly, by common carrier, or by mail; or (ii) in Minnesota by the wholesale drug distributor, by common carrier, or by mail, unless the ~~prescription~~ legend drugs are delivered to another wholesale drug distributor who sells legend drugs exclusively at wholesale. ~~Prescription~~ Legend drugs do not include nutritional products as defined in Minnesota Rules, part 9505.0325;

(8) a staff model health ~~carrier~~ plan company as gross premiums for enrollees, copayments, deductibles, coinsurance, and fees for patient services covered under its contracts with groups and enrollees;

(9) a resident pharmacy for medical supplies, appliances, and equipment; and

(10) a nonresident pharmacy for medical supplies, appliances, and equipment.

Sec. 3. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

Subd. 6a. [HOSPICE CARE SERVICES.] "Hospice care services" are services:

(1) as defined in Minnesota Rules, part 9505.0297; and

(2) provided at a recipient's residence, if the recipient does not live in a hospital, nursing facility as defined in section 62A.46, subdivision 3, or intermediate care facility for persons with mental retardation as defined in section 256B.055, subdivision 12, paragraph (d).

Sec. 4. Minnesota Statutes 1992, section 295.50, is amended by adding a subdivision to read:

Subd. 15. [LEGEND DRUG.] "Legend drug" means a legend drug as defined in section 151.01, subdivision 17.

Sec. 5. Minnesota Statutes 1993 Supplement, section 295.52, subdivision 5, is amended to read:

Subd. 5. [VOLUNTEER AMBULANCE SERVICES.] ~~Licensed~~ Volunteer ambulance services ~~for which all the ambulance attendants are "volunteer ambulance attendants" as defined in section 144.8091, subdivision 2,~~ are not subject to the tax under this section. For purposes of this requirement, "volunteer ambulance service" means an ambulance service in which all of the individuals whose primary responsibility is direct patient care meet the definition of volunteer under section 144.8091, subdivision 2. The ambulance service may employ administrative and support staff, and remain eligible for this exemption, if the primary responsibility of these staff is not direct patient care.

Sec. 6. Minnesota Statutes 1993 Supplement, section 295.53, subdivision 1, is amended to read:

Subdivision 1. [EXEMPTIONS.] The following payments are excluded from the gross revenues subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.57:

(1) payments received for services provided under the Medicare program, including payments received from the government, and organizations governed by sections 1833 and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, and enrollee deductibles, coinsurance, and copayments, whether paid by the individual or by insurer or other third party. Payments for services not covered by Medicare are taxable;

(2) medical assistance payments including payments received directly from the government or from a prepaid plan;

(3) payments received for home health care services;

(4) payments received from hospitals or surgical centers for goods and services on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), (2), (7), (8), or (10);

(5) payments received from health care providers for goods and services on which liability for tax is imposed under sections 295.52 to 295.57 or the source of funds for the payment is exempt under clause (1), (2), (7), (8), or (10);

(6) amounts paid for ~~prescription~~ legend drugs, other than nutritional products, to a wholesale drug distributor reduced by reimbursements received for prescription drugs under clauses (1), (2), (7), and (8);

(7) payments received under the general assistance medical care program including payments received directly from the government or from a prepaid plan;

(8) payments received for providing services under the MinnesotaCare program including payments received directly from the government or from a prepaid plan and enrollee deductibles, coinsurance, and copayments;

(9) payments received by a resident health care provider or the wholly owned subsidiary of a resident health care provider for care provided outside Minnesota to a patient who is not domiciled in Minnesota;

(10) payments received from the chemical dependency fund under chapter 254B;

(11) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

(12) payments received for providing patient services if the services are incidental to conducting medical research;

(13) payments received from any governmental agency for services benefiting the public, not including payments made by the government in its capacity as an employer or insurer;

(14) payments received for services provided by community residential mental health facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690, community support programs and family community support programs approved under Minnesota Rules, parts 9535.1700 to 9535.1760, and community mental health centers as defined in section 245.62, subdivision 2; ~~and~~

(15) government payments received by a regional treatment center;

(16) payments received for hospice care services;

(17) payments received by a resident health care provider or the wholly owned subsidiary of a resident health care provider for medical supplies, appliances and equipment delivered outside of Minnesota;

(18) payments from student fees received by a university or college student health service; and

(19) payments received for services provided by: residential care homes licensed under chapter 144B; board and lodging establishments providing only custodial services, that are licensed under chapter 157 and registered under section 157.031 to provide supportive services or health supervision services; and assisted living programs, congregate housing programs, and other senior housing options.

Sec. 7. Minnesota Statutes 1993 Supplement, section 295.53, subdivision 2, is amended to read:

Subd. 2. [DEDUCTIONS FOR STAFF MODEL HEALTH ~~CARRIERS~~ PLAN COMPANY.] In addition to the exemptions allowed under subdivision 1, a staff model health ~~carrier~~ plan company may deduct from its gross revenues for the year:

(1) amounts paid to hospitals, surgical centers, and health care providers that are not employees of the staff model health ~~carrier~~ plan company for services on which liability for the tax is imposed under section 295.52;

(2) amounts added to reserves, if total reserves do not exceed 200 percent of the statutory net worth requirement, the calculation of which may be determined on a consolidated basis, taking into account the amounts held in reserve by affiliated staff model health ~~carriers~~ plan companies;

(3) assessments for the comprehensive health insurance plan under section 62E.11; and

(4) amounts spent for administration as reported as total administration to the department of health in the statement of revenues, expenses, and net worth pursuant to section 62D.08, subdivision 3, clause (a).

Sec. 8. Minnesota Statutes 1993 Supplement, section 295.53, subdivision 5, is amended to read:

Subd. 5. [DEDUCTIONS FOR PHARMACIES.] (a) Pharmacies may deduct from their gross revenues subject to tax payments for medical supplies, appliances, and devices that are exempt under subdivision 1, except payments under subdivision 1, clauses (3), (6), (9), (11), and (14).

(b) Resident pharmacies may deduct from their gross revenues subject to tax payments received for medical supplies, appliances, and equipment delivered outside of Minnesota.

Sec. 9. Minnesota Statutes 1993 Supplement, section 295.54, is amended to read:

295.54 [CREDIT FOR TAXES PAID ~~TO ANOTHER STATE~~.]

Subdivision 1. [TAXES PAID TO ANOTHER STATE.] A resident hospital, resident surgical center, pharmacy, or resident health care provider who is liable for taxes payable to another state or province or territory of Canada measured by gross receipts and is subject to tax under section 295.52 is entitled to a credit for the tax paid to another state or province or territory of Canada to the extent of the lesser of (1) the tax actually paid to the other state or province or territory of Canada, or (2) the amount of tax imposed by Minnesota on the gross receipts subject to tax in the other taxing jurisdictions.

Subd. 2. [PHARMACY CREDIT.] A resident pharmacy may claim a quarterly credit against the total amount of tax the pharmacy owes during that quarter under section 295.52, subdivision 1b, as provided in this subdivision. The credit shall equal two percent of the amount paid by the pharmacy to a wholesale drug distributor subject to tax under section 295.52, subdivision 3, for legend drugs delivered by the pharmacy outside of Minnesota. If the amount of the credit exceeds the tax liability of the pharmacy under section 295.52, subdivision 1b, the commissioner shall provide the pharmacy with a refund equal to the excess amount.

Sec. 10. Minnesota Statutes 1992, section 295.55, subdivision 2, is amended to read:

Subd. 2. [ESTIMATED TAX; HOSPITALS; SURGICAL CENTERS.] (a) Each hospital or surgical center must make estimated payments of the taxes for the calendar year in monthly installments to the commissioner within ten days after the end of the month.

(b) Estimated tax payments are not required of hospitals or surgical centers if the tax for the calendar year is less than $500 or if ~~the~~ a hospital has been allowed a grant under section 144.1484, subdivision 2, for the year.

(c) Underpayment of estimated installments bear interest at the rate specified in section 270.75, from the due date of the payment until paid or until the due date of the annual return at the rate specified in section 270.75. An underpayment of an estimated installment is the difference between the amount paid and the lesser of (1) 90 percent of one-twelfth of the tax for the calendar year or (2) the tax for the actual gross revenues received during the month.

Sec. 11. Minnesota Statutes 1992, section 295.55, subdivision 3, is amended to read:

Subd. 3. [ESTIMATED TAX; OTHER TAXPAYERS.] (a) Each taxpayer, other than a hospital or surgical center, must make estimated payments of the taxes for the calendar year in quarterly installments to the commissioner by April 15, July 15, October 15, and January 15 of the following calendar year.

(b) Estimated tax payments are not required if the tax for the calendar year is less than $500.

(c) Underpayment of estimated installments bear interest at the rate specified in section 270.75, from the due date of the payment until paid or until the due date of the annual return at the rate specified in section 270.75. An underpayment of an estimated installment is the difference between the amount paid and the lesser of (1) 90 percent of one-quarter of the tax for the calendar year or (2) the tax for the actual gross revenues received during the quarter.

Sec. 12. Minnesota Statutes 1993 Supplement, section 295.58, is amended to read:

295.58 [DEPOSIT OF REVENUES AND PAYMENT OF REFUNDS.]

The commissioner shall deposit all revenues, including penalties and interest, derived from the taxes imposed by sections 295.50 to 295.57 and from the insurance premiums tax on health maintenance organizations, community integrated service networks, integrated service networks, and nonprofit health service plan corporations in the health care access fund in the state treasury. Refunds of overpayments must be paid from the health care access fund in the state treasury. There is annually appropriated from the health care access fund to the commissioner of revenue the amount necessary to make any refunds required under section 295.54.

Sec. 13. Minnesota Statutes 1993 Supplement, section 295.582, is amended to read:

295.582 [AUTHORITY.]

(a) A hospital, surgical center, pharmacy, or health care provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor, may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. The expense must not exceed two percent of the gross revenues received under the third-party contract, ~~including~~ plus two percent of copayments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, ~~or 62H,~~ 65A, 65B, 79, or 79A, or under section 471.61 or 471.617, must pay the transferred expense in addition to any payments due under existing ~~or future~~ contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. A third-party purchaser of health care services includes, but is not limited to, a health carrier, integrated service network, or community integrated service network that pays for health care services on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures patients for health care services. A third-party purchaser shall comply with this section regardless of whether the third-party purchaser is a for-profit, not-for-profit, or nonprofit entity. A wholesale drug distributor may transfer additional expense generated by section 295.52 obligations to entities that purchase from the wholesaler. Nothing in this ~~subdivision~~ section limits the ability of a hospital, surgical center, pharmacy, wholesale drug distributor, or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

(b) Each third-party purchaser regulated under any chapter cited in paragraph (a) shall include with its annual renewal for certification of authority or licensure documentation indicating compliance with paragraph (a). If the commissioner responsible for regulating the third-party purchaser finds at any time that the third-party purchaser has not complied with paragraph (a) the commissioner may by order fine or censure the third-party purchaser or revoke or suspend the certificate of authority or license of the third-party purchaser to do business in this state. The third-party purchaser may appeal the commissioner's order through a contested case hearing in accordance with chapter 14.

Sec. 14. Laws 1992, chapter 549, article 9, section 22, is amended to read:

Sec. 22. [GROSS RECEIPTS TAX; EFFECTIVE DATE.]

Sections 1 and 16 to 21 are effective the day following final enactment. Section 4 is effective for taxable years beginning after December 31, 1992. Section 7, subdivision 1, is effective for gross revenues generated by services performed and goods sold after December 31, 1992. Section 7, subdivisions 2 to 4, are effective for gross revenues generated by services performed and goods sold after December 31, 1993. Section 8 is effective for hospitals and surgical centers for gross revenues generated by services performed and goods sold after December 31, 1992, except the exclusion under subdivision 1, clause (6) applies to payments for prescription drug purchases made after December 31, 1993. Section 8 is effective for health care providers for gross revenues generated by services performed and goods sold after December 31, 1993, except the exclusion under subdivision 1, clause (6) applies to payments for prescription drug purchases made after December 31, 1993. Sections 14 and 15 are effective July 1, 1992.

Sec. 15. [CLARIFICATION; STATEMENT OF INTENT.]

The amendment in section 14 corrects and clarifies an effective date in the 1992 legislation enacting the gross receipts tax on hospitals and health care providers. This legislation imposed a gross receipts tax on hospitals effective January 1, 1993 and on health care providers and wholesale drug distributors effective January 1, 1994. To avoid double taxation or pyramiding of the tax burden, hospitals and health care providers were allowed an exclusion for amounts paid to wholesale drug distributors for prescription drugs. These amounts would already be taxed to the wholesale drug distributors. The section creating this exclusion did not contain an effective date. As a result, under Minnesota Statutes, section 645.02, the law may permit hospitals to deduct these amounts for prescription drugs purchased during 1993, even though no tax was imposed on the wholesale drug distributor and no double taxation or pyramiding of the tax could occur. Section 14 corrects this by providing an explicit effective date that makes it clear that the exclusion applies only after the wholesale drug distributor tax goes into effect.

