Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
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Senate

State of Minnesota

S.F. No. 718 - Presumptive Hospital Licensure

Author: Senator Dallas Sams

Prepared by: David Giel, Senate Research (651/296-7178)

Date: February 21, 2005

S.F. No. 718 authorizes inspection and accreditation by the American Osteopathic Association (AOA) to qualify Minnesota hospitals for state licensure in lieu of regular Minnesota Department of Health (MDH) inspections. Currently, only the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has this presumptive licensure authority.

Section 1 (144.122) sets the state licensure fee for an OAO-approved hospital at the same level as the fee charged a hospital approved by the JCAHO.

Section 2 (144.55, subdivision 2) amends the hospital licensure law by adding a definition of "approved accrediting organization," which includes JCAHO and AOA, to replace a definition of "joint commission," which only includes JCAHO.

Section 3 (144.55, subdivision 4) provides that a hospital with a currently valid accreditation from JCAHO or AOA is presumed to comply with state licensure standards and no further routine inspections may be conducted, except for validation inspections of a limited sample of hospitals.

Section 4 (144.55, subdivision 5) inserts the term "an approved accrediting organization" to replace "the joint commission" in a section requiring routine state inspections of hospitals and outpatient surgical centers to be coordinated.

DG:rdr

Senators Sams and Larson introduced--

S.F. No. 718: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; authorizing an additional hospital accrediting organization for presumptive licensure purposes; amending Minnesota Statutes 2004, sections 144.122; 144.55, subdivisions 2, 4, 5.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 144.122, is amended to read:

144.122 [LICENSE, PERMIT, AND SURVEY FEES.]

(a) The state commissioner of health, by rule, may prescribe reasonable procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first

approved by the Department of Finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO ~~hospitals~~) <u>and American Osteopathic Association (AOA) hospitals</u>	$7,055
Non-JCAHO <u>and non-AOA</u> hospitals	$4,680 plus $234 per bed
Nursing home	$183 plus $91 per bed

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	$1,512
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.

(e) Unless prohibited by federal law, the commissioner of

health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	$ 900
Swing bed surveys for nursing homes	$1,200
Psychiatric hospitals	$1,400
Rural health facilities	$1,100
Portable x-ray providers	$ 500
Home health agencies	$1,800
Outpatient therapy agencies	$ 800
End stage renal dialysis providers	$2,100
Independent therapists	$ 800
Comprehensive rehabilitation outpatient facilities	$1,200
Hospice providers	$1,700
Ambulatory surgical providers	$1,800
Hospitals	$4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 2. Minnesota Statutes 2004, section 144.55, subdivision 2, is amended to read:

Subd. 2. [DEFINITIONS.] For the purposes of this section, the following terms have the meanings given:

(a) "Outpatient surgical center" or "center" means a freestanding facility organized for the specific purpose of providing elective outpatient surgery for preexamined, prediagnosed, low-risk patients. Admissions are limited to procedures that utilize general anesthesia or conscious sedation

and that do not require overnight inpatient care. An outpatient surgical center is not organized to provide regular emergency medical services and does not include a physician's or dentist's office or clinic for the practice of medicine, the practice of dentistry, or the delivery of primary care.

(b) ~~"joint commission"~~ "Approved accrediting organization" means the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association.

Sec. 3. Minnesota Statutes 2004, section 144.55, subdivision 4, is amended to read:

Subd. 4. [ROUTINE INSPECTIONS; PRESUMPTION.] Any hospital surveyed and accredited under the standards of the hospital accreditation program of ~~the joint commission~~ an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance. Notwithstanding the provisions of sections 144.54 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this section. The provisions of section 144.653 relating to the assessment and collection of fines shall not apply to any hospital. The commissioner of health shall annually conduct, with notice, validation inspections of a selected sample of the number of hospitals accredited by ~~the joint commission~~ an approved accrediting organization, not to exceed ten percent of accredited hospitals, for the purpose of determining compliance with the provisions of subdivision 3. If a validation survey discloses a failure to comply with subdivision 3, the provisions of section 144.653 relating to correction orders, reinspections, and notices of noncompliance shall apply. The commissioner

shall also conduct any inspection necessary to determine whether hospital construction, addition, or remodeling projects comply with standards for construction promulgated in rules pursuant to subdivision 3. Pursuant to section 144.653, the commissioner shall inspect any hospital that does not have a currently valid hospital accreditation certificate from ~~the joint commission~~ an approved accrediting organization. Nothing in this subdivision shall be construed to limit the investigative powers of the Office of Health Facility Complaints as established in sections 144A.51 to 144A.54.

Sec. 4. Minnesota Statutes 2004, section 144.55, subdivision 5, is amended to read:

Subd. 5. [COORDINATION OF INSPECTIONS.] Prior to conducting routine inspections of hospitals and outpatient surgical centers, a state agency shall notify the commissioner of its intention to inspect. The commissioner shall then determine whether the inspection is necessary in light of any previous inspections conducted by the commissioner, any other state agency, or ~~the joint commission~~ an approved accrediting organization. The commissioner shall notify the agency of the determination and may authorize the agency to conduct the inspection. No state agency may routinely inspect any hospital without the authorization of the commissioner. The commissioner shall coordinate, insofar as is possible, routine inspections conducted by state agencies, so as to minimize the number of inspections to which hospitals are subject.

PROPOSED LEGISLATION AUTHORIZING AN ADDITIONAL HOSPITAL ACCREDITING ORGANIZATION FOR PRESUMPTIVE LICENSURE

H.F. 681, S.F. 718

House Authors: Westrom, Otremba, Simpson and Heidgerken

Senate Authors: Sams and Larson

FACT SHEET:

1. All hospitals licensed in the state of Minnesota must be surveyed by either the Department of Health or the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission).

2. Douglas County Hospital (DCH) is the only Minnesota hospital with dual accreditation from the Joint Commission and the American Osteopathic Association (AOA).

3. The federal government recognizes both the Joint Commission and AOA to accredit and survey hospitals.

4. The state of Minnesota only recognizes the Joint Commission.

5. The AOA Health Care Accreditation Program has been in existence since 1945 and accredits 220 hospitals nationwide.

6. The AOA accreditation program has been granted "deemed status" in 22 states.

7. DCH pursued AOA accreditation so we would be eligible to become a Medicare Rural Referral Center.

8. Medicare Rural Referral Centers receive a higher Medicare reimbursement.

9. To keep our Medicare Rural Referral Center status, we will need to maintain our AOA accreditation.

10. Because it is costly for DCH to maintain dual accreditation, we are asking for legislation to grant deemed status to both the Joint Commission and AOA.

11. The Minnesota Department of Health is recommending that we pursue legislation to grant deeming authority for both the Joint Commission and AOA.

12. Our experience with the AOA survey team and accreditation process was outstanding. The three-day survey was conducted by a physician, nurse and administrator. It was very thorough and rigorous relative to both federal and state hospital licensing laws/regulations.

William G. Flaig, Administrator
Douglas County Hospital, Alexandria, MN
February 24, 2005

(AOA/proposedlegis)

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

February 4, 2005

William G. Flaig, Administrator
Douglas County Hospital
111 17th Avenue East
Alexandria, Minnesota 56308

Dear Mr. Flaig:

This is in response to your letter, dated January 11, 2005, concerning the need to amend Minnesota Statutes Section 144.55, Subd. 4. in order to accord the same "deemed status" to hospitals receiving accreditation by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA).

It is important to note that the Minnesota Department of Health has not done a crosswalk between the accreditation standards of JCAHO and AOA to determine their relative comparability. However, given the fact that AOA is approved by the Centers for Medicare and Medicaid Services as a national accreditation organization for hospitals that request participation in the Medicare program, we would not be opposed to amending M.S. 144.55, Subd. 4. to include the American Osteopathic Association.

If you have not already done so, you may wish to communicate with the Minnesota Hospital Association concerning your intentions. Please advise us when language is drafted and bill authors have been identified.

Thank you.

Sincerely,

for Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, MN 55164-0882

HFAP Healthcare Facilities Accreditation Program

American Osteopathic Association

ACCREDITING HEALTHCARE FACILITIES FOR OVER 50 YEARS

142 East Ontario Street • Chicago, IL 60611-2864 • 800-621-1773 • 312-202-8000 • Fax 312-202-8206

January 12, 2005

William G. Flo
Administrator
Douglas County Hospital
111 – 17th Avenue East
Alexandria, MN 46308

Dear Bill:

This is in response to your letter dated January 4th, 2004 requesting the current deeming authority of Healthcare Facilities Accreditation Program (HFAP) of the AOA. The American Osteopathic Association (AOA) is recognized officially by the following states for accreditation of health care facilities. Additional states may recognize AOA through generic terminology such as, "...or other nationally recognized accreditation organizations."

Alaska	Alaska Stat §18.20.080
Arizona	A.R.S. § 36-422
California	Cal Wel & Inst Code § 14043.26
Delaware	24 Del. C. § 1133
Florida	Fla. Stat. § 395.002
Georgia	O.C.G.A § 31-7-3 (b)
Illinois	225 ILCS 62/5
Iowa	Iowa Code § 135B.9
Kansas	K.S.A. § 65-429
Kentucky	KRS § 216B.185
Maine	22 M.R.S. § 1817
Massachusetts	105 CMR 130.202
New Mexico	N.M. Stat. Ann § 24-1-5
New York	10 NYCRR § 405.1
Ohio	ORC Ann § 2108.01
Oklahoma	63 Okl. St. § 3240.4
Oregon	ORS § 441.055
Pennsylvania	40 P.S. § 3103
Rhode Island	R.I. Gen. Laws § 23-17-15.1
Texas	Tex. Health & Safety Code § 241.023
Washington	WAC § 246-318-010 Rev. Code Wash. Ann § 70.41.122
West Virginia	W. Va. Code § 16-5B-5a

If there is any additional information that you require, please feel free to contact me.

Sincerely

George A. Reuther

George A. Reuther
Director

GAR/jaf

✓cc: John Diehl

Senate Counsel & Research

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Senate
State of Minnesota

S.F. No. 886 - Children and Youth at Risk Collaborative Services

Author: Senator Sandra Pappas

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: February 18, 2005

S.F. No. 886 requires the Commissioner of Human Services to fund one or more projects that identify and serve children and youth who are at high risk for child maltreatment, substance abuse, mental illness, and serious and violent offending. The projects must utilize all available funding streams and must include the components listed in the bill.

JW:rdr

Senators Pappas, Anderson, Ranum, Koering and Skoglund introduced—

S. F. No. 886 Referred to the Committee on Health & Family Security

A bill for an act

relating to human services; collaborative services for at-risk children and youth; proposing coding for new law in Minnesota Statutes, chapter 256.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [256.996] [COLLABORATIVE SERVICES FOR HIGH-RISK CHILDREN AND YOUTH.]

In order to provide early intervention collaborative services to children and youth who are at high risk for child maltreatment, substance abuse, mental illness, and serious and violent offending, the commissioner of human services shall fund one or more projects that identify and serve these children and youth. Projects must utilize all available funding streams. The projects shall include the following program components:

(1) identification using multidimensional screening instruments;

(2) multidisciplinary and multijurisdictional collaborative services;

(3) integrated information system;

(4) intensive in-home and in-community casework;

(5) continuous tracking of outcomes; and

(6) multidimensional evaluations and cost-benefit analysis.

St. Paul Pioneer Press (MN) January 18, 2005

INCREASE FUNDS FOR INTERVENTION PROGRAMS

Edition: s
Section: Editorial
Page: B6
Index Terms:
EDITORIAL

Today's prisons are full of people for whom an intervention at the right time could have made a big difference. A coalition of youth intervention programs will be asking state legislators for a modest increase in funding to step-up their practical and cost-effective prevention efforts. We believe that it would be money well-spent and a fiscally sound investment by state taxpayers.

The state can continue to expand the populations of its prisons and county jails through underfunding of youth intervention programs, or it can shore up those programs that contribute to a productive life. A Vanderbilt University study in the 1990s estimated that each youngster saved from a life of crime saves taxpayers $1.7 million to $2.3 million. And the Rand Corp. found that governments saved $2 to $4 for every dollar spent on early childhood and youth programs, even before factoring in the savings to victims and society from decreased crime.

We've been impressed with the Ramsey County All Children Excel - or ACE - program, and believe it provides some lessons for lawmakers considering funding for youth prevention programs. We like that ACE has systematically measured the success of its efforts since it began in 1999. ACE brings together a community of adults in education, social services and law enforcement to work with a child and his family after the child's arrest for a serious crime. About 60 children who have been arrested for multiple serious crimes by age 10 are in the ACE program. The program has a 65 percent success rate with children who have been in the program for more than six months.