Sec. 16. [EFFECTIVE DATES.]

(a) Sections 5, 7, and 12 are effective the day following final enactment.

(b) Sections 1, 3, 8, and 9 and the section 13 amendment to section 295.582, creating paragraph (b), are effective July 1, 1994. The section 6 amendment to section 295.53, subdivision 1, creating clauses (16) to (18), is effective July 1, 1994.

(c) Section 4 is effective retroactively from January 1, 1994. Section 2 amending section 295.50, subdivision 3, and the section 6 amendment to section 295.53, subdivision 1, clause (6), are effective retroactively from January 1, 1994.

(d) The section 13 amendment to section 295.582, paragraph (a), is effective retroactively from January 1, 1993, except that it is effective for pharmacies and wholesale drug distributors July 1, 1994.

ARTICLE 14

APPROPRIATIONS

Section 1. [APPROPRIATIONS; SUMMARY.]

Except as otherwise provided in this act, the sums set forth in the columns designated "fiscal year 1994" and "fiscal year 1995" are appropriated from the general fund, or other named fund, to the agencies for the purposes specified in this act and are added to the appropriations for the fiscal years ending June 30, 1994, and June 30, 1995, in Laws 1993, chapter 345, or another named law.

SUMMARY BY FUND

	APPROPRIATIONS 1994	1995
General Fund	-0-	$ 4,579,000
HCAF Fund	($ 10,810,000)	($ 16,820,000)

Subdivision 1. Department of Human Services

(a) Rate Reduction - Health Care Access Fund	-0-	(145,000)
This reduction is to the appropriation in Laws 1993, chapter 345, article 14, section 2, due to the imposition of a five percent rate reduction for hospitals not providing preadmission certification of MinnesotaCare enrollees receiving inpatient services.		
(b) Delayed Enrollment of Single Adults Health Care Access Fund	(8,974,000)	(14,576,000)

	APPROPRIATIONS 1994	1995
Subd. 2. Department of Employee Relations		
Health Care Access Fund	(1,854,000)	(6,125,000)
This reduction is to the appropriation in Laws 1993, chapter 345, article 14, section 9, due to a negotiation of a third-party carrier contract for Minnesota employers insurance program.		
Subd. 3. Department of Health		
Health Care Access Fund	-0-	3,447,000
Money appropriated before fiscal year 1995 to the commissioner of health for the administrative functions in connection with the data institute may be used by the data institute for the administration of the patient satisfaction survey to the extent that there are matching financial contributions from the private sector.		
Subd. 4. Higher Education Coordinating Board		
Health Care Access Fund	-0-	200,000
Of this appropriation, $200,000 in fiscal year 1995 is to provide a medical school planning grant and to study physical therapist degree programs, as required under article 12.		
Subd. 5. Department of Commerce		
Health Care Access Fund	18,000	379,000

Sec. 2. TRANSFERS

The commissioner of finance shall transfer $3,963,000 in fiscal year 1994 and $11,101,000 in fiscal year 1995 from the health care access fund to the general fund. Of the amount transferred in fiscal year 1995, $4,579,000 is appropriated to the commissioner of human services for general assistance medical care grants."

Delete the title and insert:

"A bill for an act relating to health; MinnesotaCare; establishing and regulating community integrated service networks; defining terms; creating a reinsurance and risk adjustment association; classifying data; requiring reports; mandating studies; modifying provisions relating to the regulated all-payer option; requiring administrative rulemaking; setting timelines and requiring plans for implementation; designating essential community providers; establishing an expedited fact finding and dispute resolution process; requiring proposed legislation; establishing task forces; providing for demonstration models; mandating universal coverage; requiring insurance reforms; providing grant programs; establishing the Minnesota health care administrative simplification act; implementing electronic data interchange standards; creating the Minnesota center for health care electronic data interchange; providing standards for the Minnesota health care identification card; establishing and regulating health care cooperatives; appropriating money; providing penalties; amending Minnesota Statutes 1992, sections 60A.15, subdivision 1; 62A.303; 62A.48, subdivision 1; 62D.04, by adding a subdivision; 62E.02, subdivisions 10, 18, 20, and 23; 62E.10, subdivisions 1, 2, and 3; 62E.141; 62E.16; 62J.03, by adding a subdivision; 62L.02, subdivisions 9, 13, 16, 17, 24, and by adding subdivisions; 62L.03, subdivision 1; 62L.05, subdivisions 1, 5, and 8; 62L.08, subdivisions 2, 5, 6, and 7; 62L.12; 62L.21, subdivision 2; 62M.02, subdivisions 5 and 21; 62M.03, subdivisions 1, 2, and 3; 62M.05, subdivision 3; 62M.06, subdivision 3; 62M.09, subdivision 5; 144.1485; 144.581, subdivision 2; 145.64, subdivision 1; 256.9358, subdivision 4; 290.092, subdivision 2; 295.50, by adding subdivisions; 295.55, subdivisions 2 and 3; and 318.02, by adding a subdivision;

Minnesota Statutes 1993 Supplement, sections 43A.317, by adding a subdivision; 60K.14, subdivision 7; 61B.20, subdivision 13; 62A.011, subdivision 3; 62A.31, subdivision 1h; 62A.36, subdivision 1; 62A.65, subdivisions 2, 3, 4, 5, and by adding subdivisions; 62D.12, subdivision 17; 62J.03, subdivision 6; 62J.04, subdivisions 1 and 1a; 62J.09, subdivision 2; 62J.2916, subdivision 2; 62J.32, subdivision 4; 62J.33, by adding subdivisions; 62J.35, subdivisions 2 and 3; 62J.38; 62J.41, subdivision 2; 62J.45, subdivision 11, and by adding subdivisions; 62L.02, subdivisions 8, 11, 15, 19, and 26; 62L.03, subdivisions 3, 4, and 5; 62L.04, subdivision 1; 62L.08, subdivisions 4 and 8; 62N.01; 62N.02, subdivisions 1, 8, and by adding a subdivision; 62N.06, subdivision 1; 62N.065, subdivision 1; 62N.10, subdivisions 1 and 2; 62N.22; 62N.23; 62P.01; 62P.03; 62P.04; 62P.05; 80A.15, subdivision 2; 144.1464; 144.1486; 151.21, subdivisions 7 and 8; 256.9352, subdivision 3; 256.9354, subdivision 5, and by adding a subdivision; 256.9363, subdivisions 6, 7, and 9; 256.9657, subdivision 3; 295.50, subdivisions 3, 4, and 12b; 295.52, subdivision 5; 295.53, subdivisions 1, 2, and 5; 295.54; 295.58; and 295.582; Laws 1992, chapter 549, article 9, section 22; proposing coding for new law in Minnesota Statutes, chapters 43A; 62A; 62J; 62N; 62P; 144; 317A; proposing coding for new law as Minnesota Statutes, chapters 62Q; and 308B; repealing Minnesota Statutes 1992, sections 62A.02, subdivision 5; 62E.51; 62E.52; 62E.53; 62E.531; 62E.54; 62E.55; and 256.362, subdivision 5; Minnesota Statutes 1993 Supplement, sections 62J.04, subdivision 8; 62N.07; 62N.075; 62N.08; 62N.085; and 62N.16."

The motion prevailed and the amendment was adopted.

Greenfield moved to amend S. F. No. 2192, as amended, as follows:

Page 83, line 17, delete everything after "plans"

Page 83, line 18, delete everything before the period

Page 133, after line 10, insert:

"Sec. 53. [CHISAGO COUNTY HOSPITAL PROJECT.]

(a) Notwithstanding the provisions of Minnesota Statutes, section 144.551, subdivision 1, paragraph (a), a project to replace a hospital in Chisago county may be commenced if:

(1) the new hospital is located within ten miles of the current site;

(2) the project will result in a net reduction of licensed hospital beds; and

(3) all hospitals within ten miles of the project agree to the general location criteria, or if the hospitals do not agree by July 1, 1994, the commissioner of health approves the project through the process described in paragraph (b). The hospitals may notify the commissioner and request a mutually agreed upon extension of time not to extend beyond August 15, 1994, for submission of this project to the commissioner. The commissioner shall render a decision on the project within 60 days after submission by the parties. The commissioner's decision is the final administrative decision of the agency.

(b) As expressly authorized under paragraph (a), the commissioner shall approve a project if it is determined that replacement of the existing hospital or hospitals will:

(1) promote high quality care and services;

(2) provide improved access to care;

(3) not involve a substantial expansion of inpatient service capacity; and

(4) benefit the region to be served by the new regional facility.

(c) Prior to making this determination, the commissioner shall solicit and review written comments from hospitals and community service agencies located within ten miles of the new hospital site and from the regional coordinating board.

(d) For the purposes of pursuing the project established under this section, Chisago health services and district memorial hospital may pursue discussions and work cooperatively with each other, and with another organization mutually agreed upon, to plan for a new hospital facility to serve the area presently served by the two hospitals."

Page 139, line 20, delete "July 1, 1995" and insert "January 1, 1996"

Page 140, line 2, delete "unique physician" and insert "uniform provider"

Page 140, line 5, delete "July 1, 1995" and insert "January 1, 1996"

Page 140, line 9, delete "Unique Identification Number" and insert "uniform provider identification number"

Page 140, line 22, delete "unique physician" and insert "uniform provider"

Page 140, line 25, delete "July 1, 1995" and insert "January 1, 1996"

Page 141, line 12, delete "July 1, 1995" and insert "January 1, 1996"

Page 146, line 20, after "January" insert "1,"

Page 146, line 25, after "January" insert "1,"

Page 149, line 6, delete everything after the period

Page 149, delete line 7

Page 205, delete lines 17 to 18 and insert:

"(18) payments received by a postsecondary educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants. Fee for service payments and payments for extended coverage are taxable;"

Page 211, line 15, delete everything after "1993" and insert a period

Page 211, delete lines 16 and 17

Reorder sections 42, 43, and 44 of Article 8 to be consistent with the statutory coding

Renumber the sections in sequence

Correct internal reference

The motion prevailed and the amendment was adopted.

Greenfield moved to amend S. F. No. 2192, as amended, as follows:

Page 78, after line 16, insert:

"(e) Notwithstanding paragraphs (a), (b), and (c), no health plan company shall renew any individual or group health plan, except in compliance with this paragraph. No premium rate for any policy holder or contract holder shall increase or decrease upon renewal, as a result of this subdivision, by more than 15 percent per year. The increase or decrease described in this paragraph is in addition to any premium increase or decrease caused by legally permissible factors other than this subdivision. If a premium increase or decrease is constrained by this paragraph, the health plan company may implement the remaining portion of the increase or decrease at the time of subsequent annual renewals, but never to exceed 15 percent per year for paragraphs (a), (b), and (c) combined."

The motion prevailed and the amendment was adopted.

Carlson moved to amend S. F. No. 2192, as amended, as follows:

Page 125, after line 28, insert:

"Sec. 41. Minnesota Statutes 1993 Supplement, section 256.9357, is amended by adding a subdivision to read:

Subd. 4. [EXEMPTION FROM PERIOD UNINSURED.] The requirement in subdivision 3 of at least four months of no health coverage prior to application for the MinnesotaCare program does not apply to families, children, and individuals who have gross family incomes that are equal to or less than 150 percent of the federal poverty guidelines and who want to apply for the MinnesotaCare program upon termination from a health plan, as defined in section 62A.011, that:

(1) provides only hospital coverage or only hospital and surgical coverage;

(2) requires an annual deductible that exceeds $1,000 per person; or

(3) has a limit on total annual out-of-pocket expenses that exceeds $3,000 per person."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Cooper moved to amend S. F. No. 2192, as amended, as follows:

Page 79, line 32, delete everything after "for"

Page 79, line 35, after the period, insert "Subdivision 6 is not effective until an effective date is specified in future legislation."

The motion prevailed and the amendment was adopted.

Cooper moved to amend S. F. No. 2192, as amended, as follows:

Page 35, line 19, after "persons;" insert "persons with serious and persistent mental illness and children with severe emotional disturbance;"

The motion prevailed and the amendment was adopted.

Cooper, Davids and Kinkel moved to amend S. F. No. 2192, as amended, as follows:

Pages 60 and 61, delete section 5 and insert:

"Sec. 5. [62N.381] [AMBULANCE SERVICE RATE NEGOTIATION.]

Subdivision 1. [APPLICABILITY.] This section applies to all reimbursement rate negotiations between ambulance services and community integrated service networks or integrated service networks.

Subd. 2. [RANGE OF RATES.] The reimbursement rate negotiated for a contract period must not be more than 20 percent above or below the individual ambulance service's current customary charges, plus the rate of growth allowed under section 62J.04, subdivision 1. If the network and ambulance service cannot agree on a reimbursement rate, each party shall submit their rate proposal along with supportive data to the commissioner.

Subd. 3. [DEVELOPMENT OF CRITERIA.] The commissioner, in consultation with representatives of the Minnesota Ambulance Association, emergency medical services programs, community integrated service networks and integrated service networks, shall develop guidelines to use in reviewing rate proposals and making a final reimbursement rate determination.

Subd. 4. [REVIEW OF RATE PROPOSALS.] The commissioner, using the guidelines developed under subdivision 3, shall review the rate proposals of the ambulance service and community integrated service network or integrated service network and shall adopt either the network's or the ambulance service's proposal. The commissioner shall require the network and ambulance service to adhere to this reimbursement rate for the contract period."

The motion prevailed and the amendment was adopted.

Cooper and Gruenes moved to amend S. F. No. 2192, as amended, as follows:

Page 74, line 10, after the comma, insert "solely"

The motion prevailed and the amendment was adopted.

Cooper, Lourey, Huntley, Gruenes and Nelson moved to amend S. F. No. 2192, as amended, as follows:

Pages 186 to 192, delete sections 1, 2, and 3

Page 192, line 9, delete "[308B.01]" and insert "[62R.01]"

Page 192, line 29, delete "[308B.02]" and insert "[62R.02]"

Page 192, line 32, delete "[308B.03]" and insert "[62R.03]"

Page 192, line 34, delete "organizing under this chapter"

Page 193, line 8, delete "organized under this chapter"

Page 193, line 22, delete "organized under this chapter"

Page 193, line 30, delete "308B.06" and insert "62R.06"

Page 193, line 31, delete "[308B.04]" and insert "[62R.04]"

Page 194, line 3, delete "308B.03" and insert "62R.03"

Page 194, delete lines 12 to 21

Page 194, line 32, delete "[308B.05]" and insert "[62R.05]"

Renumber remaining subdivisions

Page 195, delete lines 27 to 36

Page 196, delete lines 1 to 26

Page 196, line 27, delete "[308B.11]" and insert "[62R.06]"

Page 196, line 35, delete "and 308B"

Page 197, after line 25, insert:

"Sec. 15. Minnesota Statutes 1992, section 308A.005, is amended by adding a subdivision to read:

Subd. 8a. [HEALTH CARE COOPERATIVE.] "Health care cooperative" has the meaning given in section 62R.04, subdivision 2.

Sec. 16. [308A.503] [HEALTH CARE COOPERATIVE MEMBERS.]

Subdivision 1. [HEALTH CARE NETWORK COOPERATIVE.] For a health care network cooperative, the policyholder is the member provided that if the policy holder is an individual enrollee, the individual enrollee is the member, and if the policyholder is an employer or other group type, entity, or association, the group policyholder is the member.

Subd. 2. [HEALTH PROVIDER COOPERATIVE.] For a health provider cooperative, the licensed health care provider, professional corporation, partnership, hospital, or other licensed provider is the member, as provided in the articles or bylaws.

Subd. 3. [STATE AND HOSPITAL MEMBERS AUTHORIZED.] The state, or any agency, instrumentality, or political subdivision of the state, may be a member of a health care cooperative. Any governmental hospital authorized, organized or operated under chapters 158, 250, 376, or 397 or under sections 246A.10 to 246A.27, 412.221, 447.05 to 447.13, or 471.50, or under any special law authorizing or establishing a hospital or hospital district, may be a member of a health care provider cooperative.

Sec. 17. Minnesota Statutes 1992, section 308A.635, is amended by adding a subdivision to read:

Subd. 5. [HEALTH CARE COOPERATIVE.] Notwithstanding the provisions of this section, the requirements and procedures for membership voting for a health care cooperative shall be as provided in the bylaws."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Asch, Davids, Gruenes and Bertram moved to amend S. F. No. 2192, as amended, as follows:

Page 153, lines 34 to 36, delete the new language.

Page 154, delete lines 1 to 5

Page 186, after line 2, insert:

"Sec. 46. [STUDY OF LOSS RATIOS: MEDICARE RELATED COVERAGE.]

The commissioner of commerce and the commissioner of health shall jointly study the loss ratios experienced with respect to all coverages regulated under Minnesota Statutes, section 62A.36, subdivision 1. The commissioners shall determine, using sound actuarial analysis, the effects of increasing the minimum loss ratios for those coverages by one percentage point per year for seven years. The commissioners shall jointly report their findings, analysis, and conclusions to the legislature, in compliance with Minnesota Statutes, section 3.195, no later than December 15, 1994. The commissioners shall conduct the entire study jointly and attempt to arrive at and report unified consistent findings, analysis, and conclusions; the commissioners shall not study separately only the coverages that each commissioner respectively regulates."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Asch et al amendment and the roll was called. There were 92 yeas and 41 nays as follows:

Those who voted in the affirmative were:

Abrams	Dempsey	Jefferson	Limmer	Olson, M.	Rodosovich	Van Engen
Asch	Dorn	Jennings	Lindner	Onnen	Rukavina	Vickerman
Beard	Erhardt	Johnson, A.	Lynch	Opatz	Sarna	Waltman
Bergson	Evans	Johnson, R.	Macklin	Osthoff	Seagren	Weaver
Bertram	Finseth	Johnson, V.	McCollum	Ozment	Smith	Wolf
Bettermann	Frerichs	Kalis	Milbert	Pauly	Solberg	Worke
Bishop	Girard	Kinkel	Molnau	Pawlenty	Steensma	Workman
Brown, C.	Goodno	Klinzing	Morrison	Pelowski	Sviggum	Spk. Anderson, I.
Commers	Gruenes	Knickerbocker	Mosel	Perlt	Swenson	
Cooper	Gutknecht	Knight	Neary	Peterson	Tomassoni	
Dauner	Haukoos	Koppendrayer	Nelson	Pugh	Tompkins	
Davids	Holsten	Krinkie	Ness	Reding	Trimble	
Dehler	Hugoson	Leppik	Olson, E.	Rhodes	Tunheim	
Delmont	Jacobs	Lieder	Olson, K.	Rice	Van Dellen	

Those who voted in the negative were:

Anderson, R.	Clark	Hasskamp	Kelso	Mahon	Orfield	Vellenga
Battaglia	Dawkins	Hausman	Krueger	Mariani	Ostrom	Wagenius
Bauerly	Farrell	Huntley	Lasley	McGuire	Rest	Wejcman
Brown, K.	Garcia	Jaros	Long	Munger	Sekhon	Wenzel
Carlson	Greenfield	Kahn	Lourey	Murphy	Simoneau	Winter
Carruthers	Greiling	Kelley	Luther	Orenstein	Skoglund	

The motion prevailed and the amendment was adopted.

Asch and Davids moved to amend S. F. No. 2192, as amended, as follows:

Page 78, delete lines 24 to 36

Page 79, delete lines 1 to 13

Reletter the clauses and correct the internal references

Amend the title accordingly

The motion did not prevail and the amendment was not adopted.

Winter moved to amend S. F. No. 2192, as amended, as follows:

Page 73, after line 23, insert:

"Sec. 9. [STUDY OF HEALTH PLAN PRACTICES INHIBITING FORMATION OF LOCALLY-CONTROLLED HEALTH NETWORKS.]

The commissioner of health shall conduct a study and report to the Legislative Oversight Commission by November 15, 1994, concerning the impact of health plan practices that frustrate or inhibit the formation of locally based competing health care networks or cooperatives. The commissioner should recommend the prohibition of those practices significantly impeding the development of local plans."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Olson, K., and Winter moved to amend S. F. No. 2192, as amended, as follows:

Page 133, after line 25, insert:

"Sec. 56. [EFFECTIVE DATE.]

Laws 1994, chapter 433, is effective the day following final enactment of this act."

The motion prevailed and the amendment was adopted.

Weaver moved to amend S. F. No. 2192, as amended, as follows:

Page 125, after line 28, insert:

"Sec. 41. Minnesota Statutes 1993 Supplement, section 256.9357, subdivision 2, is amended to read:

Subd. 2. [MUST NOT HAVE ACCESS TO EMPLOYER-SUBSIDIZED COVERAGE.] (a) To be eligible for subsidized premium payments based on a sliding scale, a family or individual must not have access to subsidized health coverage through an employer, and must not have had access to subsidized health coverage through an employer for the 18 months prior to application for subsidized coverage under the MinnesotaCare plan. The requirement that the family or individual must not have had access to employer-subsidized coverage during the previous 18 months does not apply if employer-subsidized coverage was lost for reasons that would not disqualify the individual for unemployment benefits under section 268.09 and the family or individual has not had access to employer-subsidized coverage since the layoff. If employer-subsidized coverage was lost for reasons that disqualify an individual for unemployment benefits under section 268.09, children of that individual are exempt from the requirement of no access to employer subsidized coverage for the 18 months prior to application, as long as the children have not had access to employer subsidized coverage since the disqualifying event.

(b) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee, excluding dependent coverage, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision."

Page 133, line 25, after the period, insert "Section 41 is effective for MinnesotaCare applications submitted on or after November 1, 1993."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Neary and Dawkins moved to amend S. F. No. 2192, as amended, as follows:

Page 64, line 36, delete "and"

Page 65, line 3, delete the period and insert "; and"

Page 65, after line 3, insert:

"(11) The desirability of including coverage for all court-ordered mental health services for juveniles."

The motion prevailed and the amendment was adopted.

Neary; Asch; Tompkins; Brown, K.; Greiling; Onnen; Swenson and Clark moved to amend S. F. No. 2192, as amended, as follows:

Page 23, after line 27, insert:

"Sec. 7. [62J.47] [MORATORIUM ON MERGERS OR ACQUISITIONS BY HOSPITAL SYSTEMS AND HEALTH CARRIERS.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, "health carrier" has the meaning given in section 62A.011, subdivision 2.

Subd. 2. [RESTRICTIONS.] Until July 1, 1996, the following hospitals, hospital systems, and health carriers are prohibited from merging with, or acquiring, directly or indirectly, any other hospital, hospital systems, or health carrier:

(1) a hospital or hospital system whose number of patients served in the state in the previous calendar year exceeds 7.5 percent of the total number of patients served by all hospitals in that year in the state of Minnesota;

(2) a hospital or hospital system whose number of patients served in the seven-county metropolitan area in the previous calendar year exceeds 15 percent of the total number of patients served by all hospitals in that year in the seven-county metropolitan area;

(3) a health carrier whose number of enrollees residing in the state in the previous calendar year exceeds five percent of the total number of insured persons in that year residing in the state of Minnesota; and

(4) a health carrier whose number of enrollees residing in the seven-county metropolitan area in the previous calendar year exceeds ten percent of the total number of insured persons in that year residing in the seven-county metropolitan area.

Subd. 3. [ENFORCEMENT.] The district court in Ramsey county has jurisdiction to enjoin an alleged violation of subdivision 2. The attorney general may bring an action to enjoin an alleged violation. The commissioner of health or commerce shall not issue or renew a license or certificate of authority to any hospital or health carrier in violation of subdivision 2."

Page 38, line 13, after the period insert:

"Section 7 is effective the day following final enactment."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

Greenfield moved to amend the Neary et al amendment to S. F. No. 2192, as amended, as follows:

Page 1, line 5, delete "HOSPITAL SYSTEMS AND"

Page 1, lines 9 and 10, delete "the following hospitals, hospital systems, and"

Page 1, line 12, delete "hospital, hospital systems, or" and before the colon, insert ", unless the merger or acquisition has been approved by the commissioner under the antitrust exception approval process established under sections 62J.2911 to 62J.2921"

Page 1, delete lines 13 to 21

Renumber clauses in sequence

Page 2, line 11, delete "hospital or"

Page 2, line 12, after the period, insert:

"Subd. 4. [EXCEPTIONS.] This section does not prohibit: (1) joint ventures or collaborative efforts between health carriers and community integrated service networks or integrated service networks; or (2) any merger or direct or indirect acquisition approved by the commissioner that is intended to assure continuous coverage for enrollees and avoid liquidation or insolvency under chapter 60B."

The motion prevailed and the amendment to the amendment was adopted.

The question recurred on the Neary et al amendment, as amended, to S. F. No. 2192, as amended. The motion prevailed and the amendment, as amended, was adopted.

Greenfield moved to amend S. F. No. 2192, as amended, as follows:

Page 3, line 24, after the period, insert "Notwithstanding the foregoing, an organization licensed as a community integrated service network that accepts payments for health care services on a capitated basis from a program of self-insurance maintained by an employer as described in section 60A.02, subdivision 3, paragraph (b), shall not be regulated as a community integrated service network with respect to the receipt of such payments, nor are any such payments "premium revenues" for the purposes of calculating the community integrated service network's liability for otherwise applicable state taxes, assessments, or surcharges with the exceptions of the MinnesotaCare provider tax, the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d), and the Minnesota comprehensive health association assessment under section 62E.11, provided that the community integrated service network does not bear risk for health service expenses in excess of 110 percent of the self-insurance program's expected costs, and provided that the community integrated service network and the employer comply with the data submission and the administrative simplification provisions of chapter 62J and the provider tax passthrough provision of section 295.582, and provided that the employer has more than 100 employees and the employer does not carry stop loss, excess loss, or similar coverage with respect to the self-insurance program; risk borne by the community network shall affect its required reserves in the same manner as other capitation arrangements, with an appropriate adjustment for the portion of the risk retained by the employer."