One concern is that children who move from the county - even just down the block from the West Side to West St. Paul - are dropped from the ACE program. We'd like to see a more regional approach and better coordination of these sorts of prevention programs. The $1.4 million in additional prevention funding requested by the Minnesota Youth Intervention Programs Association would help to fill in the gaps on the state map. Declaration of programs like ACE as state projects of regional significance for funding purposes would also help to replicate efforts that work and save taxpayers money. We as a society can pay a small amount now in intervention costs, or pay much more later.

COMPARING COSTS

Youth intervention programs are a cost-effective way to prevent future crimes and to slow the growth in prison populations.

Cost of youth intervention programs: 52 cents a day per child.

Cost of ACE program: $25 a day per child.

Cost of incarceration: $45 a day per state inmate.
Cost of sex offender incarceration and treatment: $286 a day per offender.

Source: Minnesota Youth Intervention Programs Association

Record Number: 0501190205

RAMSEY COUNTY ACE [ALL CHILDREN EXCEL]
Early Intervention for High Risk Very Young Offenders

Program Description: Ramsey County ACE is based on Justice Department research. The target population is children, starting at ages 7-9, likely to become chronic serious and violent juvenile offenders. *They will become the 10% of adolescents that commit over 70% of serious, violent crimes.* ACE integrates mental health, child welfare, education, corrections, and community-based services in a *unified and sustained* effort to reduce risk and promote healthy development.

Cost Effectiveness and Other Benefits: A National Institutes of Justice study estimates the lifetime cost to society of a chronic serious and violent offender at $1.7 – $2.3 million.[1] ACE estimates that 2-4% of these costs accrue to Ramsey County and 22% accrue to the State of Minnesota.[2]

Since minority children comprise 68% of the ACE high-risk population, *ACE has the potential to reduce disproportionate minority confinement in the criminal justice system* with its negative impact on minority families and labor market participation.

Program Features: Based on intensive in-home and in-community case management, components include **a)** *accurate identification* of the target population with a comprehensive risk assessment instrument, **b)** *service coordination* by a county multi-disciplinary team, **c)** an *integrated information system* that tracks costs to outcomes, and **d)** *continuous evaluation.*

Prevention Goals: Prevention of chronic serious and violent offending, prevention of substance abuse, prevention of school dropout.
Healthy Development Outcomes: School attendance and academic success, social competence (especially impulse control and anger management), connections with pro-social adults and peers, sustained involvement in extra-curricular, skill-building activities.

Outcomes:
A 2004 evaluation showed that although a majority of children had histories of chronic delinquent behavior prior to enrollment in ACE, 65% had no further police contact and 86% had not been charged with a subsequent offense over a 4 year period.

A 2002 preliminary evaluation showed that 60% displayed no disruptive behavior at school, attended regularly, and got passing grades.

Awards for Innovation:

- John F. Kennedy School of Government, Harvard University, *Innovations in American Government Award* (semi-finalist 2001)
- Association of MN Counties, *2000 Achievement Award*
- William T. Grant Foundation *2003 Youth Development Prize* (top ten finalist)
- Invited presentation to J. Robert Flores, Administrator, and his staff at the *U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP)*, Washington, D.C., May 8, 2003 (ACE team)
- Invited presentation, national conference on Juvenile Delinquency and Child Maltreatment, Child Welfare League of America, Miami, FL, June 2003 (Melton)
- Invited presentation, Congressional Briefing on Violence and Violence Prevention, Washington DC, June 4, 2003
- Selected as a Research-to-Practice (R2P) program by the *Child Welfare League of America* and featured in their publication *Children's Voice* (September 2003)

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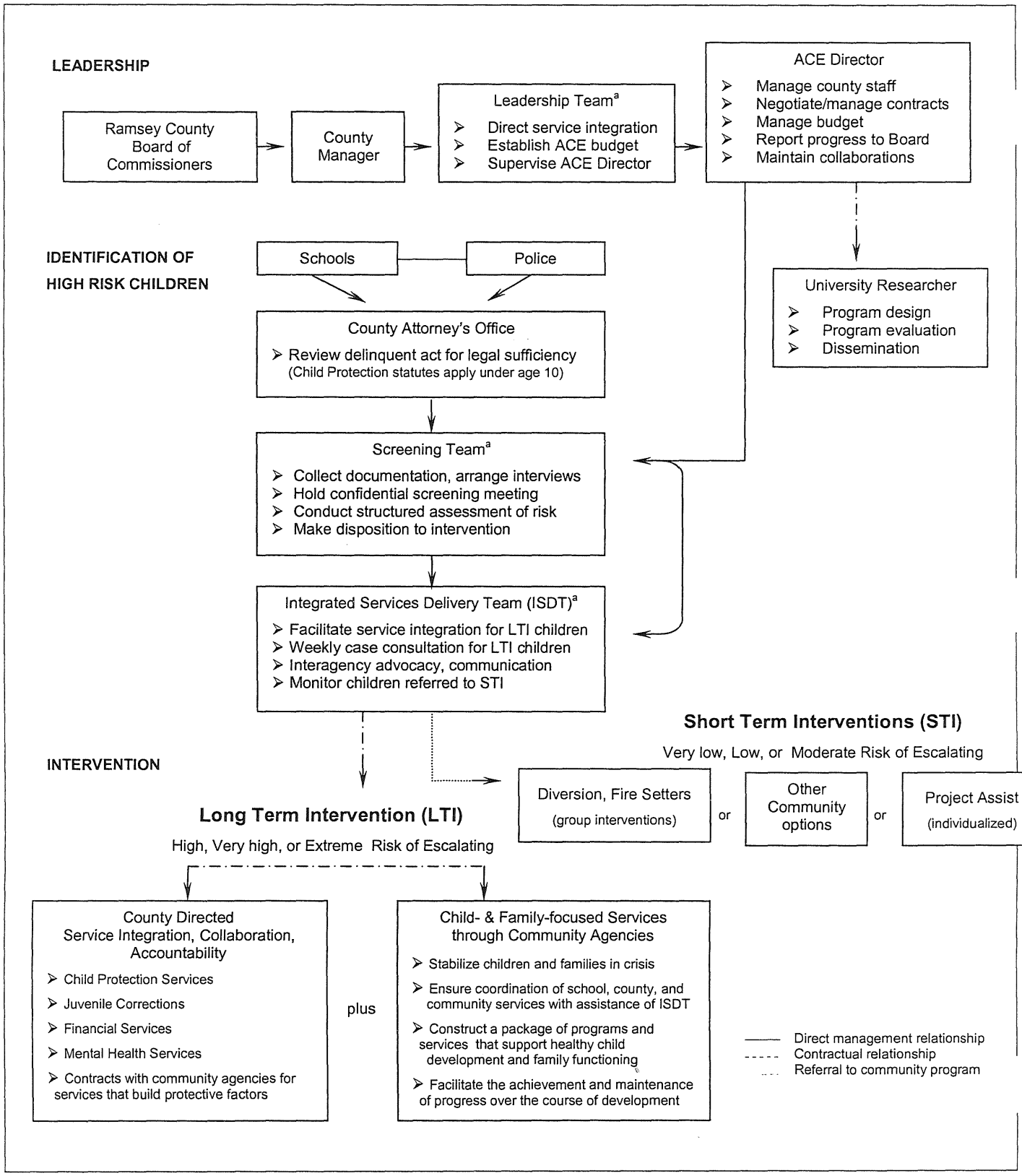
[1] Cohen, M. (1998) The Monetary Value of Saving a High Risk Youth. *Journal of Quantitative Criminology,* 14(1), 5-33. Includes criminal justice, victim, substance abuse, and lost productivity costs.
[2] For example, based on 2003 costs, the 2005 per diem civil commitment cost of a chronic sex offender is approximately $336 and a mentally ill and dangerous offender is $470.

ACE Model of Multi-Sector Collaboration and Accountability



[a] The Screening and Integrated Services Delivery Teams include 7 representatives from the departments of Public Health, Human Services (Mental Health, Child Protection, Financial Services), Corrections, and the County Attorney's Office. Program oversight is provided by the directors of those four departments (Leadership Team).

RAMSEY COUNTY ACE [ALL CHILDREN EXCEL]

Early Intervention for High-Risk Child Delinquents

Figure 2

Demographic Characteristics of Early Onset Delinquents (by Risk of Escalating)

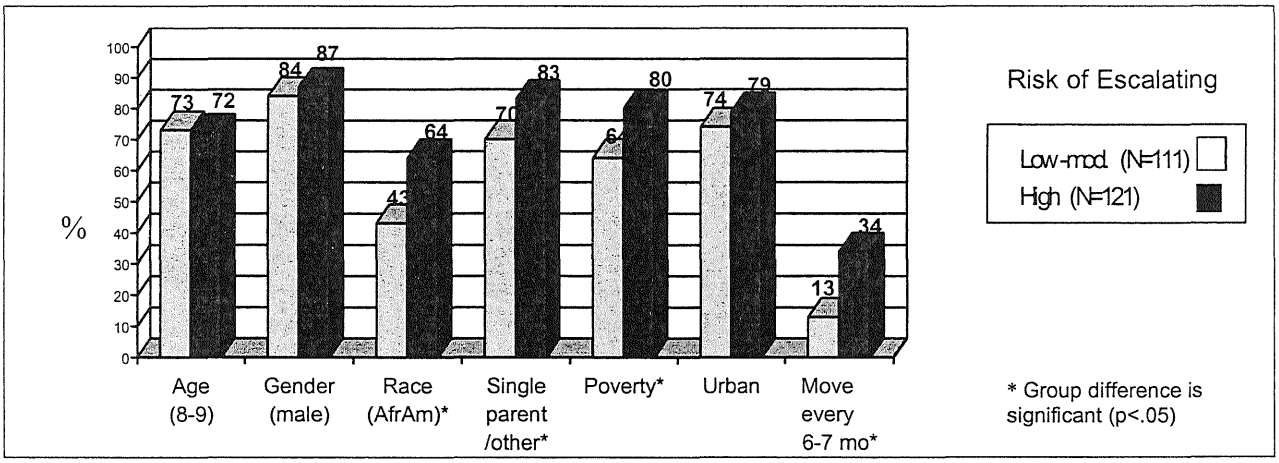
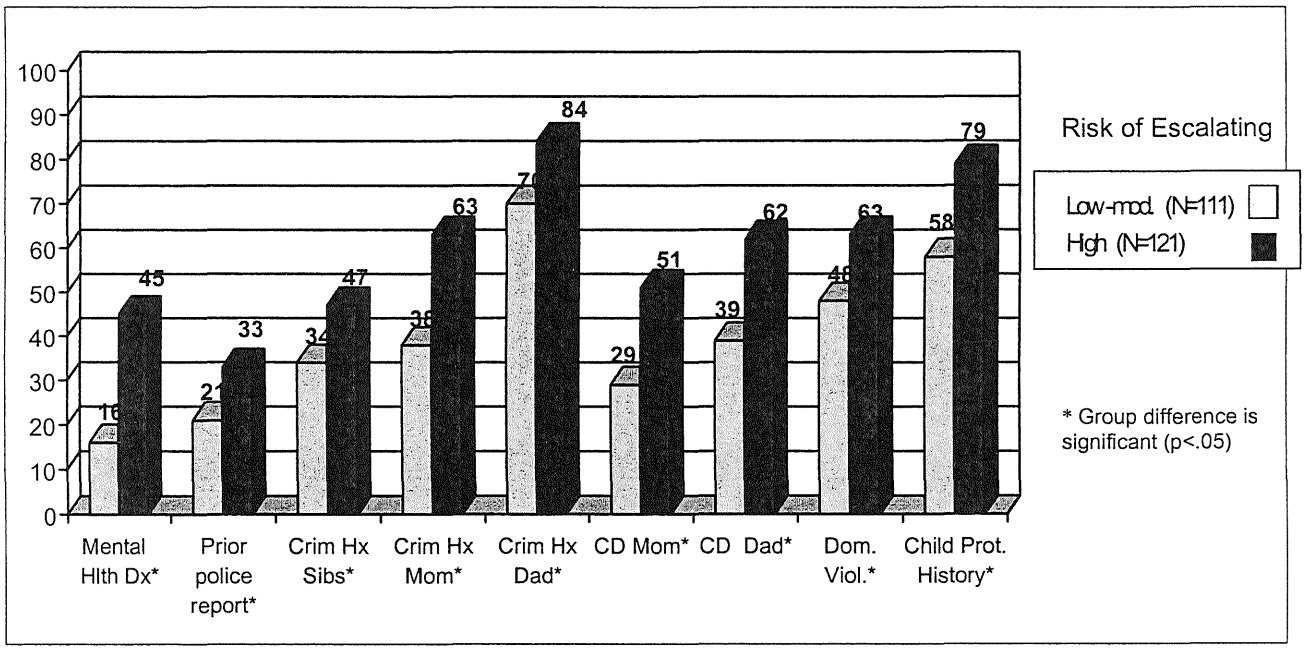


Figure 3

Prevalence of Risk Factors Among Early Onset Delinquents (by Risk of Escalating)



Senators Bakk and Saxhaug introduced--

S.F. No. 520: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; exempting hot tubs on rental houseboats from regulation as public pools; amending Minnesota Statutes 2004, section 144.1222, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 144.1222, is amended by adding a subdivision to read:

Subd. 2c. [HOT TUBS ON RENTAL HOUSEBOATS.] A hot water pool intended for seated recreational use, including a hot tub or whirlpool, that is located on a houseboat that is rented to the public is not a public pool and is exempt from the requirements for public pools under Minnesota Rules, chapter 4717.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

Senate Counsel & Research

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Senate
State of Minnesota

S.F. No. 695 - MinnesotaCare Definition of Income

Author: Senator Paul Koering

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KC

Date: February 18, 2005

S.F. No. 695 eliminates the add-back of depreciation for farm self-employed income for purposes of determining MinnesotaCare income eligibility. Income for farm self-employed would be determined by the adjusted gross income as reported on the applicant's federal income tax form for the previous year.