Page 4, line 4, after the period, insert:

"Notwithstanding the foregoing, an organization licensed as an integrated service network that accepts payments for health care services on a capitated basis from a program of self-insurance maintained by an employer as described in section 60A.02, subdivision 3, paragraph (b), shall not be regulated as an integrated service network with respect to the receipt of such payments, nor are any such payments "premium revenues" for the purposes of calculating the integrated service network's liability for otherwise applicable state taxes, assessments, or surcharges with the exceptions of the MinnesotaCare provider tax, the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d), and the Minnesota comprehensive health association assessment under section 62E.11, provided that the integrated service network does not bear risk for health service expenses in excess of 110 percent of the self-insurance program's expected costs, and provided that the integrated service network and the employer comply

with the data submission and the administrative simplification provisions of chapter 62J and the provider tax passthrough provision of section 295.582, and provided that the employer has more than 500 employees, the employer's self-insurance program was in effect on April 1, 1994, and the employer does not carry stop loss, excess loss, or similar coverage with respect to the self-insurance program; risk borne by the network shall affect required reserves in the same manner as other capitation arrangements, with an appropriate adjustment for the portion of the risk retained by the employer."

Page 91, after line 15, insert:

"Sec. 2. Minnesota Statutes 1992, section 60A.02, subdivision 3, is amended to read:

Subd. 3. [INSURANCE.] (a) "Insurance" is any agreement whereby one party, for a consideration, undertakes to indemnify another to a specified amount against loss or damage from specified causes, or to do some act of value to the assured in case of such loss or damage. A program of self-insurance, self-insurance revolving fund or pool established under section 471.981 is not insurance for purposes of this subdivision.

(b) Capitation payments to a capitated entity for health care services by a program of self-insurance maintained by an employer with more than 500 employees do not constitute insurance for the purposes of this subdivision so long as the employer maintained the program of self-insurance on April 1, 1994, shares risk with the capitated entity such that the capitated entity does not assume risk in excess of 110 percent of the self-insurance program's expected costs, and does not carry stop loss, excess loss, or similar coverage with respect to the self-insurance program, and so long as the employer and the capitated entity comply with the data submission and administrative simplification provisions of chapter 62J and the provider tax passthrough provision of section 295.582. For purposes of this subdivision, a capitated entity must be licensed as a health maintenance organization, integrated service network, or community integrated service network. This paragraph applies only to programs of self-insurance in existence as of April 1, 1994; all other insurance as defined in paragraph (a), even if maintained by an employer that also offers programs of self-insurance, continues to be subject to all applicable state regulations."

Page 95, after line 2, insert:

"Sec. 5. Minnesota Statutes 1992, section 62D.02, subdivision 4, is amended to read:

Subd. 4. "Health maintenance organization" means a nonprofit corporation organized under chapter 317A, or a local governmental unit as defined in subdivision 11, controlled and operated as provided in sections 62D.01 to 62D.30, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee. Notwithstanding the foregoing, an organization licensed as a health maintenance organization that accepts payments for health care services on a capitated basis from a program of self-insurance maintained by an employer, as described in section 60A.02, subdivision 3, paragraph (b), shall not be regulated as a health maintenance organization with respect to the receipt of such payments, nor are any such payments "premium revenues" for the purposes of calculating the health maintenance organization's liability for otherwise applicable state taxes, assessments, or surcharges with the exceptions of the MinnesotaCare provider tax, the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d), and the Minnesota comprehensive health association assessment under section 62E.11, provided that the health maintenance organization does not bear risk for health service expenses in excess of 110 percent of the self-insurance program's expected costs, and provided that the health maintenance organization and the employer comply with the data submission and the administrative simplification provisions of chapter 62J and the provider tax pass-through provision of section 295.582, and provided that the employer has more than 500 employees, the employer's self-insurance program was in effect on April 1, 1994, and the employer does not carry stop loss, excess loss, or similar coverage with respect to the self-insurance program; risk borne by the health maintenance organization shall affect required reserves in the same manner as other capitation arrangements, with an appropriate adjustment for the portion of the risk retained by the employer."

Renumber the sections of article 8 in sequence

Correct the internal references

Amend the title accordingly

Abrams moved to amend the Greenfield amendment to S. F. No. 2192, as amended, as follows:

Page 2, line 18, delete "500" and insert "100" and delete everything after the comma

Page 2, line 19, delete everything before "and"

Page 3, line 1, delete "500" and insert "100"

Page 3, line 3, delete everything after "employer"

Page 3, line 4, delete "1994,"

Page 3, line 14, delete "This"

Page 3, delete line 15

Page 3, line 16, delete everything before "other" and insert "All"

Page 4, line 17, delete "500" and insert "100" and delete everything after the comma

Page 4, line 18, delete everything before "and"

The motion prevailed and the amendment to the amendment was adopted.

The question recurred on the Greenfield amendment, as amended, to S. F. No. 2192, as amended. The motion prevailed and the amendment, as amended, was adopted.

Krueger moved to amend S. F. No. 2192, as amended, as follows:

Page 82, line 16, delete "financing mechanisms" and insert "funding" and delete "should" and insert "may"

Page 82, line 16, after "raised" insert "by reducing other general fund spending or"

Page 82, line 17, delete "an income or payroll tax with consideration given" and insert "broad-based taxes, including income or payroll, as long as they can be adjusted"

Page 82, line 18, delete "providing" and insert "provide"

Page 82, line 34, delete everything after "sources" and insert a period

Page 82, delete line 35

The motion prevailed and the amendment was adopted.

Leppik, Tompkins, Pauly, Lourey, Gruenes, Greenfield and Cooper moved to amend S. F. No. 2192, as amended, as follows:

Page 6, line 10, delete "shall" and insert "may"

Page 7, after line 28, insert:

"Subd. 7. [POINT OF SERVICE PRODUCT.] A community network that does not offer an expanded network under this section shall make available to its contract holders each of the following contracts:

(1) a contract that provides coverage for covered services obtained from health care providers, as defined in section 62J.03, subdivision 8, not employed by or under contract with the community network;

(2) a contract that provides coverage for covered services obtained from allied independent health care providers not employed by or under contract with the community network; and

(3) a contract that provides coverage for covered services obtained from health care providers, as defined in section 62J.03, subdivision 8, other than allied independent health providers, not employed by or under contract with the community network.

The community network may establish separate premium rates and cost-sharing requirements for those contracts, if those premium rates and cost-sharing requirements are actuarially justified and approved by the commissioner as otherwise required by law."

The motion prevailed and the amendment was adopted.

Leppik, Tompkins, Lourey, Pauly, Cooper and Greenfield moved to amend S. F. No. 2192, as amended, as follows:

Page 36, line 26, before "A" insert:

"Subdivision 1. [SAME LICENSURE.]"

Page 36, line 36, delete "section" and insert "subdivision"

Page 37, after line 1, insert:

"Subd. 2. [CHOICE OF NONEXCLUSIVE CONTRACT.] A health plan company that enters into a contract with a health care provider, that obligates the health care provider to provide health care services exclusively to the enrollees or insureds of the health plan company, must offer the health care provider the option of instead entering into a contract that does not require exclusivity. The nonexclusive contract must be identical, except for the exclusivity requirement and related provisions that are not applicable to nonexclusive relationships, including, but not limited to, provider location, fringe benefits, leasing of space, and arrangements regarding equipment and supplies. This subdivision does not apply to health care providers employed by a health plan company."

The motion prevailed and the amendment was adopted.

The Speaker called Bauerly to the Chair.

Worke and Davids moved to amend S. F. No. 2192, as amended, as follows:

Page 66, line 36, delete everything after "must" and insert "offer enrollees a choice of the following annual per-person deductibles: $100, $250, $500, $1,000, and $2,500, may vary only on the basis of these deductibles and other cost-sharing features, and must provide"

Page 67, line 1, delete "cost sharing and encompass"

The motion did not prevail and the amendment was not adopted.

Worke, Lindner and Girard moved to amend S. F. No. 2192, as amended, as follows:

Page 125, after line 10, insert:

"Sec. 40. Minnesota Statutes 1993 Supplement, section 256.9353, subdivision 3, is amended to read:

Subd. 3. [INPATIENT HOSPITAL SERVICES.] (a) Beginning July 1, 1993, covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services

with eligibility under the medical assistance spend-down. The inpatient hospital benefit for adult enrollees is subject to an annual benefit limit of $10,000. The commissioner shall provide enrollees with at least 60 days' notice of coverage for inpatient hospital services and any premium increase associated with the inclusion of this benefit.

(b) Enrollees shall apply for and cooperate with the requirements of medical assistance by the last day of the third month following admission to an inpatient hospital. If an enrollee fails to apply for medical assistance within this time period, the enrollee and the enrollee's family shall be disenrolled from the plan within one calendar month. Enrollees and enrollees' families disenrolled for not applying for or not cooperating with medical assistance may not reenroll.

(c) All application material for MinnesotaCare must clearly state in 10-point capitalized letters the following notice:

"NOTICE

The MinnesotaCare program has a limited annual inpatient benefit of $10,000. You may be personally responsible for any hospital bills exceeding this amount unless you have limited assets and qualify for medical assistance." "

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Worke et al amendment and the roll was called. There were 55 yeas and 72 nays as follows:

Those who voted in the affirmative were:

Anderson, R.	Erhardt	Holsten	Krinkie	Morrison	Rhodes	Van Engen
Asch	Finseth	Hugoson	Leppik	Munger	Seagren	Vickerman
Bertram	Frerichs	Johnson, R.	Limmer	Ness	Smith	Waltman
Bettermann	Girard	Johnson, V.	Lindner	Olson, M.	Stanius	Weaver
Commers	Goodno	Klinzing	Lynch	Onnen	Sviggum	Wolf
Davids	Gruenes	Knickerbocker	Macklin	Ozment	Swenson	Worke
Dehler	Gutknecht	Knight	Mahon	Pauly	Tompkins	Workman
Dempsey	Haukoos	Koppendrayer	Molnau	Pawlenty	Van Dellen	

Those who voted in the negative were:

Battaglia	Dawkins	Jacobs	Lieder	Opatz	Rodosovich	Vellenga
Bauerly	Delmont	Jaros	Long	Orenstein	Rukavina	Wagenius
Beard	Dorn	Jefferson	Lourey	Orfield	Sarna	Wejcman
Bergson	Evans	Jennings	Luther	Ostrom	Sekhon	Wenzel
Brown, C.	Farrell	Johnson, A.	McCollum	Pelowski	Simoneau	Winter
Brown, K.	Garcia	Kahn	McGuire	Perlt	Skoglund	Spk. Anderson, I.
Carlson	Greenfield	Kalis	Milbert	Peterson	Solberg	
Carruthers	Greiling	Kelley	Murphy	Pugh	Steensma	
Clark	Hasskamp	Kinkel	Neary	Reding	Tomassoni	
Cooper	Hausman	Krueger	Nelson	Rest	Trimble	
Dauner	Huntley	Lasley	Olson, E.	Rice	Tunheim	

The motion did not prevail and the amendment was not adopted.

Klinzing; Worke; Lindner; Brown, K.; Bettermann; Bauerly; Olson, E.; Swenson; Bertram; Wejcman; Limmer; Garcia; Johnson, V.; Jaros; Delmont; Wenzel; Kinkel; Tomassoni; Rukavina; Ness; Milbert; Perlt; Vickerman; Koppendrayer; Rhodes; Peterson; Lasley; Jacobs; Tunheim; Pugh; Dauner; Stanius; Holsten; Hausman; Long; Winter; Clark; Mosel; Jennings; Mahon and Steensma moved to amend S. F. No. 2192, as amended, as follows:

Page 6, delete lines 9 to 17, and insert:

"Subdivision 1. [PROVIDER ACCEPTANCE REQUIRED.] Each health plan company with the exception of community integrated service networks and health plan companies that are exempt under subdivision 5 shall establish an expanded network of allied independent health providers, in addition to a preferred network. A health plan company shall accept as a provider in the expanded network any allied independent health provider who: (1) meets the health plan company's credentialing standards; (2) agrees to the terms of the health plan company's provider contract; and (3) agrees to comply with all managed care protocols of the health plan company. A community integrated service network may offer to its enrollees an expanded network of allied independent health providers as described under this section. This subdivision is effective January 1, 1995."

Page 6, line 31, delete "community"

Page 6, line 32, delete "network may" and insert "health plan company shall"

Page 35, after line 36, insert:

"Sec. 19. [62Q.10] [NONDISCRIMINATION.]

If a health plan company, with the exception of a community integrated service network or an indemnity insurer licensed under chapter 60A who does not offer a product through a preferred provider network, offers coverage of a health care service as part of its plan, it may not deny provider network status to a qualified health care provider type who meets the credentialing requirements of the health plan company solely because the provider is an allied independent health care provider as defined in section 62N.255."

Page 36, line 11, after "enrollee" insert ", health care provider, or applicant for network provider status" and delete "of a health"

Page 36, line 12, delete "plan company"

Page 36, line 15, after "enrollee" insert ", health care provider, or applicant for network provider status"

Page 36, after line 24, insert:

"Sec. 21. [62Q.12] [DENIAL OF ACCESS.]