KC:rdr

Senators Koering, Lourey, Higgins, Rosen and Berglin introduced--
S.F. No. 695: Referred to the Committee on Health and Family Security.

A bill for an act

relating to MinnesotaCare; modifying the definition of gross income; amending Minnesota Statutes 2004, section 256L.01, subdivision 4.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256L.01, subdivision 4, is amended to read:

Subd. 4. [GROSS INDIVIDUAL OR GROSS FAMILY INCOME.] (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year ~~and adding back in reported depreciation amounts that apply to the business in which the family is currently engaged~~.

(c) Applicants shall report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. The report may be in the form of percentage increase or decrease.

[**EFFECTIVE DATE.**] This section is effective July 1, 2005, or upon receipt of federal approval, whichever is later.

Senators Kelley, Higgins, Kiscaden, Fischbach and Koering introduced--

S.F. No. 722: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health occupations; authorizing a psychologist to release information to law enforcement without the consent of the client; proposing coding for new law in Minnesota Statutes, chapter 148.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [148.977] [CRIMES AGAINST A PROVIDER.]

Notwithstanding section 144.335, if the provider has been the victim of a crime and knows that the crime was committed by a client or former client, the provider may disclose the identity of the client or former client, and acknowledge the professional relationship to the appropriate law enforcement agency. The provider shall not disclose any private information contained in the client's health record that is not specifically related to the crime.

Senator ..... moves to amend S.F. No. 722 as follows:

Page 1, after line 6, insert:

"Section 1. Minnesota Statutes 2004, section 13.384, subdivision 3, is amended to read:

Subd. 3. [CLASSIFICATION OF MEDICAL DATA.] Unless the data is summary data or a statute specifically provides a different classification, medical data are private but are available only to the subject of the data as provided in section 144.335, and shall not be disclosed to others except:

(a) pursuant to section 13.05;

(b) pursuant to section 253B.0921;

(c) pursuant to a valid court order;

(d) to administer federal funds or programs;

(e) to the surviving spouse, parents, children, and siblings of a deceased patient or client or, if there are no surviving spouse, parents, children, or siblings, to the surviving heirs of the nearest degree of kindred;

(f) to communicate a patient's or client's condition to a family member or other appropriate person in accordance with acceptable medical practice, unless the patient or client directs otherwise; or

(g) as otherwise required or permitted by law.

Sec. 2. Minnesota Statutes 2004, section 13.46, subdivision 7, is amended to read:

Subd. 7. [MENTAL HEALTH DATA.] (a) Mental health data are private data on individuals and shall not be disclosed, except:

(1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;

(2) pursuant to court order;

(3) pursuant to a statute specifically authorizing access to or disclosure of mental health data or as otherwise provided by this subdivision; ~~or~~

(4) with the consent of the client or patient; or

(5) as otherwise permitted by law.

(b) An agency of the welfare system may not require an

individual to consent to the release of mental health data as a condition for receiving services or for reimbursing a community mental health center, mental health division of a county, or provider under contract to deliver mental health services.

(c) Notwithstanding section 245.69, subdivision 2, paragraph (f), or any other law to the contrary, the responsible authority for a community mental health center, mental health division of a county, or a mental health provider must disclose mental health data to a law enforcement agency if the law enforcement agency provides the name of a client or patient and communicates that the:

(1) client or patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) data is necessary to protect the health or safety of the client or patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to respond to the emergency. Disclosure under this paragraph may include, but is not limited to, the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the client or patient. A law enforcement agency that obtains mental health data under this paragraph shall maintain a record of the requestor, the provider of the information, and the client or patient name. Mental health data obtained by a law enforcement agency under this paragraph are private data on individuals and must not be used by the law enforcement agency for any other purpose. A law enforcement agency that obtains mental health data under this paragraph shall inform the subject of the data that mental health data was obtained.

(d) In the event of a request under paragraph (a), clause (4), a community mental health center, county mental health division, or provider must release mental health data to Criminal Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal Mental Health Court personnel communicate that the:

(1) client or patient is a defendant in a criminal case pending in the district court;

(2) data being requested is limited to information that is necessary to assess whether the defendant is eligible for participation in the Criminal Mental Health Court; and

(3) client or patient has consented to the release of the mental health data and a copy of the consent will be provided to the community mental health center, county mental health division, or provider within 72 hours of the release of the data.

For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty criminal calendar of the Hennepin County District Court for defendants with mental illness and brain injury where a primary goal of the calendar is to assess the treatment needs of the defendants and to incorporate those treatment needs into voluntary case disposition plans. The data released pursuant to this paragraph may be used for the sole purpose of determining whether the person is eligible for participation in mental health court. This paragraph does not in any way limit or otherwise extend the rights of the court to obtain the release of mental health data pursuant to court order or any other means allowed by law."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

SF 0722 "Crimes Against a Provider" Situation Analysis by James A. Klein, Ph.D. Feb. 24, 2005

Situation	Example	Current Law/Ethics		Effect of SF0722	Negative Impacts and Other Issues				
		OK to Report Crime and Name Offender?	OK to Disclose the Therapeutic Relationship?						
Crime committed outside of therapeutic context - evidence exists	Mugging "on the street"; Break-in to house; etc.	Yes - not privileged	No - not pertinent	Relationship now OK to disclose	Non-pertinent disclosure authorized		"Cat Out of the Bag" Syndrome - non-regulated people have unnecessary access to privileged information	Certain allegations may gain credibility: "I am/was his therapist and I know that...(fill in the blank)"	
Crime comitted outside but confessed within therapeutic context	"I'm the one who slashed your tires last week"	No - privileged like any other disclosure except for the mandatory reporting issues	Not Applicable	Crime and Relationship now OK to disclose	Disclosure of the Relationship is not necessarily always pertinent or needed	Establishes providers as a privileged class of crime victim in the therapy session	"Cat Out of the Bag" Syndrome - non-regulated people have unnecessary access to privileged information	Certain allegations may gain credibility: "I am his therapist and he told me that...(fill in the blank)"	What stops an unethical or impaired provider from fabricating a "confession", or acting on mis-construal?
Crime committed within therapeutic context	Stealing from office; Violence committed in office	Gray area. Probably "No", but there are practical problems	Almost certainly "No", but there are practical problems	Crime and Relationship now OK to disclose					What stops an unethical or impaired provider from fabrication or simple error?

Gary Schoener is a Licensed Psychologist and the Executive Director of the Walk-In Counselling Centre in Minneapolis, Minnesota. For over 30 years, he has consulted and presented internationally on ethical and professional practice issues, including workshops and presentations for practitioners of various health disciplines. Mr. Schoener has testified in legal cases related to boundaries in both the USA and Canada. In addition to co-authoring books on assisting impaired psychologists and on psychotherapists' sexual involvement with clients, he has also authored seven journal articles, twenty-eight book chapters, and hundreds of monographs.

****

Re: A Bill Before the Legislature - SF0722

Jim,

The strongest argument, in my opinion, and one I think most professionals would agree with is:

There may be an issue here, and additional remedies may be needed. That remains to be seen. **But what is crystal clear is that when the public goes for personal therapy, marriage counseling, or family therapy, etc. they may end up seeing a licensed psychologist, social worker, marriage & family therapist, professional counselor, psychiatrist, alcoholism or substance abuse counselor, or unlicensed mental health therapist.**

All are regulated by the state. The client is often unclear who they are seeing. But even more central is the fact that a sizeable number of professionals hold two licenses or certificates. For example, many Licensed Marriage & Family Therapists also hold a social work license or a psychology license.

SO, WHAT'S THE PROBLEM WITH THIS? Well, the standards for such things as the duty to breach confidentiality to protect third parties from violent acts by the client are currently (like this proposed bill), inside of the various licensure laws. The standards are different.

The same is true of standards for reporting of misconduct by health care professionals. For example, a psychologist must report all sorts of misconduct by other licensed health care professionals to their boards, but when the offender is a psychologist, NO reporting is required if learned of

from the offender during a therapy session, and even then only three things are mandated reports.

So, if a Licensed Marriage & Family Therapist who is also a Licensed Psychologist comes in for help and admits to the psychologist that he is horribly impaired and has done damage to a number of clients, the psychologist has NO duty to report to the Board of Psychology but has to report to the Board of Marriage & Family Therapy. If a psychologist admits the same things to a licensed marriage and family counselor, there is no reporting duty to the board of psychology. But if the psychologist also holds a social work or nursing license, a report is mandated to the social work or nursing board.

CONFUSING? You bet! The state needs to ask the boards to get together and try to develop statutes or language that apply across the board. To have literally dozens of standards benefits nobody. As a professional who teaches in this area, I can tell you that I spend a good deal of time just answering professional's questions about these duties.

Also, it is nearly impossible to explain things to consumers when getting informed consent. The consumer comes for help, but to actually try to explain all of this is going to take an hour of valuable time.

You can quote me on this.

Since there is no urgency for this Bill, perhaps this is as good a time as any to get the boards to work out similar rules and language for standards of confidentiality and its limits, for the duty to warn, and for duties to report other professionals.

Gary

EXHIBIT: One Real-Life Example of false "knowing" by an L.P. of a crime

BEFORE THE MINNESOTA BOARD OF PSYCHOLOGY

STIPULATION AND CONSENT ORDER

May 7, 1999

In the Matter of

Renee Fredrickson, Ph.D., L.P.

License No. LP2653

IT IS HEREBY STIPULATED AND AGREED by Renee Fredrickson, Ph.D., L.P. (Licensee) and the Minnesota Board of Psychology (Board) as follows:

.....

.....

III. _Providing Psychological Services to Clients When Licensee's Objectivity and Effectiveness were Impaired_

.....

.....

Exhibiting Signs of a Possible Mental Dysfunction

37. Beginning in September 1996, and continuing through December 1996, Licensee repeatedly contacted the St. Paul Police Department to report incidents of alleged stalking. Licensee believed she was being stalked based on a certain number of these incidents. She exhibited symptoms of a possible mental dysfunction, her objectivity was impaired, and she failed to protect the privacy of clients. For example, Licensee reported the following incidents to the police:

a. Licensee made numerous complaints to the police, including that persons had broken into her home; cultic ritual marks were left by these persons; her mail had been tampered with; clothing or personal items had been stolen, moved, or misplaced in her home; items had been mysteriously damaged and then repaired. She expressed concern that naturally occurring incidents, such as a large tree branch caught upside down in wires next to her home and the presence of a large eviscerated bug with a fresh carapace found on her step might be related to stalking. These complains were investigated by the police and were not confirmed.

.....

.....

Investigating Officer's Observations and Conclusions

54. On October 8, 1996, the police sergeant interviewed clients #2 and #3. In a memorandum prepared after the interview, the sergeant noted that although Licensee had told him the clients were survivors of satanic/ritual abuse by their parents and a satanic cult form Oregon, their report to him of abuse was vague and lacked detail of occult-specific data. The sergeant concluded: "While it is evident these women believe the reported incidents themselves, there is neither physical evidence, nor reported evidence to substantiate a belief in the accuracy of the incidents recalled."

55. In his December 26, 1996, report, the sergeant noted the following: "Most of the reports of unusual occurrences have a logical explanation... These occurrences most often are normal actions or results of same.... While the complainant does not appear to accept any of these explanations, there is insufficient evidence to proceed further at this time."

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IV. _Failure to Obtain Informed Written Consent to Disclose Private Information_

68. In September 1996, Licensee failed to protect the privacy of client #2 and client #3 in that she reveled their full names as well a certain therapy issues to police officers without permission from the clients. Licensee also discussed client #2 with client #4 without having obtained informed written consent from client #2 to do so.

.....

.....

RENEE FREDRICKSON, Ph.D., L.P. NORMAN L. JAMES, Ph.D., L.P.
Licensee
Dated: May 3, 1999 Dated: May 7, 1999

SAMUEL ALBERT, Ph.D., L.P.

Dated: May 7, 1999

THOMAS SANNER	ROSELLEN CONDON
Hinshaw & Culbertson	Assistant Attorney General
3200 Piper Jaffray Tower	500 Capitol Office Building
222 South Ninth Street	535 Park Street
Minneapolis, MN 55402	St. Paul. MN 55103-2106
Telephone: (612)	Telephone: (651) 297-1050
Attorney for Licensee	Attorney for Committee
Dated: 5/3, 1999	Dated: 5-7, 1999

ORDER

Upon consideration of this stipulation and all the files, record, and proceedings herein,

IT IS HEREBY ORDERED that the Licensee is placed in a RESTRICTED AND CONDITIONAL status and that all other terms of this stipulation are adopted and implemented by the Board this 7th day of May, 1999.

MINNESOTA BOARD OF PSYCHOLOGY

PAULINE WALKER-SINGLETON
Executive Director

Reasons to Oppose SF0722 (v.1 – e-mailed to Sen. H&FS Comm. 2/22/05)

The proposed Statute is not needed.

No prohibition. There is nothing in the Statutes barring a provider who has been the victim of a crime from naming the alleged violator to law enforcement.

Relationship not pertinent. There are no actions that a client might take that would be crimes *because* of the existence of a therapist-client relationship. The existence of the professional relationship is not pertinent to any crime.

The proposed Statute replaces a tested standard with a dangerous new precedent.

First Discretionary Exception. Ethical psychologists NEVER voluntarily breach client confidence. Several provisions of existing statutes create for providers a DUTY to breach confidentiality in specific circumstances, and one provision permits providers to comply with a subpoena. SF0722 would create the first entirely discretionary exception to client-therapist confidentiality.

Slippery Slope. SF0722 singles out providers as a privileged class of crime victim. Why shouldn't providers be allowed to report all client crimes of which they have knowledge, regardless of the victim?

False Sense of Security. It may seem that the provider is allowed by the Bill to disclose very little. However, the three most sensitive items of confidential information in a therapeutic relationship are the fact that the client is "in therapy"; the diagnosis; and the identity of the therapist. In the case where the therapist is a "specialist", the disclosure of the therapist's identity approaches disclosure of diagnosis. SF0722 authorizes a provider to disclose very sensitive information.

Once the Cat Is Out of the Bag... SF0722 authorizes the disclosure of confidential client information to individuals who are not, in turn, bound by any expectations for confidentiality. One shudders to consider a prominent citizen's psychotherapeutic relationship being divulged to personnel in law enforcement, who are not bound in any effective way to protect against wider dissemination.

The proposed Statute will have a dangerous and unintended effect.

Creating a Prejudice in Law Enforcement. Since the professional relationship is not pertinent, the primary effect of permitting a provider to acknowledge the relationship to law enforcement will be to attach to a provider's accusations a level of credibility and authority they might not have on their merits alone.

The proposed Statute is misplaced and inappropriate in its scope.

Protect the Public. The Minnesota Psychology Practice Act (Sections 148.88-148.98) is to "protect the public from the practice of psychology by unqualified persons and from unethical or unprofessional conduct by persons licensed to practice psychology". Proper regulation of a profession seeks to protect the public against the acts of the few. SF0722 provides a new way in which an unethical provider can harm a client without providing any new protections.

Why Only Psychologists? If there is a need, the need should apply as well at least to all regulated health care professionals for whom there is an expectation of client confidentiality, such as MDs, LMFTs, LPCs, and others.

What Do Other Professions Think? The proposed statute would impact public perception of all health care professionals. The input of the other regulated professions should be sought by the Legislature before such a statute is enacted.

The proposed Statute is further flawed.

Over-broad. SF0722 applies to "a crime". There are many acts defined as crimes that, occurring within the context of a therapeutic relationship, would not be viewed as criminal by most ethical providers. For example, a verbal exchange which might be construed "on the street" as assault might be construed during a therapy session by a therapist as "grist for the mill". We understand that SF0722 is largely motivated by a desire to protect providers against violent crimes and stalking. To minimize the danger to the client public of the proposed statute, however, such major crimes should be called out specifically.

Lacks Definition. SF0722 prohibits disclosure from the "health record" that is "not specifically related to the crime". Is a diagnosis (e.g. kleptomania) "specifically related" to a crime (e.g. theft of a book from a provider's office)? Better definition of this term is clearly needed.

Neglects the Client. SF0722 fails to deal with the important therapeutic process of Termination. A provider should not continue to provide care to an active client whose confidentiality he has compromised via a criminal complaint. The proposed statute should mandate Termination, and require that it be carried out according to the ethical standards of the profession.

Liability. If the proposed statute is to be a part of Section 148, it should specifically point out that the provider continues to have ethical responsibilities. These should include, at least, a responsibility to take all reasonable steps to be certain that a crime has in fact been committed and that the client is the perpetrator. It should make explicit that a provider who acts in bad faith, acts on mere suspicion, or fails in any way to make reasonable efforts may still be guilty of one or more violations of the Minnesota Psychology Practice Act.

S.F. No. 722, as introduced 84th Legislative Session (2005-2006) Posted on Feb 02, 2005

A bill for an act

relating to health occupations; authorizing a psychologist to release information to law enforcement without the consent of the client; proposing coding for new law in Minnesota Statutes, chapter 148.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [148.977] [CRIMES AGAINST A PROVIDER.]

Notwithstanding section 144.335, if the provider has been the victim of a crime and knows that the crime was committed by a client or former client, the provider may disclose the identity of the client or former client, and acknowledge the professional relationship to the appropriate law enforcement agency. The provider shall not disclose any private information contained in the client's health record that is not specifically related to the crime.

Senate Counsel, Research, and Fiscal Analysis

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Senate
State of Minnesota

S.F. No. 880 - Changing State Law to Conform with Federal Medicare Prescription Drug Coverage

Author: Senator Brian LeClair

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC
Tom Pender, House Research (651/296-1885)

Date: February 23, 2005

S.F. No. 880 changes Minnesota law to conform to the recent changes in federal law involving Medicare prescription drug coverage (Medicare Part D).

Article 1 makes technical changes in state law involving Medicare supplement ("Medigap") insurance.

Section 1 (62A.31, subdivision 1f) states that a suspended Medicare supplement policy must be replaced by an equivalent policy, except that it must not cover outpatient prescription drugs if the insured has enrolled in Medicare Part D.

Section 2 (62A.31, subdivision 1k) makes technical formatting changes. States that guaranteed renewability is satisfied if a policy is renewed without coverage of outpatient prescription drugs.

Section 3 (62A.31, subdivision 1n) states that receipt of outpatient drug benefits is not counted in calculating a continuous loss for purposes of extension of coverage beyond a policy's termination date. Clarifies existing language.

Section 4 (62A.31, subdivision 1s) specifies what happens to drug coverage under Medicare supplement policies in various situations. The general principles are: (1) enrollees may keep that existing coverage if they choose not to enroll in Medicare Part D; (2) no new Medicare supplement policies that cover outpatient prescription drugs may be issued; and (3) individuals who choose to

enroll in Part D may renew their existing Medicare supplement policy, but without the drug coverage and with a corresponding premium reduction.

Section 5 (62A.31, subdivision 1t) amends the required notice that a policy does not cover drugs to include the effects of the federal changes. Removes obsolete language.

Section 6 (62A.31, subdivision 1u) paragraph (a), makes a clarifying change and a change to conform to federal law.

Paragraph (b) makes changes to conform to the federal name change from Medicare+Choice to Medicare Advantage and creates a new way to be eligible for guaranteed issue involving an individual who had Medicare supplement insurance with prescription drug coverage, who enrolls in Medicare Part D, and therefore needs a new Medicare supplement policy without drug coverage.

Paragraph (c) makes federally required changes regarding when a guaranteed issue period begins and ends.

Paragraph (e) makes federally required changes regarding what kind of Medicare supplement policy in which an individual has guaranteed issue rights to enroll.

Section 7 (62A.31, subdivision 3) makes a number of technical and clarifying changes to definitions. Creates a new definition of "outpatient prescription drugs" to clarify how that term relates to Medicare coverage.

Section 8 (62A.31, subdivision 4) permits Medicare supplement policies issued before January 1, 2006, to cover outpatient prescription drugs even though Medicare Part D covers them.

Section 9 (62A.31, subdivision 7) eliminates language made obsolete by the federal Medicare changes.

Sections 10 and 11 (62A.315 and 62A.316) make changes to conform to federal law by prohibiting the sale of a new Medicare supplement policy that covers outpatient prescription drugs after the end of 2005. Section 10 applies to the extended basic plan and section 11 applies to the basic plan.

Section 12 (62A.318) divides the existing law into subdivisions and paragraphs. Makes changes to conform to federal law by prohibiting the sale of Medicare Select products with drug coverage after 2005.

Section 13 (62A.36) makes technical clarifications. Clarifies how the deletion of prescription drug coverage and related premium reductions will be handled for purposes of regulation. Provides a catch-all failsafe requirement that enrollees be given all federally required notices.

Section 14 instructs the Revisor of Statutes to reorder definitions and make necessary changes in cross-references.

Section 15 states that the effective date of this article is January 1, 2006, except for certain provisions that need to be in place to prepare for that date.

Article 2 creates a procedure for licensing and solvency regulation of stand alone prescription drug plans that could provide prescription drug coverage under Medicare Part D or Medicare Part D prescription drug plans (PDPs).

Section 1 (62A.451) defines terms. Adds a definition of "limited health service," which limits the services to pharmaceutical services covered under Medicare Part D.

Section 2 (62A.4511) requires insurers offering PDPs to be licensed under these sections.

Section 3 (62A.4512) lists what has to be in an application for licensure.

Section 4 (62A.4513) requires the commissioner to issue a license if the applicant meets the requirements. Permits the applicant to appeal a denial of the application.

Section 5 (62A.4514) provides a way for an entity that is already licensed under a law that does not permit offering a PDP plan to use a simplified application process to apply for approval from the commissioner.

Section 6 (62A.4515) requires a PDP plan to file with the commissioner for approval any modifications in the information filed at the time of licensing.

Section 7 (62A.4516) requires the PDP plans to provide enrollees with evidence of coverage required under federal law.

Section 8 (62A.4517) provides an exemption from other insurance laws unless another law specifically says it applies to these organizations. States that operating a PDP plan is not a "healing art" and that PDP plans are not covered by laws regulating advertising by health professionals.

Section 9 (62A.4518) permits other group insurance to exclude coverage of things covered by PDP plans if the group is covered separately by group PDP coverage for those benefits.

Section 10 (62A.4519) requires insurers issuing PDPs to comply with federal Medicare requirements regarding complaints from enrollees.

Section 11 (62A.4520) permits the commissioner to examine the records of an entity licensed under these sections.

Section 12 (62A.4521) requires the entity's assets to be invested under the guidelines that apply to health maintenance organizations (HMOs).

Section 13 (62A.4522) requires that PDP coverage be sold only through persons authorized to sell health coverage in this state.

Section 14 (62A.4523) requires that entities maintain net worth of the greater of $100,000 or two percent of its premium income, not to exceed the amount of capital and surplus required of a health insurance company. Requires additional net equity of 25 percent of uncovered expenses in excess of $100,000. Requires a deposit of liquid assets of $50,000 plus 25 percent of required tangible net equity, but the required deposit cannot exceed $200,000. Specifies the status of the deposit. Permits the commissioner to waive the net equity requirement under certain circumstances, including a guarantee provided by a guaranteeing organization. Defines "uncovered expenses."