No health plan company may deny access to a covered health care service unless the denial is made by, or under the direction of, or subject to the review of a health care professional licensed to provide the service in question."

Page 50, after line 33, insert:

"Subd. 5. [ADVISORY COMMITTEE.] The commissioner shall convene an advisory committee made up of a broad array of health care professionals that will be affected by the fee schedule. Recommendations of this committee must be submitted to the commissioner by November 15, 1994, and must be incorporated in the implementation report due January 1, 1995."

Page 65, delete lines 4 to 13, and insert:

"Subd. 5. [ADVISORY COMMITTEE ON THE UNIVERSAL BENEFITS SET.] The commissioner shall appoint an advisory committee to develop recommendations regarding the services other than dental services to be included in the universal benefits set. The committee must include representatives of health care providers, consumers, health plan companies, and counties. No more than half plus one of the members may be of the same gender. The health

care provider representatives must include both physicians and allied independent health care providers representing both physical and mental health conditions. The committee shall report these recommendations to the commissioner by October 1, 1994."

Page 66, line 21, delete ", subdivision 2"

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

Greenfield moved to amend the Klinzing et al amendment to S. F. No. 2192, as amended, as follows:

Page 1, delete lines 3 to 24 and insert:

"Pages 6 and 7, delete section 6 of article 1

Page 69, after line 11, insert:

"Sec. 14. [62Q.31] [MANDATORY POINT OF SERVICE PRODUCT.]

Each health plan company, other than an integrated service network or a community integrated service network, shall make available to its policy or contract holders a policy or contract that provides coverage for covered services obtained from health care providers, as defined in section 62J.03, subdivision 8, not employed by or under contract with the health plan company. The health plan company may establish separate premium rates and cost-sharing requirements for this policy or contract, if those premium rates and cost-sharing requirements are actuarially justified and approved by the appropriate commissioner as otherwise required by law. This section does not apply to a health plan company that does not contract with or employ providers in this state, that has fewer than 20,000 enrollees in this state, or that has no health plans open to new enrollees in this state."

Delete pages 2 and 3

A roll call was requested and properly seconded.

The question was taken on the amendment to the amendment and the roll was called. There were 36 yeas and 94 nays as follows:

Those who voted in the affirmative were:

Abrams	Girard	Huntley	Lourey	Ness	Smith
Bishop	Greenfield	Johnson, A.	Mahon	Pauly	Sviggum
Commers	Greiling	Kahn	McGuire	Pawlenty	Trimble
Cooper	Gruenes	Kelley	Molnau	Peterson	Van Dellen
Erhardt	Gutknecht	Knickerbocker	Morrison	Simoneau	Wagenius
Frerichs	Hugoson	Leppik	Munger	Skoglund	Spk. Anderson, I.

Those who voted in the negative were:

Anderson, R.	Beard	Bettermann	Carlson	Davids	Delmont	Evans
Asch	Bergson	Brown, C.	Clark	Dawkins	Dempsey	Farrell
Battaglia	Bertram	Brown, K.	Dauner	Dehler	Dorn	Finseth

Garcia	Johnson, V.	Limmer	Neary	Ozment	Solberg	Weaver
Goodno	Kalis	Lindner	Nelson	Pelowski	Stanius	Wejcman
Hasskamp	Kelso	Long	Olson, E.	Perlt	Steensma	Wenzel
Haukoos	Kinkel	Luther	Olson, K.	Pugh	Swenson	Winter
Hausman	Klinzing	Lynch	Olson, M.	Reding	Tomassoni	Wolf
Holsten	Knight	Macklin	Onnen	Rhodes	Tompkins	Worke
Jacobs	Koppendrayer	Mariani	Opatz	Rice	Tunheim	Workman
Jaros	Krinkie	McCollum	Orenstein	Rodosovich	Van Engen	
Jefferson	Krueger	Milbert	Orfield	Rukavina	Vellenga	
Jennings	Lasley	Mosel	Osthoff	Sarna	Vickerman	
Johnson, R.	Lieder	Murphy	Ostrom	Sekhon	Waltman	

The motion did not prevail and the amendment to the amendment was not adopted.

Pauly was excused between the hours of 4:00 p.m. and 5:55 p.m.

The question recurred on the Klinzing et al amendment and the roll was called. There were 97 yeas and 34 nays as follows:

Those who voted in the affirmative were:

Anderson, R.	Delmont	Jefferson	Limmer	Nelson	Pugh	Tomassoni
Asch	Dempsey	Jennings	Lindner	Ness	Reding	Tompkins
Battaglia	Dorn	Johnson, A.	Long	Olson, E.	Rhodes	Tunheim
Bauerly	Evans	Johnson, R.	Luther	Olson, M.	Rice	Van Engen
Beard	Farrell	Johnson, V.	Lynch	Onnen	Rodosovich	Vellenga
Bertram	Finseth	Kalis	Macklin	Opatz	Rukavina	Vickerman
Bettermann	Garcia	Kelso	Mariani	Orenstein	Sarna	Waltman
Brown, K.	Goodno	Kinkel	McCollum	Orfield	Sekhon	Weaver
Carlson	Hasskamp	Klinzing	McGuire	Osthoff	Smith	Wejcman
Carruthers	Haukoos	Koppendrayer	Milbert	Ostrom	Solberg	Wenzel
Clark	Hausman	Krinkie	Molnau	Ozment	Stanius	Winter
Dauner	Holsten	Krueger	Mosel	Pelowski	Steensma	Worke
Davids	Jacobs	Lasley	Murphy	Perlt	Sviggum	Workman
Dawkins	Jaros	Lieder	Neary	Peterson	Swenson	

Those who voted in the negative were:

Abrams	Cooper	Greenfield	Huntley	Leppik	Pawlenty	Van Dellen
Bergson	Dehler	Greiling	Kahn	Lourey	Seagren	Wagenius
Bishop	Erhardt	Gruenes	Kelley	Mahon	Simoneau	Wolf
Brown, C.	Frerichs	Gutknecht	Knickerbocker	Morrison	Skoglund	Spk. Anderson, I.
Commers	Girard	Hugoson	Knight	Olson, K.	Trimble	

The motion prevailed and the amendment was adopted.

Goodno moved to amend S. F. No. 2192, as amended, as follows:

Page 206, after line 20, insert:

"Sec. 9. Minnesota Statutes 1993 Supplement, section 295.53, is amended by adding a subdivision to read:

Subd. 6. [EXEMPTION FOR BORDER PROVIDERS.] (a) For purposes of this subdivision, "border provider" means a resident health care provider, resident hospital, resident surgical center, or resident pharmacy whose location or practice site is located in a border city that has an enterprise zone designated pursuant to section 469.168, subdivision 4, clause (c), except for cities of the first class.

(b) Gross revenues received by border providers are exempt from the taxes imposed under section 295.52, if these revenues are received for services provided to a patient who is not a Minnesota resident at a location or practice site located in a border city that has an enterprise zone designated pursuant to section 469.168, subdivision 4, clause (c), except for cities of the first class. Revenues received by border providers for services provided to Minnesota residents, or provided at a location or practice site that is not located in a border city that has an enterprise zone designated pursuant to section 469.168, subdivision 4, clause (c), except for cities of the first class are subject to the taxes imposed under section 295.52."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Cooper moved to amend S. F. No. 2192, as amended, as follows:

Page 28, lines 9 to 11, delete the new language

The motion prevailed and the amendment was adopted.

Van Engen; Tompkins; Klinzing; Olson, M.; Workman; Steensma; Onnen; Cooper; Waltman; Hasskamp; Bettermann; Johnson, V., and Lynch moved to amend S. F. No. 2192, as amended, as follows:

Page 37, line 7, after the period, insert "Nothing in this section shall force or require a health plan company to provide elective, induced abortions, except as allowed in section 256B.0625, subdivision 16, whether performed in a hospital, other abortion facility, or the office of a physician."

A roll call was requested and properly seconded.

The question was taken on the Van Engen et al amendment and the roll was called. There were 83 yeas and 43 nays as follows:

Those who voted in the affirmative were:

Anderson, R.	Dempsey	Jacobs	Lasley	Nelson	Pugh	Van Dellen
Battaglia	Dorn	Johnson, R.	Lieder	Ness	Reding	Van Engen
Bauerly	Finseth	Johnson, V.	Limmer	Olson, E.	Rodosovich	Vickerman
Beard	Frerichs	Kalis	Lindner	Olson, K.	Seagren	Waltman
Bertram	Girard	Kelso	Lynch	Olson, M.	Smith	Weaver
Bettermann	Goodno	Kinkel	Macklin	Onnen	Solberg	Wenzel
Brown, C.	Gruenes	Klinzing	Milbert	Opatz	Stanius	Winter
Commers	Gutknecht	Knickerbocker	Molnau	Ostrom	Steensma	Wolf
Cooper	Hasskamp	Knight	Morrison	Ozment	Sviggum	Worke
Dauner	Haukoos	Koppendrayer	Mosel	Pawlenty	Swenson	Workman
Davids	Holsten	Krinkie	Munger	Pelowski	Tompkins	Spk. Anderson, I.
Dehler	Hugoson	Krueger	Murphy	Peterson	Tunheim	

Those who voted in the negative were:

Abrams	Brown, K.	Dawkins	Greenfield	Jefferson	Kelley	Luther
Asch	Carlson	Delmont	Greiling	Jennings	Leppik	Mariani
Bergson	Carruthers	Erhardt	Hausman	Johnson, A.	Long	McCollum
Bishop	Clark	Evans	Huntley	Kahn	Lourey	McGuire

Neary	Osthoff	Rhodes	Simoneau	Vellenga
Orenstein	Perlt	Rice	Skoglund	Wagenius
Orfield	Rest	Sekhon	Tomassoni	Wejcman

The motion prevailed and the amendment was adopted.

Abrams moved to amend S. F. No. 2192, as amended, as follows:

Page 7, lines 30 and 36, delete "shall" and insert "may"

Page 8, line 5, delete "shall" and insert "may"

The motion prevailed and the amendment was adopted.

Tompkins offered an amendment to S. F. No. 2192, as amended.

POINT OF ORDER

Pugh raised a point of order pursuant to rule 3.09 that the Tompkins amendment was not in order. Speaker pro tempore Bauerly ruled the point of order well taken and the amendment out of order.

Sviggum appealed the decision of the Chair.

A roll call was requested and properly seconded.

CALL OF THE HOUSE

On the motion of Long and on the demand of 10 members, a call of the House was ordered. The following members answered to their names:

Abrams	Davids	Hausman	Krinkie	Mosel	Peterson	Tunheim
Anderson, R.	Dehler	Holsten	Krueger	Murphy	Pugh	Van Dellen
Asch	Delmont	Huntley	Lasley	Neary	Reding	Van Engen
Battaglia	Dempsey	Jaros	Leppik	Nelson	Rhodes	Vellenga
Bauerly	Dorn	Jefferson	Lieder	Ness	Rice	Vickerman
Beard	Erhardt	Jennings	Limmer	Olson, E.	Rodosovich	Wagenius
Bergson	Evans	Johnson, A.	Lindner	Olson, K.	Seagren	Waltman
Bertram	Farrell	Johnson, R.	Long	Olson, M.	Sekhon	Weaver
Bettermann	Finseth	Johnson, V.	Lourey	Onnen	Simoneau	Wejcman
Bishop	Frerichs	Kahn	Luther	Opatz	Skoglund	Wenzel
Brown, C.	Garcia	Kalis	Lynch	Orenstein	Smith	Winter
Brown, K.	Goodno	Kelley	Macklin	Orfield	Solberg	Wolf
Carlson	Greenfield	Kelso	Mariani	Osthoff	Stanius	Worke
Carruthers	Greiling	Kinkel	McCollum	Ostrom	Steensma	Workman
Clark	Gruenes	Klinzing	McGuire	Ozment	Sviggum	
Commers	Gutknecht	Knickerbocker	Milbert	Pawlenty	Swenson	
Cooper	Hasskamp	Knight	Molnau	Pelowski	Tomassoni	
Dauner	Haukoos	Koppendrayer	Morrison	Perlt	Tompkins	

Carruthers moved that further proceedings of the roll call be dispensed with and that the Sergeant at Arms be instructed to bring in the absentees. The motion prevailed and it was so ordered.