Section 15 (62A.4524) requires a fidelity bond or an equivalent deposit for that purpose.

Section 16 (62A.4525) requires filing of an annual financial report with the commissioner.

Section 17 (62A.4526) provides the grounds and procedures involved in suspending or revoking a license under these sections.

Section 18 (62A.4527) provides for administrative enforcement of these sections by the commissioner.

Section 19 (62A.4528) states that insolvency of an entity licensed under these sections is handled as insolvency of a regular insurance company. States that the obligations of these entities are not covered by the life and health insurance guaranty association.

Section 20 states that the effective date for this act is March 15, 2005, for licensure procedures to begin, but that no entity can operate a PDP plan until 2006. (Under federal law, an entity can apply for a federal waiver of state licensing of a PDP if there is no state licensing procedure available as of March 15, 2005.)

Article 3 makes miscellaneous technical conforming changes.

Section 1 (62L.12, subdivision 2) updates references to federal Medicare laws.

Section 2 (62Q.01, subdivision 6) updates references to federal Medicare laws.

Section 3 (256.9657, subdivision 3) updates references to federal Medicare laws in a section involving the medical assistance surcharge.

KC:vs

Senator LeClair introduced—

S. F. No. 880 Referred to the Committee on Health & Family Security

A bill for an act

relating to insurance; making federally conforming changes in Medicare-related coverage; providing financial solvency regulation for stand-alone Medicare Part D prescription drug plans; making related technical changes; amending Minnesota Statutes 2004, sections 62A.31, subdivisions 1f, 1k, 1n, 1s, 1t, 1u, 3, 4, 7; 62A.315; 62A.316; 62A.318; 62A.36, subdivision 1; 62L.12, subdivision 2; 62Q.01, subdivision 6; 256.9657, subdivision 3; 295.53, subdivision 1; 297I.15, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 62A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

FEDERALLY CONFORMING CHANGES IN MEDICARE-RELATED COVERAGES

Section 1. Minnesota Statutes 2004, section 62A.31, subdivision 1f, is amended to read:

Subd. 1f. [SUSPENSION BASED ON ENTITLEMENT TO MEDICAL ASSISTANCE.] (a) The policy or certificate must provide that benefits and premiums under the policy or certificate shall be suspended for any period that may be provided by federal regulation at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to this assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy or certificate shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) The policy must provide that upon reinstatement (1) there is no additional waiting period with respect to treatment of preexisting conditions, (2) coverage is provided which is substantially equivalent to coverage in effect before the date of the suspension, provided that on or after January 1, 2006, reinstatement of coverage for outpatient prescription drugs is at the option of the policyholder, and (3) premiums are classified on terms that are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had coverage not been suspended.

Sec. 2. Minnesota Statutes 2004, section 62A.31, subdivision 1k, is amended to read:

Subd. 1k. [GUARANTEED RENEWABILITY.] The policy must guarantee renewability.

(a) Only the ~~following~~ standards for renewability provided in this subdivision may be used in Medicare supplement insurance policy forms.

(b) No issuer of Medicare supplement insurance policies may cancel or nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(c) If a group Medicare supplement insurance policy is terminated by the group policyholder and is not replaced as provided in this clause, the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder, provides for continuation of the benefits contained in the group policy; or provides for such

benefits and benefit packages as otherwise meet the requirements of this clause.

(d) If an individual is a certificate holder in a group Medicare supplement insurance policy and the individual terminates membership in the group, the issuer of the policy shall offer the certificate holder the conversion opportunities described in this clause; or offer the certificate holder continuation of coverage under the group policy.

(e) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the policy as modified for that purpose is deemed to satisfy the guaranteed renewal requirements of this subdivision.

Sec. 3. Minnesota Statutes 2004, section 62A.31, subdivision 1n, is amended to read:

Subd. 1n. [TERMINATION OF COVERAGE.] (a) Termination by an issuer of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that began while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy or certificate was in force may be conditioned on the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. The extension of benefits does not apply when the termination is based on fraud, misrepresentation, or nonpayment of premium. Receipt of Medicare Part D benefits is not considered in determining a continuous loss.

(b) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days before discontinuing the availability of the form of the policy or certificate. An issuer that discontinues the availability of a policy form or certificate form shall not file for approval a new policy form or certificate form of the same type for the same Medicare supplement benefit plan as the discontinued form

for five years after the issuer provides notice to the commissioner of the discontinuance. ~~The~~ This period of ~~discontinuance~~ ineligibility to file a form for approval may be reduced if the commissioner determines that a shorter period is appropriate. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section. A change in the rating structure or methodology shall be considered a discontinuance under this section unless the issuer complies with the following requirements:

(1) the issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resulting rates differ from the existing rating methodology and resulting rates; and

(2) the issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

Sec. 4. Minnesota Statutes 2004, section 62A.31, subdivision 1s, is amended to read:

Subd. 1s. [PRESCRIPTION DRUG COVERAGE.] ~~Beginning January 1, 1993, a health maintenance organization that issues Medicare related coverage must offer, to each person to whom it offers any contract described in this subdivision, at least one contract that either:~~

~~(1) covers 80 percent of the reasonable and customary charge for prescription drugs or the co-payment equivalency; or~~

~~(2) offers the coverage described in clause (1) as an optional rider that may be purchased separately from other optional coverages~~ (a) Subject to subdivisions 1k, 1m, 1n, and 1p, a Medicare supplement policy with benefits for outpatient prescription drugs, in existence prior to January 1, 2006, must be renewed, at the option of the policyholder, for current

policyholders who do not enroll in Medicare Part D.

(b) A Medicare supplement policy with benefits for outpatient prescription drugs must not be issued after December 31, 2005.

(c) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs must not be renewed after the policyholder enrolls in Medicare Part D unless:

(1) the policy is modified to eliminate outpatient prescription drug coverage for expenses of outpatient prescription drugs incurred on or after the effective date of the individual's coverage under Medicare Part D; and

(2) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

(d) An issuer of a Medicare supplement policy or certificate must comply with the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended, including any federal regulations, as amended, adopted under that act. This paragraph does not require compliance with any provision of that act until the date upon which that act requires compliance with that provision. The commissioner has authority to enforce this paragraph.

Sec. 5. Minnesota Statutes 2004, section 62A.31, subdivision 1t, is amended to read:

Subd. 1t. [NOTICE OF LACK OF DRUG COVERAGE.] Each policy or contract issued without prescription drug coverage by any insurer, health service plan corporation, health maintenance organization, or fraternal benefit society must contain, displayed prominently by type or other appropriate means, on the first page of the contract, the following:

"Notice to buyer: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you by retaining existing coverage you may have or by enrolling in Medicare Part D. Please ask for further details."

~~From January 1, 1993 to February 28, 1993, compliance with this paragraph is optional. If a health maintenance organization does not comply with this paragraph during that period, the health maintenance organization must extend any person's six-month eligibility period provided under subdivision 1h that began prior to or during that period and ends during or after that period. The length of the extension must be no less than that portion of the person's six-month eligibility period during which the health carrier did not comply with this paragraph. The extended eligibility period applies only to contracts that provide the prescription drug coverage required by this paragraph.~~

Sec. 6. Minnesota Statutes 2004, section 62A.31, subdivision 1u, is amended to read:

Subd. 1u. [GUARANTEED ISSUE FOR ELIGIBLE PERSONS.] (a)(1) Eligible persons are those individuals described in paragraph (b) who seek to enroll under the policy during the period specified in paragraph (c) and who submit evidence of the date of termination or disenrollment described in paragraph (b), or of the date of Medicare Part D enrollment, with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not: deny or condition the issuance or effectiveness of a Medicare supplement policy described in paragraph (c) that is offered and is available for issuance to new enrollees by the issuer; discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, medical condition, or age; or impose an exclusion of benefits based upon a preexisting condition under such a Medicare supplement policy.

(b) An eligible person is an individual described in any of the following:

(1) the individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the

individual;

(2) the individual is enrolled with a ~~Medicare+Choice~~ Medicare Advantage organization under a ~~Medicare+Choice~~ Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the federal Social Security Act, and there are circumstances similar to those described in this clause that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a ~~Medicare+Choice~~ Medicare Advantage plan:

(i) the organization's or plan's certification under Medicare Part C has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(ii) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, United States Code, title 42, section 1395w-21(g)(3)(b) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the federal Social Security Act, United States Code, title 42, section 1395w-26), or the plan is terminated for all individuals within a residence area;

(iii) the individual demonstrates, in accordance with guidelines established by the Secretary, that:

(A) the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality

standards; or

(B) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(iv) the individual meets such other exceptional conditions as the secretary may provide;

(3)(i) the individual is enrolled with:

(A) an eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) an organization under an agreement under section 1833(a)(1)(A) of the federal Social Security Act, United States Code, title 42, section 1395l(a)(1)(A) (health care prepayment plan); or

(D) an organization under a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under clause (2);

(4) the individual is enrolled under a Medicare supplement policy, and the enrollment ceases because:

(i)(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(B) of other involuntary termination of coverage or enrollment under the policy;

(ii) the issuer of the policy substantially violated a material provision of the policy; or

(iii) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5)(i) the individual was enrolled under a Medicare supplement policy and terminates that enrollment and subsequently enrolls, for the first time, with any ~~Medicare+Choice~~ Medicare Advantage organization under a

~~Medicare+Choice~~ Medicare Advantage plan under Medicare Part C; any eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost); any similar organization operating under demonstration project authority; any PACE provider under section 1894 of the federal Social Security Act, or a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the subsequent enrollment under item (i) is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the federal Social Security Act; ~~or~~

(6) the individual, upon first enrolling for benefits under Medicare Part B, enrolls in a ~~Medicare+Choice~~ Medicare Advantage plan under Medicare Part C, or with a PACE provider under section 1894 of the federal Social Security Act, and disenrolls from the plan by not later than 12 months after the effective date of enrollment; or

(7) the individual enrolls in a Medicare Part D plan during the initial Part D enrollment period, as defined under United States Code, title 42, section 1395ss(v)(6)(d), and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (e), clause (4).

(c)(1) In the case of an individual described in paragraph (b), clause (1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation~~.~~; or (ii) the date that the applicable coverage terminates or ceases; and ends 63 days after the ~~date of the applicable notice~~ later of those two dates.

(2) In the case of an individual described in paragraph (b), clause (2), (3), (5), or (6), whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in paragraph (b), clause (4), item (i), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (ii) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in paragraph (b), clause (2), (4), (5), or (6), who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(5) In the case of an individual described in paragraph (b), clause (7), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in paragraph (b) but not described in this paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d)(1) In the case of an individual described in paragraph (b), clause (5), or deemed to be so described, pursuant to this paragraph, whose enrollment with an organization or provider described in paragraph (b), clause (5), item (i), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls

with another such organization or provider, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (5).

(2) In the case of an individual described in paragraph (b), clause (6), or deemed to be so described, pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (b), clause (6), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (6).

(3) For purposes of paragraph (b), clauses (5) and (6), no enrollment of an individual with an organization or provider described in paragraph (b), clause (5), item (i), or with a plan or in a program described in paragraph (b), clause (6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with the organization, provider, plan, or program.

(e) The Medicare supplement policy to which eligible persons are entitled under:

(1) paragraph (b), clauses (1) to (4), is any Medicare supplement policy that has a benefit package consisting of the basic Medicare supplement plan described in section 62A.316, paragraph (a), plus any combination of the three optional riders described in section 62A.316, paragraph (b), clauses (1) to (3), offered by any issuer;

(2) paragraph (b), clause (5), is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, any policy described in clause (1) offered by any issuer~~;~~, except that after December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy to which the individual is entitled under paragraph (b), clause (5), is:

(i) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) at the election of the policyholder, a policy described in clause (4), except that the policy may be one that is offered and available for issuance to new enrollees that is offered by any issuer;

(3) paragraph (b), clause (6), ~~shall include~~ is any Medicare supplement policy offered by any issuer;

(4) paragraph (b), clause (7), is a Medicare supplement policy that has a benefit package classified as a basic plan under section 62A.316 if the enrollee's existing Medicare supplement policy is a basic plan or, if the enrollee's existing Medicare supplement policy is an extended basic plan under section 62A.315, a basic or extended basic plan at the option of the enrollee, provided that the policy is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. The issuer must permit the enrollee to retain all optional benefits contained in the enrollee's existing coverage, other than outpatient prescription drugs, subject to the provision that the coverage be offered and available for issuance to new enrollees by the same issuer.