The vote was taken on the question "Shall the decision of Speaker pro tempore Bauerly stand as the judgment of the House?" and the roll was called. There were 89 yeas and 44 nays as follows:

Those who voted in the affirmative were:

Anderson, R.	Cooper	Jaros	Lasley	Murphy	Pugh	Swenson
Asch	Dawkins	Jefferson	Lieder	Neary	Reding	Tomassoni
Battaglia	Delmont	Jennings	Long	Nelson	Rest	Trimble
Bauerly	Dorn	Johnson, A.	Lourey	Olson, E.	Rice	Tunheim
Beard	Evans	Johnson, R.	Luther	Olson, K.	Rodosovich	Vellenga
Bergson	Farrell	Kahn	Macklin	Opatz	Rukavina	Wagenius
Bertram	Garcia	Kalis	Mahon	Orenstein	Sarna	Weaver
Bishop	Greenfield	Kelley	Mariani	Orfield	Sekhon	Wejcman
Brown, C.	Greiling	Kelso	McCollum	Osthoff	Simoneau	Wenzel
Brown, K.	Hasskamp	Kinkel	McGuire	Ostrom	Skoglund	Winter
Carlson	Hausman	Klinzing	Milbert	Pelowski	Smith	Spk. Anderson, I.
Carruthers	Huntley	Knickerbocker	Mosel	Perlt	Solberg	
Clark	Jacobs	Krueger	Munger	Peterson	Steensma	

Those who voted in the negative were:

Abrams	Erhardt	Haukoos	Leppik	Olson, M.	Sviggum	Worke
Bettermann	Finseth	Holsten	Limmer	Onnen	Tompkins	Workman
Commers	Frerichs	Hugoson	Lindner	Ozment	Van Dellen	
Dauner	Girard	Johnson, V.	Lynch	Pawlenty	Van Engen	
Davids	Goodno	Knight	Molnau	Rhodes	Vickerman	
Dehler	Gruenes	Koppendrayer	Morrison	Seagren	Waltman	
Dempsey	Gutknecht	Krinkie	Ness	Stanius	Wolf	

So it was the judgment of the House that the decision of Speaker pro tempore Bauerly should stand.

CALL OF THE HOUSE LIFTED

Long moved that the call of the House be dispensed with. The motion prevailed and it was so ordered.

Ozment was excused while in conference.

Vellenga was excused for the remainder of today's session.

Sviggum and Davids moved to amend S. F. No. 2192, as amended, as follows:

Page 77, delete lines 26 to 36

Page 78, delete lines 1 to 16

Renumber the subdivisions in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Sviggum and Davids amendment and the roll was called. There were 63 yeas and 67 nays as follows:

Those who voted in the affirmative were:

Abrams	Dempsey	Holsten	Knickerbocker	Milbert	Pawlenty	Tompkins
Asch	Erhardt	Hugoson	Knight	Molnau	Pelowski	Van Dellen
Bergson	Finseth	Jennings	Koppendrayer	Morrison	Rhodes	Van Engen
Bertram	Frerichs	Johnson, R.	Krinkie	Nelson	Seagren	Vickerman
Bettermann	Girard	Johnson, V.	Leppik	Ness	Smith	Waltman
Bishop	Goodno	Kalis	Limmer	Olson, M.	Stanius	Weaver
Commers	Gruenes	Kelso	Lindner	Onnen	Steensma	Wolf
Davids	Gutknecht	Kinkel	Lynch	Osthoff	Sviggum	Worke
Dehler	Hasskamp	Klinzing	Macklin	Ozment	Swenson	Workman

Those who voted in the negative were:

Anderson, R.	Dauner	Huntley	Long	Olson, E.	Rest	Trimble
Battaglia	Dawkins	Jacobs	Lourey	Olson, K.	Rice	Tunheim
Bauerly	Delmont	Jaros	Luther	Opatz	Rodosovich	Wagenius
Beard	Dorn	Jefferson	Mahon	Orenstein	Rukavina	Wejcman
Brown, C.	Evans	Johnson, A.	Mariani	Orfield	Sarna	Wenzel
Brown, K.	Farrell	Kahn	McGuire	Ostrom	Sekhon	Winter
Carlson	Garcia	Kelley	Mosel	Perlt	Simoneau	Spk. Anderson, I.
Carruthers	Greenfield	Krueger	Munger	Peterson	Skoglund	
Clark	Greiling	Lasley	Murphy	Pugh	Solberg	
Cooper	Hausman	Lieder	Neary	Reding	Tomassoni	

The motion did not prevail and the amendment was not adopted.

Bergson and Goodno moved to amend S. F. No. 2192, as amended, as follows:

Page 129, after line 22, insert:

"Sec. 49. Minnesota Statutes 1993 Supplement, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. [DRUGS.] (a) Medical assistance covers drugs, except for fertility drugs, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, or by a physician enrolled in the medical assistance program as a dispensing physician. The commissioner, after receiving recommendations from professional medical associations and professional pharmacist associations, shall designate a formulary committee to advise the commissioner on the names of drugs for which payment is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve three-year terms and shall serve without compensation. Members may be reappointed once.

(b) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the administrative procedure act, but the formulary committee shall review and comment on the formulary contents. The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; and

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include:

(i) drugs or products for which there is no federal funding;

(ii) over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, and vitamins for children under the age of seven and pregnant or nursing women;

(iii) any other over-the-counter drug identified by the commissioner, in consultation with the drug formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14;

(iv) anorectics; and

(v) drugs for which medical value has not been established.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee established by the commissioner, the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee or the usual and customary price charged to the public. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 7.6 percent effective January 1, 1994. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the administrative procedure act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written - brand necessary" on the prescription as required by section 151.21, subdivision 2. Implementation of any change in the fixed dispensing fee that has not been subject to the administrative procedure act is limited to not more than 180 days, unless, during that time, the commissioner initiates rulemaking through the administrative procedure act.

(d) Until the date the on-line, real-time Medicaid Management Information System (MMIS) upgrade is successfully implemented, as determined by the commissioner of administration, a pharmacy provider may require individuals who seek to become eligible for medical assistance under a one-month spend-down, as provided in section 256B.056, subdivision 5, to pay for services to the extent of the spend-down amount at the time the services are provided. A pharmacy provider choosing this option shall file a medical assistance claim for the pharmacy services provided. If medical assistance reimbursement is received for this claim, the pharmacy provider shall return to the individual the total amount paid by the individual for the pharmacy services reimbursed by the medical assistance program. If the claim is not eligible for medical assistance reimbursement because of the provider's failure to comply with the provisions of the medical assistance program, the pharmacy provider shall refund to the individual the total amount paid by the individual. Pharmacy providers may choose this option only if they apply similar credit restrictions to private pay or privately insured individuals. A pharmacy provider choosing this option must inform individuals who

seek to become eligible for medical assistance under a one-month spend-down of (1) their right to appeal the denial of services on the grounds that they have satisfied the spend-down requirement, and (2) their potential eligibility for the health right program or the children's health plan."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Cooper and Worke moved to amend S. F. No. 2192, as amended, as follows:

Page 133, after line 10, insert:

"Sec. 53. [STUDY OF ANESTHESIA PRACTICES.]

The commissioner of health shall study and report to the legislature by January 15, 1995, on anesthesia services provided in health care facilities of this state by nurse anesthetists and anesthesiologists. The study shall compare different third party reimbursement practices and contractual and employment arrangements between health care facilities, nurse anesthetists, and anesthesiologists in terms of their effect on:

(1) patient outcomes, including mortality/morbidity as related to provider and practice methods in urban and rural settings as disclosed by retrospective or prospective study or other statistical analysis;

(2) the cost of the service provided under each arrangement to hospitals, third-party purchasers, and patients; and

(3) any inequitable or anticompetitive effects under each arrangement.

The report shall also include the commissioner's recommendations on the most appropriate method to provide anesthesia services to ensure cost-effective delivery of quality anesthesia services."

Renumber the sections of article 8 in sequence

Correct the internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Evans, Garcia, Mahon, Murphy, Long, Neary, Rest, McGuire, Munger, Wejcman, Clark, Pauly, Orenstein, Luther, Reding, Skoglund, Knickerbocker, Greenfield, Mariani, Orfield, Asch, Trimble, Kahn, McCollum, Kalis, Wagenius, Sekhon, Hausman, Hasskamp, Greiling and Carlson offered an amendment to S. F. No. 2192, as amended.

POINT OF ORDER

Frerichs raised a point of order pursuant to rule 3.09 that the Evans et al amendment was not in order. Speaker pro tempore Bauerly ruled the point of order well taken and the amendment out of order.

Knight moved to amend S. F. No. 2192, as amended, as follows:

Page 203, after line 25, insert:

"Sec. 6. Minnesota Statutes 1992, section 295.52, is amended by adding a subdivision to read:

Subd. 6. [DENTISTS.] Dentists are exempt from the health care provider tax imposed by this section unless the funds collected are used solely for dental care."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Knight amendment and the roll was called. There were 101 yeas and 29 nays as follows:

Those who voted in the affirmative were:

Abrams	Dawkins	Holsten	Krinkie	Mosel	Pugh	Tunheim
Anderson, R.	Dehler	Hugoson	Lasley	Murphy	Rest	Van Dellen
Asch	Delmont	Huntley	Leppik	Nelson	Rhodes	Van Engen
Bauerly	Dempsey	Jacobs	Lieder	Ness	Rice	Vickerman
Beard	Dorn	Jefferson	Limmer	Olson, K.	Rukavina	Waltman
Bergson	Erhardt	Jennings	Lindner	Olson, M.	Sarna	Weaver
Bertram	Evans	Johnson, A.	Long	Onnen	Seagren	Winter
Bettermann	Farrell	Johnson, R.	Lynch	Opatz	Solberg	Wolf
Bishop	Finseth	Johnson, V.	Macklin	Orenstein	Stanius	Worke
Brown, K.	Frerichs	Kalis	Mahon	Osthoff	Steensma	Workman
Carlson	Girard	Kelso	McCollum	Ozment	Sviggum	Spk. Anderson, I.
Commers	Goodno	Klinzing	McGuire	Pawlenty	Swenson	
Cooper	Gutknecht	Knickerbocker	Milbert	Pelowski	Tomassoni	
Dauner	Hasskamp	Knight	Molnau	Perlt	Tompkins	
Davids	Haukoos	Koppendrayer	Morrison	Peterson	Trimble	

Those who voted in the negative were:

Battaglia	Greenfield	Kahn	Mariani	Ostrom	Skoglund
Brown, C.	Greiling	Kelley	Munger	Reding	Wagenius
Carruthers	Gruenes	Krueger	Neary	Rodosovich	Wejcman
Clark	Hausman	Lourey	Olson, E.	Sekhon	Wenzel
Garcia	Jaros	Luther	Orfield	Simoneau	

The motion prevailed and the amendment was adopted.

McCollum was excused while in conference.

Gutknecht moved to amend S. F. No. 2192, as amended, as follows:

Page 52, delete section 9

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Gutknecht amendment and the roll was called. There were 51 yeas and 73 nays as follows:

Those who voted in the affirmative were:

Abrams	Dehler	Gutknecht	Koppendrayer	Ness	Sviggum	Wolf
Asch	Dempsey	Haukoos	Krinkie	Olson, M.	Swenson	Worke
Bergson	Erhardt	Holsten	Leppik	Onnen	Tompkins	Workman
Bertram	Finseth	Hugoson	Limmer	Pawlenty	Van Dellen	
Bettermann	Frerichs	Johnson, V.	Lindner	Pelowski	Van Engen	
Bishop	Girard	Kalis	Lynch	Rhodes	Vickerman	
Commers	Goodno	Knickerbocker	Molnau	Seagren	Waltman	
Davids	Gruenes	Knight	Morrison	Stanius	Weaver	

Those who voted in the negative were:

Anderson, R.	Delmont	Jefferson	Lieder	Neary	Pugh	Tomassoni
Battaglia	Dorn	Jennings	Long	Nelson	Reding	Trimble
Bauerly	Evans	Johnson, A.	Lourey	Olson, E.	Rest	Tunheim
Beard	Farrell	Johnson, R.	Luther	Olson, K.	Rice	Wejcman
Brown, C.	Garcia	Kahn	Mahon	Opatz	Rodosovich	Wenzel
Carlson	Greenfield	Kelley	Mariani	Orenstein	Rukavina	Winter
Carruthers	Greiling	Kelso	McGuire	Orfield	Sarna	Spk. Anderson, I.
Clark	Hausman	Kinkel	Milbert	Osthoff	Simoneau	
Cooper	Huntley	Klinzing	Mosel	Ostrom	Skoglund	
Dauner	Jacobs	Krueger	Munger	Perlt	Solberg	
Dawkins	Jaros	Lasley	Murphy	Peterson	Steensma	

The motion did not prevail and the amendment was not adopted.

Speaker pro tempore Bauerly called Kahn to the Chair.

Gutknecht moved to amend S. F. No. 2192, as amended, as follows:

Page 73, line 31, after the period, insert "The commissioners of health and human services shall study and report to the legislature by January 1, 1995, the cost of achieving universal coverage. The commissioners should also include in this study an implementation plan for achieving universal coverage and how it will be paid for."

The motion prevailed and the amendment was adopted.

Bauerly was excused for the remainder of today's session.

Asch moved to amend S. F. No. 2192, as amended, as follows:

Page 73, line 33, after "have" insert "access to"

Page 76, delete lines 25 to 27

Renumber remaining subdivisions

Correct internal references

A roll call was requested and properly seconded.