(f)(1) At the time of an event described in paragraph (b), because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in paragraph (b), because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for

the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated within ten working days of the issuer receiving notification of disenrollment.

(g) Reference in this subdivision to a situation in which, or to a basis upon which, an individual's coverage has been terminated does not provide authority under the laws of this state for the termination in that situation or upon that basis.

(h) An individual's rights under this subdivision are in addition to, and do not modify or limit, the individual's rights under subdivision 1h.

Sec. 7. Minnesota Statutes 2004, section 62A.31, subdivision 3, is amended to read:

Subd. 3. [DEFINITIONS.] (a) The definitions provided in this subdivision apply to sections 62A.31 to 62A.44.

(b) "Accident," "accidental injury," or "accidental means" means to employ "result" language and does not include words that establish an accidental means test or use words such as "external," "violent," "visible wounds," or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under a workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(c) "Applicant" means:

(1) in the case of an individual Medicare supplement policy or certificate, the person who seeks to contract for insurance

benefits; and

(2) in the case of a group Medicare supplement policy or certificate, the proposed certificate holder.

(d) "Bankruptcy" means a situation in which a ~~Medicare+Choice~~ Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(e) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(f) "Certificate" means a certificate delivered or issued for delivery in this state or offered to a resident of this state under a group Medicare supplement policy or certificate.

(g) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(h) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(i) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in United States Code, title 29, section 1002 (Employee Retirement Income Security Act).

(j) "Health care expenses" means, for purposes of section 62A.36, expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. The expenses shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

(k) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of

Hospitals, but not more restrictively than as defined in the Medicare program.

(l) "Insolvency" means a situation in which an issuer, licensed to transact the business of insurance in this state, including the right to transact business as any type of issuer, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(m) "Issuer" includes insurance companies, fraternal benefit societies, health service plan corporations, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare supplement policies or certificates in this state or offering these policies or certificates to residents of this state.

(n) "Medicare" shall be defined in the policy and certificate. Medicare may be defined as the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, as amended, or title I, part I, of Public Law 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as amended.

(o) "Medicare eligible expenses" means health care expenses covered by Medicare Part A or B, to the extent recognized as reasonable and medically necessary by Medicare.

(p) "~~Medicare+Choice~~ Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 of the federal Social Security Act, United States Code, title 42, section 1395w-28, and includes:

(1) coordinated care plans which provide health care services, including, but not limited to, health maintenance organization plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) medical savings account plans coupled with a contribution into a ~~Medicare+Choice~~ Medicare Advantage medical savings account; and

(3) ~~Medicare+Choice~~ Medicare Advantage private fee-for-service plans.

(q) "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts) or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law 105-33), Sections 1851 to 1859 of the Social Security Act establishing part C of the Medicare program, known as the "~~Medicare+Choice~~ Medicare Advantage program."

(r) "Medicare supplement policy or certificate" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, ~~or~~ other than those policies or certificates covered by section 1833 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., or an issued policy under a demonstration project specified under amendments to the federal Social Security Act, which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan that provides benefits under an agreement under section 1833(a)(1)(A) of the Social Security Act.

(s) "Physician" shall not be defined more restrictively than as defined in the Medicare program or section 62A.04, subdivision 1, or 62A.15, subdivision 3a.

(t) "Policy form" means the form on which the policy is

delivered or issued for delivery by the issuer.

(u) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(v) "Sickness" shall not be defined more restrictively than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under a workers' compensation, occupational disease, employer's liability, or similar law.

(w) "Outpatient prescription drug" means a prescription drug prescribed or administered under circumstances that qualify for coverage under Medicare Part D and not under Medicare Part A or Part B.

Sec. 8. Minnesota Statutes 2004, section 62A.31, subdivision 4, is amended to read:

Subd. 4. [PROHIBITED POLICY PROVISIONS.] (a) A Medicare supplement policy or certificate in force in the state shall not contain benefits that duplicate benefits provided by Medicare or contain exclusions on coverage that are more restrictive than those of Medicare. Duplication of benefits is permitted to the extent permitted under subdivision 1s, paragraph (a), for benefits provided by Medicare Part D.

(b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions, except as permitted under subdivision 1b.

Sec. 9. Minnesota Statutes 2004, section 62A.31, subdivision 7, is amended to read:

Subd. 7. [MEDICARE PRESCRIPTION DRUG BENEFIT.] If Congress enacts legislation creating a prescription drug benefit in the Medicare program, nothing in this section or any other section shall prohibit an issuer of a Medicare supplement policy from offering this prescription drug benefit consistent with the

applicable federal law or regulations. ~~If an issuer offers the federal benefit, such an offer shall be deemed to meet the issuer's mandatory offer obligations under this section and may, at the discretion of the issuer, constitute replacement coverage as defined in subdivision 11 for any existing policy containing a prescription drug benefit.~~

Sec. 10. Minnesota Statutes 2004, section 62A.315, is amended to read:

62A.315 [EXTENDED BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.]

The extended basic Medicare supplement plan must have a level of coverage so that it will be certified as a qualified plan pursuant to section 62E.07, and will provide:

(1) coverage for all of the Medicare Part A inpatient hospital deductible and coinsurance amounts, and 100 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare;

(2) coverage for the daily co-payment amount of Medicare Part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, and the Medicare Part B deductible amount;

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law~~,~~; the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a foreign country~~,~~; and prescription drug expenses, not covered by Medicare. An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare supplement policy or certificate issued on or after January 1, 2006;

(5) coverage for the reasonable cost of the first three

pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations;

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer, including mammograms and pap smears;

(7) preventive medical care benefit: coverage for the following preventive health services:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare;

(8) at-home recovery benefit: coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) for purposes of this benefit, the following definitions shall apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(ii) coverage requirements and limitations:

(A) at-home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as medically necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $100 per visit;

(III) $4,000 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by unpaid volunteers or providers who are not care providers.

Sec. 11. Minnesota Statutes 2004, section 62A.316, is amended to read:

62A.316 [BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.]

(a) The basic Medicare supplement plan must have a level of coverage that will provide:

(1) coverage for all of the Medicare part A inpatient hospital coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare, after satisfying the Medicare part A deductible;

(2) coverage for the daily co-payment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the coinsurance amount, or in the case of outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare part B regardless of hospital confinement, subject to the Medicare part B deductible amount;

(4) 80 percent of the hospital and medical expenses and supplies incurred during travel outside the United States as a

result of a medical emergency;

(5) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations;

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer screening including mammograms and pap smears; and

(7) 80 percent of coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes. Coverage must include persons with gestational, type I, or type II diabetes.

(b) Only the following optional benefit riders may be added to this plan:

(1) coverage for all of the Medicare part A inpatient hospital deductible amount;

(2) a minimum of 80 percent of eligible medical expenses and supplies not covered by Medicare part B, not to exceed any charge limitation established by the Medicare program or state law;

(3) coverage for all of the Medicare part B annual deductible;

(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses. An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006;

(5) coverage for the following preventive health services:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal

examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test, administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for a procedure covered by Medicare;

(6) coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) For purposes of this benefit, the following definitions apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aid, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at-home recovery visit" means the period of a visit

required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(ii) Coverage requirements and limitations:

(A) at-home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) Coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by family members, unpaid volunteers, or providers who are not care providers;

(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually under this benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4). An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006.

Sec. 12. Minnesota Statutes 2004, section 62A.318, is amended to read:

62A.318 [MEDICARE SELECT POLICIES AND CERTIFICATES.]

Subdivision 1. [APPLICABILITY AND ADVERTISING LIMITATION.] (a) This section applies to Medicare select policies and certificates, as defined in this section, including those issued by health maintenance organizations.

(b) No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

~~(b)~~ Subd. 2. [DEFINITIONS.] For the purposes of this section:

(1) "complaint" means any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers;

(2) "grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare select issuer or its network providers;

(3) "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate;

(4) "Medicare select policy" or "Medicare select certificate" means a Medicare supplement policy or certificate that contains restricted network provisions;

(5) "network provider" means a provider of health care, or a group of providers of health care, that has entered into a

written agreement with the issuer to provide benefits insured under a Medicare select policy or certificate;

(6) "restricted network provision" means a provision that conditions the payment of benefits, in whole or in part, on the use of network providers; and

(7) "service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare select policy or certificate.

~~(c)~~ Subd. 3. [REVIEW BY COMMISSIONER.] The commissioner may authorize an issuer to offer a Medicare select policy or certificate pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Public Law 101-508, if the commissioner finds that the issuer has satisfied all of the requirements of Minnesota Statutes.

~~(d)~~ Subd. 4. [APPROVAL; PLAN OF OPERATION.] A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

~~(e)~~ Subd. 5. [CONTENTS OF PLAN OF OPERATION.] A Medicare select issuer shall file a proposed plan of operation with the commissioner, in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) the services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(ii) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(A) to deliver adequately all services that are subject to

a restricted network provision; or

(B) to make appropriate referrals;

(iii) there are written agreements with network providers describing specific responsibilities;

(iv) emergency care is available 24 hours per day and seven days per week; and

(v) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against an individual insured under a Medicare select policy or certificate. This section does not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate;

(2) a statement or map providing a clear description of the service area;

(3) a description of the grievance procedure to be used;

(4) a description of the quality assurance program, including:

(i) the formal organizational structure;

(ii) the written criteria for selection, retention, and removal of network providers; and

(iii) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;

(5) a list and description, by specialty, of the network providers;

(6) copies of the written information proposed to be used by the issuer to comply with paragraph (i); and

(7) any other information requested by the commissioner.

~~(f)~~ Subd. 6. [FILING OF PROPOSED CHANGES; DEEMED APPROVAL.] A Medicare select issuer shall file proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner before implementing the changes. The changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

An updated list of network providers shall be filed with the commissioner at least quarterly.

~~(g)~~ Subd. 7. [NONNETWORK PROVIDERS; LIMITS ON COVERAGE RESTRICTIONS.] A Medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition; and

(2) it is not reasonable to obtain the services through a network provider.

~~(h)~~ Subd. 8. [FULL PAYMENT; SERVICES NOT AVAILABLE IN NETWORK.] A Medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

~~(i)~~ Subd. 9. [REQUIRED DISCLOSURES.] A Medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure must include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with:

(i) other Medicare supplement policies or certificates offered by the issuer; and

(ii) other Medicare select policies or certificates;

(2) a description, including address, phone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are used;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

(7) a description of the Medicare select issuer's quality assurance program and grievance procedure.

~~(j)~~ Subd. 10. [PROOF OF DISCLOSURE.] Before the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to paragraph (i) and that the applicant understands the restrictions of the Medicare select policy or certificate.

~~(k)~~ Subd. 11. [GRIEVANCE PROCEDURES.] A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure must be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances must be considered in a timely manner and must be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action must be taken promptly.

(5) All concerned parties must be notified about the results of a grievance.

(6) The issuer shall report no later than March 31 of each year to the commissioner regarding the grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of the

grievances.

~~(l)~~ Subd. 12. [OFFER OF ALTERNATIVE PRODUCT REQUIRED.] At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate otherwise offered by the issuer.

~~(m)(l)~~ Subd. 13. [RIGHT TO REPLACE WITH NONNETWORK COVERAGE.] (a) At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare ~~supplement~~ select policy or certificate has been in force for six months. If the issuer does not have available for sale a policy or certificate without restrictive network provisions, the issuer shall provide enrollment information for the Minnesota comprehensive health association Medicare supplement plans.

~~(2)~~ (b) For the purposes of this ~~paragraph~~ subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges. Coverage for outpatient prescription drugs is not permitted in Medicare supplement policies or certificates issued on or after January 1, 2006.

~~(n)~~ Subd. 14. [CONTINUATION OF COVERAGE UNDER CERTAIN CIRCUMSTANCES.] (a) Medicare select policies and certificates shall provide for continuation of coverage if the secretary of health and human services determines that Medicare select policies and certificates issued pursuant to this section should

be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment.

~~(i)~~ (b) In the event of a determination under paragraph (a), each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

~~(2)~~ (c) For the purposes of this ~~paragraph~~ subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this ~~paragraph~~ subdivision, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges. Coverage for outpatient prescription drugs must not be included for sale or issuance of a Medicare supplement policy or certificate issued on or after January 1, 2006.

~~(o)~~ Subd. 15. [PROVISION OF DATA REQUIRED.] A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program.

~~(p)~~ Subd. 16. [REGULATION BY COMMERCE DEPARTMENT.] Medicare select policies and certificates under this section shall be regulated and approved by the Department of Commerce.

~~(q)~~ Subd. 17. [TYPES OF PLANS.] Medicare select policies and certificates must be either a basic plan or an extended basic plan. Before a Medicare select policy or certificate is sold or issued in this state, the applicant must be provided with an explanation of coverage for both a Medicare select basic and a Medicare select extended basic policy or certificate and

must be provided with the opportunity of purchasing either a Medicare select basic or a Medicare select extended basic policy. The basic plan may also include any of the optional benefit riders authorized by section 62A.316. Preventive care provided by Medicare select policies or certificates must be provided as set forth in section 62A.315 or 62A.316, except that the benefits are as defined in chapter 62D.

~~(r)--(Expired)~~

Sec. 13. Minnesota Statutes 2004, section 62A.36, subdivision 1, is amended to read:

Subdivision 1. [LOSS RATIO STANDARDS AND REFUND PROVISIONS.] (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~~.

These ratios must be calculated based upon 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. For purposes of this calculation, "health care expenses" has the meaning given in section 62A.31, subdivision

3, paragraph (j). An insurer shall demonstrate that the third year loss ratio is greater than or equal to the applicable percentage.

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.

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.

(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.

(f) An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

(g) Issuers are permitted to continue to use currently approved forms as appropriate through December 31, 2005.

(h) Issuers must comply with any requirements to notify enrollees under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Sec. 14. [REVISOR INSTRUCTION.]

The revisor of statutes shall, in producing Minnesota Statutes 2006, place in alphabetical order the terms defined in Minnesota Statutes, section 62A.31, subdivision 3, and make any necessary resulting changes in cross-references.

Sec. 15. [EFFECTIVE DATE.]

Sections 1 to 13 are effective January 1, 2006, except that section 13, paragraphs (g) and (h), are effective the day following final enactment.

ARTICLE 2

REGULATION OF STAND-ALONE MEDICARE PART D PRESCRIPTION DRUG PLANS

Section 1. [62A.451] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] For purposes of sections 62A.451 to 62A.4530, the terms defined in this section have the meanings given.

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

Subd. 3. [ENROLLEE.] "Enrollee" means an individual who is entitled to limited health services under a contract with an entity authorized to provide or arrange for such services under sections 62A.451 to 62A.4530.

Subd. 4. [EVIDENCE OF COVERAGE.] "Evidence of coverage" means the certificate, agreement, or contract issued under section 62A.4516 setting forth the coverage to which an enrollee is entitled.

Subd. 5. [LIMITED HEALTH SERVICE.] "Limited health service" means pharmaceutical services covered under Medicare Part D. Limited health service does not include hospital, medical, surgical, or emergency services.

Subd. 6. [PREPAID LIMITED HEALTH SERVICE ORGANIZATION.] "Prepaid limited health service organization" means any corporation, partnership, or other entity that, in return for a prepayment, undertakes to provide or arrange for the provision of limited health services to enrollees. Prepaid limited health service organization does not include:

(1) an entity otherwise authorized under the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

(2) an entity that meets the requirements of section

62A.4514; or

(3) a provider or entity when providing or arranging for the provision of limited health services under a contract with a prepaid limited health service organization or with an entity described in clause (1) or (2).

Subd. 7. [PROVIDER.] "Provider" means a physician, pharmacist, health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health services under sections 62A.451 to 62A.4530.

Subd. 8. [SUBSCRIBER.] "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services under a contract with an entity authorized to provide or arrange for such services under sections 62A.451 to 62A.4530.

Sec. 2. [62A.4511] [CERTIFICATE OF AUTHORITY REQUIRED.]

No person, corporation, partnership, or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner under sections 62A.451 to 62A.4530.

Sec. 3. [62A.4512] [APPLICATION FOR CERTIFICATE OF AUTHORITY.]

An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the commissioner on a form prescribed by the commissioner. The application must be verified by an officer or authorized representative of the applicant and must set forth, or be accompanied by, the following:

(1) a copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments to these documents;

(2) a copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

(3) a list of the names, addresses, official positions, and

biographical information of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

(4) a statement generally describing the applicant, its facilities, personnel, and the limited health services to be offered;

(5) a copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

(6) a copy of the form of any contract made, or to be made between the applicant and any person listed in clause (3);

(7) a copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees;

(8) a copy of the form of any group contract that is to be issued to employers, unions, trustees, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

(9) a copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, satisfies this requirement unless the commissioner determines

that additional or more recent financial information is required for the proper administration of sections 62A.451 to 62A.4530;

(10) a copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

(11) a statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with section 45.028;

(12) a description of how the applicant will comply with section 62A.4523;

(13) the fee for issuance of a certificate of authority provided in section 62A.4529; and

(14) such other information as the commissioner may reasonably require to make the determinations required by sections 62A.451 to 62A.4530.

Sec. 4. [62A.4513] [ISSUANCE OF CERTIFICATE OF AUTHORITY; DENIAL.]

Subdivision 1. [ISSUANCE.] Following receipt of an application filed under section 62A.4512, the commissioner shall review the application and notify the applicant of any deficiencies. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) the requirements of section 62A.4512 have been fulfilled;

(2) the individuals responsible for conducting the applicant's affairs are competent, trustworthy, and possess good reputations, and have had appropriate experience, training, or education;

(3) the applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(i) the financial soundness of the applicant's arrangements

for limited health services;

(ii) the adequacy of working capital, other sources of funding, and provisions for contingencies;

(iii) any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(iv) the manner in which the requirements of section 62A.4523 have been fulfilled; and

(4) any deficiencies identified by the commissioner have been corrected.

Subd. 2. [DENIALS.] If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The prepaid limited health service organization has 30 days from the date of receipt of the notice to request a hearing before the commissioner under chapter 14.

Sec. 5. [62A.4514] [FILING REQUIREMENTS FOR AUTHORIZED ENTITIES.]

(a) An entity authorized under the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health service plan corporation, a fraternal benefit society, or a multiple employer welfare arrangement, and that is not otherwise authorized under the laws of this state to offer limited health services on a per capita or fixed prepayment basis, may do so by filing for approval with the commissioner the information requested by section 62A.4512, clauses (4), (5), (7), (8), and (10), and any subsequent material modification or addition to those provisions.

(b) If the commissioner disapproves the filing, the procedures provided in section 62A.4513, subdivision 2, must be followed.

Sec. 6. [62A.4515] [MATERIAL MODIFICATIONS.]

Subdivision 1. [MATERIAL MODIFICATIONS.] A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any material modification of any

matter or document furnished under section 62A.4512, together with supporting documents necessary to fully explain the modification. If the commissioner does not disapprove the filing within 60 days of its filing, the filing is deemed approved.

Subd. 2. [PROCEDURE FOR DISAPPROVAL.] If a filing under this section is disapproved, the commissioner shall notify the prepaid limited health service organization and specify the reasons for disapproval in the notice. The prepaid limited health service organization has 30 days from the date of receipt of notice to request a hearing before the commissioner under chapter 14.

Sec. 7. [62A.4516] [EVIDENCE OF COVERAGE.]

Every subscriber must be issued an evidence of coverage consistent with the requirements of Medicare Part D.

Sec. 8. [62A.4517] [CONSTRUCTION WITH OTHER LAWS.]

Subdivision 1. [APPLICATION OF OTHER INSURANCE LAWS.] (a) A prepaid limited health service organization organized under the laws of this state is deemed to be a domestic insurer for purposes of chapter 60D unless specifically exempted in writing from one or more of the provisions of that chapter by the commissioner, based upon a determination that the provision is not applicable to the organization or to providing coverage under Medicare Part D.

(b) No other provision of chapters 60 to 72C applies to a prepaid limited health service organization unless such an organization is specifically mentioned in the provision.

Subd. 2. [NOT A HEALING ART.] The provision of limited health services by a prepaid limited health service organization or other entity under sections 62A.451 to 62A.4530 must not be deemed to be the practice of medicine or other healing arts.

Subd. 3. [SOLICITATION AND ADVERTISING.] Solicitation to arrange for or provide limited health services in accordance with sections 62A.451 to 62A.4530 shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Sec. 9. [62A.4518] [NONDUPLICATION OF COVERAGE.]

Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health service plan corporation, or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services, whether in the form of services, supplies, or reimbursement, insofar as the coverage or service is provided in accordance with sections 62A.451 to 62A.4530 under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health service corporation, or a fraternal benefit society.

Sec. 10. [62A.4519] [COMPLAINT SYSTEM.]

Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers, consistent with the requirements of Medicare Part D.

Sec. 11. [62A.4520] [EXAMINATION OF ORGANIZATION.]

(a) The commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every three years.

(b) Every prepaid limited health service organization shall make its relevant books and records available for an examination and in every way cooperate with the commissioner to facilitate an examination.

(c) The reasonable expenses of an examination under this section must be charged to the organization being examined and remitted to the commissioner.

(d) In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state.

Sec. 12. [62A.4521] [INVESTMENTS.]

The funds of a prepaid limited health service organization shall be invested only in accordance with the guidelines under chapter 62D for investments by health maintenance organizations.

Sec. 13. [62A.4522] [AGENTS.]

No individual may apply, procure, negotiate, or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, nonprofit health service plan contracts, or health maintenance organization contracts.

Sec. 14. [62A.4523] [PROTECTION AGAINST INSOLVENCY; DEPOSIT.]

Subdivision 1. [NET EQUITY.] (a) Except as approved in accordance with subdivision 4, each prepaid limited health service organization shall at all times have and maintain tangible net equity equal to the greater of:

(1) $100,000; or

(2) two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(b) A prepaid limited health service organization that has uncovered expenses in excess of $100,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to 25 percent of the uncovered expense in excess of $100,000 in addition to the tangible net equity required by paragraph (a).

Subd. 2. [DEFINITIONS.] For the purpose of this section:

(1) "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner; and

(2) "tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; start-up costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors,

owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates and that are not past due.

Subd. 3. [DEPOSIT.] (a) Each prepaid limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the commissioner, in an amount equal to $50,000 plus 25 percent of the tangible net equity required in subdivision 1; provided, however, that the deposit must not be required to exceed $200,000.

(b) The deposit is an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(c) All income from deposits is an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part of it after making a substitute deposit of equal amount and value. Any securities must be approved by the commissioner before being substituted.

(d) The deposit must be used to protect the interests of the prepaid limited health service organization's enrollees and to ensure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit is an asset subject to provisions of chapter 60B.

(e) The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the

deposit.

Subd. 4. [WAIVER OF NET EQUITY REQUIREMENT.] Upon application by a prepaid limited health service organization, the commissioner may waive some or all of the requirements of subdivision 1 for any period of time the commissioner deems proper upon a finding that either:

(1) the prepaid limited health service organization has a net equity of at least $10,000,000; or

(2) an entity having a net equity of at least $10,000,000 furnishes to the commissioner a written commitment, acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

Subd. 5. [DEFINITION; UNCOVERED EXPENSES.] For the purposes of this section, "uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health organization (1) for which an enrollee may be liable in the event of the insolvency of the organization and (2) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, must be considered a covered expense.

Sec. 15. [62A.4524] [OFFICERS AND EMPLOYEES FIDELITY BOND.]

(a) A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than $20,000,000 or in any other amount prescribed by the commissioner. Except as otherwise provided by this paragraph, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this paragraph is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state in compliance with sections 60A.195 to 60A.2095 satisfies the requirements of this paragraph.

(b) In lieu of the bond specified in paragraph (a), a prepaid limited health service organization may deposit with the commissioner cash or securities or other investments of the types set forth in section 62A.4521. Such a deposit must be maintained by the commissioner in the amount and subject to the same conditions required for a bond under this paragraph.

Sec. 16. [62A.4525] [REPORTS.]

(a) Every prepaid limited health service organization shall file with the commissioner annually, on or before April 1, a report verified by at least two principal officers covering the preceding calendar year.

(b) The report must be on forms prescribed by the commissioner and must include:

(1) a financial statement of the organization, including its balance sheet, income statement, and statement of changes in financial position for the preceding year, certified by an independent public accountant, or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which must be consolidating financial statements of the prepaid limited health service organization;

(2) the number of subscribers at the beginning of the year, the number of subscribers at the end of the year, and the number of enrollments terminated during the year; and

(3) such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out the commissioner's duties under sections 62A.451 to 62A.4530.