The question was taken on the Asch amendment and the roll was called. There were 63 yeas and 64 nays as follows:

Those who voted in the affirmative were:

Abrams	Dehler	Hasskamp	Koppendrayer	Morrison	Pugh	Tompkins
Asch	Dempsey	Haukoos	Krinkie	Mosel	Rhodes	Van Dellen
Beard	Erhardt	Holsten	Leppik	Ness	Sarna	Van Engen
Bergson	Finseth	Hugoson	Limmer	Olson, M.	Seagren	Vickerman
Bertram	Frerichs	Jacobs	Lindner	Onnen	Smith	Waltman
Bettermann	Girard	Johnson, V.	Lynch	Opatz	Solberg	Weaver
Bishop	Goodno	Klinzing	Macklin	Osthoff	Stanius	Wolf
Commers	Gruenes	Knickerbocker	Milbert	Pauly	Sviggum	Worke
Davids	Gutknecht	Knight	Molnau	Pawlenty	Swenson	Workman

Those who voted in the negative were:

Anderson, R.	Delmont	Jefferson	Lasley	Neary	Reding	Wejcman
Battaglia	Dorn	Jennings	Lieder	Nelson	Rice	Wenzel
Brown, C.	Evans	Johnson, A.	Long	Olson, E.	Rodosovich	Winter
Brown, K.	Farrell	Johnson, R.	Lourey	Olson, K.	Rukavina	Spk. Anderson, I.
Carlson	Garcia	Kahn	Luther	Orenstein	Simoneau	
Carruthers	Greenfield	Kalis	Mahon	Orfield	Skoglund	
Clark	Greiling	Kelley	Mariani	Ostrom	Steensma	
Cooper	Hausman	Kelso	McGuire	Pelowski	Tomassoni	
Dauner	Huntley	Kinkel	Munger	Perlt	Trimble	
Dawkins	Jaros	Krueger	Murphy	Peterson	Tunheim	

The motion did not prevail and the amendment was not adopted.

Seagren moved to amend S. F. No. 2192, as amended, as follows:

Page 7, line 21, delete "consulting"

The motion prevailed and the amendment was adopted.

Skoglund moved to amend S. F. No. 2192, as amended, as follows:

Page 154, after line 15, insert:

"An application form for a Medicare supplement policy or certificate, as defined in this section, must prominently disclose the anticipated loss ratio and explain what it means."

The motion prevailed and the amendment was adopted.

Stanius offered an amendment to S. F. No. 2192, as amended.

POINT OF ORDER

Greenfield raised a point of order pursuant to rule 3.09 that the Stanius amendment was not in order. Speaker pro tempore Kahn ruled the point of order well taken and the amendment out of order.

Onnen moved to amend S. F. No. 2192, as amended, as follows:

Page 21, line 26, after the period, insert "The commissioner shall contract with an independent quality improvement organization to conduct the pilot study."

Page 23, after line 27, insert:

"Sec. 7. [62J.465] [INDEPENDENT QUALITY IMPROVEMENT ORGANIZATION.]

Subdivision 1. [CONTRACT.] The commissioner, in consultation with the data institute, shall contract with an independent health care quality improvement organization to conduct quality assessment and quality improvement activities, as specified by this section. The organization awarded the contract must be neither a health care provider or payer, nor a regulatory agency. The organization under contract shall provide an objective, unbiased, and comprehensive assessment of the quality of health care provided to consumers through integrated service networks and the regulated all-payer option.

Subd. 2. [DUTIES OF THE INDEPENDENT QUALITY IMPROVEMENT ORGANIZATION.] The independent quality improvement organization awarded the contract shall:

(1) provide independent analysis of the quality of health care based on the data collected by the data collection vendor, the quality indicators determined by the data institute, and other appropriate data sources;

(2) analyze data for utilization, process, and outcomes of health care services;

(3) provide technical assistance to health care providers to improve the quality of care;

(4) develop and maintain a mechanism to integrate and utilize information on quality of care from existing boards, agencies, offices of consumer advocacy and other sources;

(5) conduct independent quality assessments and provide these assessments to the data analysis unit, for inclusion in health care quality report cards; and

(6) conduct the provider information pilot study developed by the commissioner under section 62J.45, subdivision 4a, paragraph (b).

Subd. 3. [DISSEMINATION OF QUALITY OF CARE INFORMATION.] The information clearinghouse shall make reports generated by the independent quality improvement organization available to the public and health care providers."

Renumber the sections in sequence

Correct internal references

A roll call was requested and properly seconded.

The question was taken on the Onnen amendment and the roll was called. There were 50 yeas and 75 nays as follows:

Those who voted in the affirmative were:

Abrams	Erhardt	Holsten	Lindner	Osthoff	Swenson	Worke
Asch	Finseth	Hugoson	Lynch	Pauly	Tompkins	Workman
Bettermann	Frerichs	Johnson, V.	Macklin	Pawlenty	Van Dellen	
Commers	Girard	Knickerbocker	Molnau	Rhodes	Van Engen	
Davids	Goodno	Knight	Morrison	Seagren	Vickerman	
Dehler	Gutknecht	Koppendrayer	Ness	Smith	Waltman	
Dempsey	Hasskamp	Krinkie	Olson, M.	Stanius	Weaver	
Dorn	Haukoos	Limmer	Onnen	Sviggum	Wolf	

Those who voted in the negative were:

Anderson, R.	Dauner	Jacobs	Klinzing	Mosel	Pelowski	Solberg
Battaglia	Dawkins	Jaros	Krueger	Munger	Perlt	Steensma
Beard	Delmont	Jefferson	Lasley	Murphy	Peterson	Tomassoni
Bergson	Evans	Jennings	Leppik	Neary	Reding	Trimble
Bertram	Farrell	Johnson, A.	Lieder	Nelson	Rest	Tunheim
Brown, C.	Garcia	Johnson, R.	Long	Olson, E.	Rice	Wejcman
Brown, K.	Greenfield	Kahn	Lourey	Olson, K.	Rodosovich	Wenzel
Carlson	Greiling	Kalis	Luther	Opatz	Rukavina	Winter
Carruthers	Gruenes	Kelley	Mahon	Orenstein	Sarna	Spk. Anderson, I.
Clark	Hausman	Kelso	Mariani	Orfield	Simoneau	
Cooper	Huntley	Kinkel	McGuire	Ostrom	Skoglund	

The motion did not prevail and the amendment was not adopted.

The Speaker resumed the Chair.

Onnen moved to amend S. F. No. 2192, as amended, as follows:

Page 4, line 20, after the period, insert "A community integrated service network may be organized as an insurance company licensed under chapter 60A or as a corporation organized under chapter 302A or under the similar laws of another state."

Page 57, line 27, delete "or"

Page 57, line 28, before the period insert ", or as a corporation organized under chapter 302A or under the similar laws of another state"

The motion did not prevail and the amendment was not adopted.

Cooper moved to amend S. F. No. 2192, as amended, as follows:

Page 1, line 17 of the Klinzing et al amendment, after the period, insert "A health plan company may require that providers who wish to apply for admission to the expanded network pay to the health plan company an application fee designed to cover the costs of establishing the expanded network. The application fee is subject to the approval of the commissioner of health."

A roll call was requested and properly seconded.

The question was taken on the Cooper amendment and the roll was called. There were 31 yeas and 91 nays as follows:

Those who voted in the affirmative were:

Abrams	Cooper	Huntley	Leppik	Mariani	Orfield	Wejcman
Brown, C.	Dawkins	Jefferson	Lieder	Neary	Rice	
Brown, K.	Garcia	Johnson, A.	Lourey	Olson, E.	Simoneau	
Carlson	Greenfield	Kahn	Luther	Olson, K.	Skoglund	
Carruthers	Greiling	Kelley	Lynch	Orenstein	Van Engen	

Those who voted in the negative were:

Anderson, R.	Beard	Bettermann	Commers	Dehler	Dorn	Finseth
Asch	Bergson	Bishop	Dauner	Delmont	Erhardt	Frerichs
Battaglia	Bertram	Clark	Davids	Dempsey	Evans	Girard

Goodno	Johnson, V.	Lasley	Mosel	Pawlenty	Seagren	Van Dellen
Gruenes	Kalis	Limmer	Munger	Pelowski	Smith	Vickerman
Gutknecht	Kelso	Lindner	Murphy	Perlt	Solberg	Waltman
Hasskamp	Kinkel	Long	Nelson	Peterson	Stanius	Weaver
Haukoos	Klinzing	Macklin	Ness	Reding	Steensma	Wenzel
Holsten	Knickerbocker	Mahon	Olson, M.	Rest	Sviggum	Winter
Hugoson	Knight	McGuire	Onnen	Rhodes	Swenson	Wolf
Jacobs	Koppendrayer	Milbert	Opatz	Rodosovich	Tomassoni	Worke
Jaros	Krinkie	Molnau	Ostrom	Rukavina	Tompkins	Workman
Johnson, R.	Krueger	Morrison	Pauly	Sarna	Tunheim	Spk. Anderson, I.

The motion did not prevail and the amendment was not adopted.

Wenzel and Krueger moved to amend S. F. No. 2192, as amended, as follows:

Page 123, after line 18, insert:

"Sec. 39. Minnesota Statutes 1992, section 144.802, is amended by adding a subdivision to read:

Subd. 3c. [LICENSURE FOLLOWING CLOSURE OF AN EXISTING SUBSTATION.]

Except for submission of a written application to the commissioner, as provided under subdivision 3, paragraph (a), an applicant seeking a license under this section shall be exempt from the provisions of subdivisions 3 and 4, provided that the applicant:

(1) is a first response team applying for a basic life support ambulance service license;

(2) has applied to provide basic life support ambulance services in a two-township area, as a result of the August, 1991, closure of a substation by an advanced life support ambulance service; and

(3) agrees to withdraw its licensure application if the advanced life support ambulance service reopens the closed substation or opens a new substation in a location from which the two-township area can be effectively served.

The commissioner shall grant a license to an applicant who meets the requirements of this subdivision within 30 days after the written application."

Page 133, line 25, after the period insert "Section 39 relating to the licensure of an ambulance service is effective the day following final enactment."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Leppik, Cooper and Abrams moved to amend S. F. No. 2192, as amended, as follows:

Page 1, line 17 of the Klinzing et al amendment, after the period, insert "Persons enrolled in health plans prior to January 1, 1995, shall be permitted to retain and renew their existing health plans with premium rates that do not reflect any costs of establishing or maintaining the expanded network, unless the person chooses to enroll in the expanded network."

A roll call was requested and properly seconded.

The question was taken on the Leppik et al amendment and the roll was called. There were 49 yeas and 77 nays as follows:

Those who voted in the affirmative were:

Abrams	Dawkins	Greenfield	Johnson, A.	Lynch	Pauly	Tomassoni
Bettermann	Dehler	Greiling	Kahn	Mariani	Pawlenty	Trimble
Bishop	Dempsey	Gruenes	Kelley	Molnau	Rhodes	Van Engen
Brown, K.	Erhardt	Haukoos	Knickerbocker	Morrison	Seagren	Vickerman
Carruthers	Frerichs	Hugoson	Leppik	Neary	Simoneau	Wagenius
Commers	Girard	Huntley	Long	Orenstein	Skoglund	Weaver
Cooper	Goodno	Jefferson	Lourey	Orfield	Sviggum	Wolf

Those who voted in the negative were:

Anderson, R.	Dorn	Kalis	Luther	Olson, E.	Reding	Swenson
Asch	Evans	Kinkel	Macklin	Olson, K.	Rest	Tompkins
Battaglia	Finseth	Klinzing	Mahon	Olson, M.	Rice	Tunheim
Beard	Garcia	Knight	McCollum	Onnen	Rodosovich	Van Dellen
Bergson	Gutknecht	Koppendrayer	McGuire	Opatz	Rukavina	Waltman
Bertram	Hasskamp	Krinkie	Milbert	Osthoff	Sarna	Wejcman
Brown, C.	Holsten	Krueger	Mosel	Ostrom	Sekhon	Wenzel
Carlson	Jacobs	Lasley	Munger	Pelowski	Smith	Winter
Dauner	Jaros	Lieder	Murphy	Perlt	Solberg	Worke
Davids	Johnson, R.	Limmer	Nelson	Peterson	Stanius	Workman
Delmont	Johnson, V.	Lindner	Ness	Pugh	Steensma	Spk. Anderson, I.

The motion did not prevail and the amendment was not adopted.