(c) The commissioner may require more frequent reports containing information necessary to enable the commissioner to carry out the commissioner's duties under sections 62A.451 to 62A.4530.

(d) The commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

Sec. 17. [62A.4526] [SUSPENSION OR REVOCATION OF

CERTIFICATE OF AUTHORITY.]

Subdivision 1. [GROUNDS FOR SUSPENSION OR REVOCATION.] The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization under sections 62A.451 to 62A.4530 upon determining that any of the following conditions exist:

(1) the prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62A.4512, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the prepaid limited health service organization issues an evidence of coverage that does not comply with the requirements of section 62A.4516;

(3) the prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) the prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) the tangible net equity of the prepaid limited health service organization is less than that required by section 62A.4523 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) the prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by section 62A.4519;

(7) the continued operation of the prepaid limited health service organization would be hazardous to its enrollees; or

(8) the prepaid limited health service organization has otherwise failed to comply with sections 62A.451 to 62A.4530.

Subd. 2. [PROCEDURE FOR SUSPENSION OR REVOCATION.] If the

commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than 60 days after the date of notification for a hearing on the matter in accordance with chapter 14.

Subd. 3. [WINDING UP AFTER REVOCATION.] When the certificate of authority of a prepaid limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

Sec. 18. [62A.4527] [PENALTIES.]

In lieu of any penalty specified elsewhere in sections 62A.451 to 62A.4530, or when no penalty is specifically provided, whenever a prepaid limited health service organization or other person, corporation, partnership, or entity subject to those sections has been found, pursuant to chapter 14, to have violated any provision of sections 62A.451 to 62A.4530, the commissioner may:

(1) issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person, or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) impose a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $10,000.

Sec. 19. [62A.4528] [REHABILITATION, CONSERVATION, OR LIQUIDATION.]

(a) Any rehabilitation, conservation, or liquidation of a prepaid limited health service organization must be deemed to be the rehabilitation, conservation, or liquidation of an insurance company and must be conducted under chapter 60B.

(b) A prepaid limited health service organization is not subject to the laws and rules governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to individuals entitled to receive limited health services from a prepaid limited health service organization.

Sec. 20. [EFFECTIVE DATE.]

Sections 1 to 19 are effective March 15, 2005, but no coverage may become effective prior to January 1, 2006.

ARTICLE 3

TECHNICAL AND CONFORMING CHANGES

Section 1. Minnesota Statutes 2004, section 62L.12, subdivision 2, is amended to read:

Subd. 2. [EXCEPTIONS.] (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees 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 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.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees as required.

(e) A health carrier may sell, issue, or renew individual 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 health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to substitute individual health plans for a group 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, 1851 to 1859, 1860D, 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.

(j) A health carrier may offer, issue, sell, or renew an individual health plan to persons eligible for an employer group health plan, if the individual health plan is a high deductible health plan for use in connection with an existing health savings account, in compliance with the Internal Revenue Code, section 223. In that situation, the same or a different health carrier may offer, issue, sell, or renew a group health plan to cover the other eligible employees in the group.

Sec. 2. Minnesota Statutes 2004, section 62Q.01, subdivision 6, is amended to read:

Subd. 6. [MEDICARE-RELATED COVERAGE.] "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health

maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts), 1851 to 1859 (Medicare Advantage), 1860D (Medicare Part D), or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law 105-33), Sections 1851 to 1859 of the Social Security Act establishing part C of the Medicare program, known as the "~~Medicare+Choice~~ Medicare Advantage program."

Sec. 3. Minnesota Statutes 2004, section 256.9657, subdivision 3, is amended to read:

Subd. 3. [HEALTH MAINTENANCE ORGANIZATION; COMMUNITY 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 community integrated service network licensed by the commissioner under 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 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 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 or a community integrated service network and the Centers for Medicare and Medicaid

Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections ~~4001 and 4002 of Public Law 105-33 received by a health maintenance organization or community integrated service network through risk sharing or Medicare Choice Plus contracts~~ 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization 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 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.

(c) When a health maintenance organization or community integrated service network merges or consolidates with or is acquired by another health maintenance organization or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(d) Effective July 1 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the second previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until

the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

(e) When a health maintenance organization or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization or community integrated service network.

(f) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(g) The surcharge assessed to a health maintenance organization or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

Sec. 4. Minnesota Statutes 2004, section 295.53, subdivision 1, is amended to read:

Subdivision 1. [EXEMPTIONS.] (a) 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 295.59:

(1) payments received for services provided under the Medicare program, including payments received from the government, and organizations governed by sections 1833<u>, 1854, 1860D-12,</u> and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, and enrollee deductibles, coinsurance, and co-payments, whether paid by the Medicare enrollee or by a Medicare supplemental coverage as

defined in section 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal Social Security Act. Payments for services not covered by Medicare are taxable;

(2) payments received for home health care services;

(3) 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), (7), (10), or (14);

(4) payments received from health care providers for goods and services on which liability for tax is imposed under this chapter or the source of funds for the payment is exempt under clause (1), (7), (10), or (14);

(5) amounts paid for legend drugs, other than nutritional products, to a wholesale drug distributor who is subject to tax under section 295.52, subdivision 3, reduced by reimbursements received for legend drugs otherwise exempt under this chapter;

(6) payments received by a health care provider or the wholly owned subsidiary of a health care provider for care provided outside Minnesota;

(7) payments received from the chemical dependency fund under chapter 254B;

(8) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

(9) payments received for providing patient services incurred through a formal program of health care research conducted in conformity with federal regulations governing research on human subjects. Payments received from patients or from other persons paying on behalf of the patients are subject to tax;

(10) 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 or payments made by the government for services provided under general assistance medical care, the MinnesotaCare program, or the medical assistance program governed by title XIX of the

federal Social Security Act, United States Code, title 42, sections 1396 to 1396v;

(11) government payments received by the commissioner of human services for state-operated services;

(12) payments received by a health care provider for hearing aids and related equipment or prescription eyewear delivered outside of Minnesota;

(13) payments received by an educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants, and for services identified in and provided under an individualized education plan as defined in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee for service payments and payments for extended coverage are taxable; and

(14) payments received under the federal Employees Health Benefits Act, United States Code, title 5, section 8909(f), as amended by the Omnibus Reconciliation Act of 1990.

(b) Payments received by wholesale drug distributors for legend drugs sold directly to veterinarians or veterinary bulk purchasing organizations are excluded from the gross revenues subject to the wholesale drug distributor tax under sections 295.50 to 295.59.

Sec. 5. Minnesota Statutes 2004, section 297I.15, subdivision 1, is amended to read:

Subdivision 1. [GOVERNMENT PAYMENTS.] Premiums under the Minnesota comprehensive health insurance plan and all payments, revenues, and reimbursements received from the federal government for Medicare-related coverage as defined in section 62A.31, subdivision 3, and for Medicare outpatient prescription drug coverage under part D of title XVII of the federal Social Security Act, are not subject to tax under this chapter.

Senator ..... moves to amend S.F. No. 880 as follows:

Page 2, line 13, delete the new language and before the comma, insert ". If the suspended policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide coverage substantially equivalent to the coverage in effect before the date of suspension"

Page 2, lines 14 and 15, delete the new language

Page 9, line 22, delete "1395ss(v)(6)(d)" and insert "1395ss(v)(6)(D)"

Page 35, line 27, delete "use" and insert "issue"

Page 35, line 28, after "approved" insert "policy and certificate"

Page 36, line 3, after "paragraphs" insert "(f)," and after "(g)" insert a comma

Page 36, lines 10 and 17, delete "62A.4530" and insert "62A.4528"

Page 37, lines 9, 14, 20, delete "62A.4530" and insert "62A.4528"

Page 39, line 2, delete "62A.4530" and insert "62A.4528"

Page 39, line 12, after the semicolon insert "and"

Page 39, delete lines 13 to 14

Page 39, line 15, delete "(14)" and insert "(13)"

Page 39, line 17, delete "62A.4530" and insert "62A.4528"

Page 39, line 23, after the period, insert "The commissioner must approve or deny an application within 90 days after receipt of a substantially complete application, or the application is deemed approved."

Page 41, lines 30 and 34, delete "62A.4530" and insert "62A.4528"

Page 42, line 10, delete "62A.4530" and insert "62A.4528"

Page 42, delete lines 31 to 33

Page 42, line 34, delete "(d)" and insert "(c)"

Page 46, line 28, delete "62A.4530" and insert "62A.4528"

Page 47, lines 5 and 35, delete "62A.4530" and insert

"62A.4528"

Page 48, lines 23 and 27, delete "62A.4530" and insert "62A.4528"

Pages 53 to 55, delete sections 4 and 5

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Summary of Medicare Technical Change Legislation

What is this legislation about?

- This bill **conforms Minnesota state law to the requirements of the Medicare Modernization Act (MMA)** of 2003.

- **It is technical in nature** and is consistent with the modifications proposed by the National Association of Insurance Commissioners (NAIC).

- **The Departments of Commerce, Human Services, Health, and Employee Relations have all worked on this legislation as have numerous outside legal counsel. Every effort has been made to limit this bill to only those technical changes that must be enacted.**

Why is this legislation needed?

- The legislation is needed **to bring state law into compliance with federal law** as well as provide state oversight over Prescription Drug Plan (PDP) sponsors. All 50 states are passing state legislation or amending regulations to conform to the new federal law.

- Importantly, **the bill spells out the rights Minnesota seniors with existing Medigap coverage have** as changes in the program are introduced.

- **Passage of the legislation will assure that there is no conflict in law between the new federal requirements and existing state law.** This is important due to the very complex nature of the new Medicare benefits.

- Without this legislation, conflicts in law would only add to the confusion of what options are legally available for Minnesota seniors.

- Such conflicts also leave health plans subject to contradictory requirements, and impose on state insurance regulators the burden of repeatedly analyzing the application of federal preemption every time a related issue arises.

- Failure to pass a licensure provision for a limited benefit plan will likely result in federal, not state, oversight of a PDP sponsor offering the new prescription drug benefit beginning on January 1, 2006.

What this legislation does

- This bill brings Minnesota state law into compliance with the requirements of the (MMA) regarding the sale of policies with prescription drug coverage by Medigap carriers after January 1, 2006.

- It spells out the rights of Medigap policyholders regarding guaranteed issue rights they have for continuing their existing coverage, switching to other policies, or carving existing drug coverage out of their policy.

- The legislation also deletes state law requirements for offering certain benefits in a Medigap policy because those benefits are now included in the Medicare program itself. All of these changes are consistent with the changes that are recommended by the NAIC.

- The legislation does not change Minnesota's status as a waivered state for Medicare supplement plans.

In addition to these changes, the bill includes a licensure provision for a limited benefit plan that offers only prescription drug coverage under the Medicare program:

- The MMA creates a stand-alone prescription drug benefit/plan (PDP) that may be offered by a PDP-sponsor that is a risk-bearing entity licensed under state law and adheres to state solvency requirements.
- If the state does not have a licensure process in place, an organization that wishes to offer this stand-alone drug benefit may request a waiver that would allow for federal, not state, regulation.
- Under the MMA, there will be a stand-alone drug benefit option in each CMS designated region in the country. The provision in this bill is limited to only licensure and solvency requirements because federal law preempts any other state oversight of this stand-alone PDP sponsor.

Background

- The Medicare Modernization Act was signed into law in December 2003. This legislation created a new voluntary prescription drug benefit in the Medicare program beginning January 1. 2006.

- As part of this very expansive piece of legislation, Medicare Supplement (Medigap) carriers will be prohibited by federal law from selling new policies with drug coverage after January 1, 2006 but may renew existing policies.

- Medicare supplement policies are regulated at the state level and the requirements for these policies are found in Minnesota state statute. However, the Medicare Modernization Act preempts state law with respect to the continued sale of new Medigap policies with drug coverage after January 1, 2006. Consequently, Minnesota state law must be amended to incorporate the changes required under the federal legislation.

- The legislation directed the NAIC to draft model rules/legislation for all states to use in implementing these changes. Minnesota is one of three states that operates as a "waivered" state that does not conform with NAIC model Medigap policies. This means that in certain instances, including prescription drug benefits, Minnesota's requirements are richer than the NAIC model act.