S. F. No. 2192, A bill for an act relating to health; MinnesotaCare; establishing and regulating community integrated service networks; defining terms; creating a reinsurance and risk adjustment association; classifying data; requiring reports; mandating studies; modifying provisions relating to the regulated all-payer option; requiring administrative rulemaking; setting timelines and requiring plans for implementation; designating essential community providers; establishing an expedited fact finding and dispute resolution process; requiring proposed legislation; establishing task forces; providing for demonstration models; mandating universal coverage; requiring insurance reforms; providing grant programs; establishing the Minnesota health care administrative simplification act; implementing electronic data interchange standards; creating the Minnesota center for health care electronic data interchange; providing standards for the Minnesota health care identification card; appropriating money; providing penalties; amending Minnesota Statutes 1992, sections 60A.02, subdivision 3; 60A.15, subdivision 1; 62A.303; 62D.02, subdivision 4; 62D.04, by adding a subdivision; 62E.02, subdivisions 10, 18, 20, and 23; 62E.10, subdivisions 1, 2, and 3; 62E.141; 62E.16; 62J.03, by adding a subdivision; 62L.02, subdivisions 9, 13, 17, 24, and by adding subdivisions; 62L.03, subdivision 1; 62L.05, subdivisions 1, 5, and 8; 62L.06; 62L.07, subdivision 2; 62L.08, subdivisions 2, 5, 6, and 7; 62L.12; 62L.21, subdivision 2; 62M.02, subdivisions 5 and 21; 62M.03, subdivisions 1, 2, and 3; 62M.05, subdivision 3; 62M.06, subdivision 3; 62M.09, subdivision 5; 144.335, by adding a subdivision; 144.581, subdivision 2; 256.9355, by adding a subdivision; 256.9358, subdivision 4; 295.50, by adding subdivisions; and 318.02, by adding a subdivision; Minnesota Statutes 1993 Supplement, sections 43A.317, by adding a subdivision; 60K.14, subdivision 7; 61B.20, subdivision 13; 62A.011, subdivision 3; 62A.65, subdivisions 2, 3, 4, 5, and by adding subdivisions; 62D.12, subdivision 17; 62J.03, subdivision 6; 62J.04, subdivisions 1 and 1a; 62J.09, subdivisions 1a and 2; 62J.33, by adding subdivisions; 62J.35, subdivisions 2 and 3; 62J.38; 62J.41, subdivision 2; 62J.45, by adding subdivisions; 62L.02, subdivisions 8, 11, 15, 16, 19, and 26; 62L.03, subdivisions 3, 4, and 5; 62L.04, subdivision 1; 62L.08, subdivisions 4 and 8; 62N.01; 62N.02, subdivisions 1, 8, and by adding a subdivision; 62N.06, subdivision 1; 62N.065, subdivision 1; 62N.10, subdivisions 1 and 2; 62N.22; 62N.23; 62P.01; 62P.03; 62P.04; 62P.05; 144.1486; 151.21, subdivisions 7 and 8; 256.9352, subdivision 3; 256.9353, subdivisions 3 and 7; 256.9354, subdivisions 1, 4, 5, and 6; 256.9356, subdivision 3; 256.9362, subdivision 6; 256.9363, subdivisions 6, 7, and 9; 256.9657, subdivision 3; 295.50, subdivisions 3, 4, and 12b; 295.52, subdivision 5; 295.53, subdivisions 1, 2, and 5; 295.54; 295.58; and 295.582; Laws 1992, chapter 549, article 9, section 22; proposing coding for new law in Minnesota Statutes, chapters 62A; 62J; 62N; 62P; 144; and 317A; proposing coding for new law as Minnesota Statutes, chapter 62Q; repealing Minnesota Statutes 1992, sections 62A.02, subdivision 5; 62E.51; 62E.52; 62E.53; 62E.531; 62E.54; 62E.55; and 256.362, subdivision 5; Minnesota Statutes 1993 Supplement, sections 62J.04, subdivision 8; 62N.07; 62N.075; 62N.08; 62N.085; and 62N.16.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 77 yeas and 55 nays as follows:

Those who voted in the affirmative were:

Anderson, R.	Delmont	Jacobs	Knickerbocker	McGuire	Reding	Solberg
Battaglia	Dorn	Jaros	Krueger	Mosel	Rest	Steensma
Beard	Evans	Jefferson	Lasley	Munger	Rhodes	Swenson
Bishop	Farrell	Jennings	Leppik	Murphy	Rice	Tomassoni
Brown, K.	Finseth	Johnson, A.	Lieder	Neary	Rodosovich	Trimble
Carlson	Garcia	Johnson, R.	Long	Nelson	Rukavina	Tunheim
Carruthers	Greenfield	Kahn	Lourey	Olson, K.	Sarna	Wagenius
Clark	Greiling	Kalis	Luther	Orenstein	Sekhon	Wejcman
Cooper	Hasskamp	Kelley	Mahon	Orfield	Simoneau	Wenzel
Dauner	Hausman	Kinkel	Mariani	Ostrom	Skoglund	Winter
Dawkins	Huntley	Klinzing	McCollum	Peterson	Smith	Spk. Anderson, I.

Those who voted in the negative were:

Abrams	Dehler	Haukoos	Limmer	Olson, E.	Pelowski	Van Engen
Asch	Dempsey	Holsten	Lindner	Olson, M.	Perlt	Vickerman
Bergson	Erhardt	Hugoson	Lynch	Onnen	Pugh	Waltman
Bertram	Frerichs	Johnson, V.	Macklin	Opatz	Seagren	Weaver
Bettermann	Girard	Kelso	Milbert	Osthoff	Stanius	Wolf
Brown, C.	Goodno	Knight	Molnau	Ozment	Sviggum	Worke
Commers	Gruenes	Koppendrayer	Morrison	Pauly	Tompkins	Workman
Davids	Gutknecht	Krinkie	Ness	Pawlenty	Van Dellen	

The bill was passed, as amended, and its title agreed to.

There being no objection, the order of business reverted to Messages from the Senate.

MESSAGES FROM THE SENATE

The following messages were received from the Senate:

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned:

H. F. No. 1985, A bill for an act relating to partnerships; providing for the registration and operation of limited liability partnerships; appropriating money; amending Minnesota Statutes 1992, sections 319A.02, subdivision 5; 319A.05; 319A.06, subdivision 2; 319A.07; 319A.12, subdivisions 1, 1a, and 2; 323.02, subdivision 8, and by adding a subdivision; 323.06; 323.14; 323.17; 323.35; and 323.39; Minnesota Statutes 1993 Supplement, section 319A.02, subdivision 7; proposing coding for new law in Minnesota Statutes, chapter 323.

PATRICK E. FLAHAVEN, Secretary of the Senate

Mr. Speaker:

I hereby announce that the Senate accedes to the request of the House for the appointment of a Conference Committee on the amendments adopted by the Senate to the following House File:

H. F. No. 2519, A bill for an act relating to prostitution; creating a civil cause of action for persons who are coerced into prostitution; proposing coding for new law in Minnesota Statutes, chapter 611A.

The Senate has appointed as such committee:

Ms. Reichgott Junge; Mr. Knutson; Ms. Kiscaden; Mr. Spear and Ms. Ranum.

Said House File is herewith returned to the House.

PATRICK E. FLAHAVEN, Secretary of the Senate

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 3193, A bill for an act relating to public finance; providing conditions and requirements for the issuance of debt; authorizing the use of revenue recapture by certain housing agencies; clarifying a property tax exemption; allowing school districts to make and levy for certain contract or lease purchases; changing contract requirements for certain projects; changing certain debt service fund requirements; authorizing use of special assessments for on-site water contamination improvements; authorizing an increase in the membership of county housing and redevelopment authorities; amending Minnesota Statutes 1992, sections 270A.03, subdivision 2; 383.06, subdivision 2; 429.011, by adding a subdivision; 429.031, subdivision 3; 469.006, subdivision 1; 469.015, subdivision 4; 469.158; 469.184, by adding a subdivision; 471.56, subdivision 5; 471.562, subdivision 3, and by adding a subdivision; 475.52, subdivision 1; 475.53, subdivision 5; 475.54, subdivision 16; 475.66, subdivision 1; and 475.79; Minnesota Statutes 1993 Supplement, sections 124.91, subdivision 3; 272.02, subdivision 1; and 469.033, subdivision 6; proposing coding for new law in Minnesota Statutes, chapter 469.

PATRICK E. FLAHAVEN, Secretary of the Senate

Rest moved that the House refuse to concur in the Senate amendments to H. F. No. 3193, that the Speaker appoint a Conference Committee of 3 members of the House, and that the House requests that a like committee be appointed by the Senate to confer on the disagreeing votes of the two houses. The motion prevailed.

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 2227, A bill for an act relating to electric currents in earth; requiring the public utilities commission to appoint a team of science advisors; mandating scientific framing of research questions; providing for studies of stray voltage and the effects of earth as a conductor of electricity; requiring scientific peer review of findings and conclusions; providing for a report to the public utilities commission; appropriating money.

PATRICK E. FLAHAVEN, Secretary of the Senate

Krueger moved that the House refuse to concur in the Senate amendments to H. F. No. 2227, that the Speaker appoint a Conference Committee of 3 members of the House, and that the House requests that a like committee be appointed by the Senate to confer on the disagreeing votes of the two houses. The motion prevailed.

Mr. Speaker:

I hereby announce that the Senate refuses to concur in the House amendments to the following Senate File:

S. F. No. 1706, A bill for an act relating to public utilities; providing legislative authorization of the construction of a facility for the temporary dry cask storage of spent nuclear fuel at Prairie Island nuclear generating plant; providing conditions for any future expansion of storage capacity; providing for a transfer of land; approving the

continued operation of pool storage at Monticello and Prairie Island nuclear generating plants; requiring development of wind power; regulating nuclear power plants; requiring increased conservation investments; providing low-income discounted electric rates; regulating certain advertising expenses related to nuclear power; providing for intervenor compensation; appropriating money; amending Minnesota Statutes 1992, sections 216B.16, subdivision 8, and by adding a subdivision; 216B.241, subdivision 1a; and 216B.243, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 216B.

The Senate respectfully requests that a Conference Committee be appointed thereon. The Senate has appointed as such committee:

Messrs. Novak, Metzen, Dille, Murphy and Riveness.

Said Senate File is herewith transmitted to the House with the request that the House appoint a like committee.

PATRICK E. FLAHAVEN, Secretary of the Senate

Jennings moved that the House accede to the request of the Senate and that the Speaker appoint a Conference Committee of 5 members of the House to meet with a like committee appointed by the Senate on the disagreeing votes of the two houses on S. F. No. 1706. The motion prevailed.

Mr. Speaker:

I hereby announce the passage by the Senate of the following Senate File, herewith transmitted:

S. F. No. 180.

PATRICK E. FLAHAVEN, Secretary of the Senate

FIRST READING OF SENATE BILLS

S. F. No. 180, A bill for an act relating to horse racing; proposing an amendment to the Minnesota Constitution, article X, section 8; permitting the legislature to authorize pari-mutuel betting on horse racing without limitation; directing the Minnesota racing commission to prepare and submit legislation to implement televised off-site betting.

The bill was read for the first time.

Simoneau moved that S. F. No. 180 and H. F. No. 3227, now on General Orders, be referred to the Chief Clerk for comparison. The motion prevailed.

SPECIAL ORDERS

Carruthers moved that the bills on Special Orders for today be continued. The motion prevailed.

GENERAL ORDERS

Carruthers moved that the bills on General Orders for today be continued. The motion prevailed.

MOTIONS AND RESOLUTIONS

Wejcman moved that the names of Mosel and Luther be added as authors on H. F. No. 2380. The motion prevailed.

Jefferson moved that the name of Solberg be added as an author on H. F. No. 3041. The motion prevailed.

Knight moved that the following statement be printed in the Journal of the House: "It was my intention to vote in the negative on Monday, April 25, 1994, when the vote was taken on the first Jennings and Dempsey amendment to S. F. No. 1706, the unofficial engrossment, as amended." The motion prevailed.

Olson, M., moved that the following statement be printed in the Journal of the House: "It was my intention to vote in the affirmative on Monday, April 25, 1994, when the vote was taken on the repassage of H. F. No. 2143, as amended by the Senate." The motion prevailed.

Olson, M., moved that the following statement be printed in the Journal of the House: "It was my intention to vote in the affirmative on Monday, April 25, 1994, when the vote was taken on the repassage of H. F. No. 2508, as amended by the Senate." The motion prevailed.

Olson, M., moved that the following statement be printed in the Journal of the House: "It was my intention to vote in the affirmative on Monday, April 25, 1994, when the vote was taken on the repassage of H. F. No. 3136, as amended by the Senate." The motion prevailed.

Van Dellen moved that the following statement be printed in the Journal of the House: "It was my intention to vote in the affirmative on Monday, April 25, 1994, when the vote was taken on the repassage of H. F. No. 3136, as amended by the Senate." The motion prevailed.

Rukavina moved that H. F. No. 2687 be recalled from the Committee on Education and be re-referred to the Committee on Capital Investment. The motion prevailed.

ANNOUNCEMENTS BY THE SPEAKER

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 1999:

Pugh, Asch and Swenson.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 2046:

Wagenius, Trimble and Ozment.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 2227:

Krueger, Jacobs and Koppendrayer.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 3193:

Rest, Abrams and Milbert.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 1706:

Jennings, Munger, Carlson, Hausman and Johnson, V.

ADJOURNMENT

Carruthers moved that when the House adjourns today it adjourn until 9:00 a.m., Wednesday, April 27, 1994. The motion prevailed.

Carruthers moved that the House adjourn. The motion prevailed, and the Speaker declared the House stands adjourned until 9:00 a.m., Wednesday, April 27, 1994.

EDWARD A. BURDICK, Chief Clerk, House of Representatives