HOUSE RESEARCH

Bill Summary

H. F. 2800, as enacted (Chapter 549) **S.F.**

SUBJECT: Minnesota Health Right Act

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ARTICLE 1
COST CONTAINMENT

Section 1. Purpose. States that it is the intent of the legislature to lay a new foundation for the delivery and financing of health care in Minnesota, through the Minnesota Health Right Act.

Sec. 2. Definitions. Defines terms.

Sec. 3. Controlling growth in health care spending. Requires the commissioner of health to collect data on health care spending and set limits for the rate of health care spending growth. Requires the Minnesota health care commission to develop a plan for achieving compliance with spending limits.

Subdivision 1. Comprehensive budget. Requires the commissioner of health to set annual limits on growth that slow the current rate of growth by at least ten percent a year. The limits must be achievable through good faith, cooperative efforts of health care consumers, purchasers, and providers.

Subd. 2. Data collection. Authorizes the commissioner to collect data on health care spending from providers and group purchasers. Requires licensing boards to cooperate with data collection efforts, makes failure to provide data grounds for disciplinary action, and authorizes fines and court orders to require providers to produce information.

Subd. 3. Cost containment duties. The duties of the commissioner include:

(1) establishing statewide and regional limits on growth in spending, monitoring statewide and regional compliance with the limits, and taking action to achieve compliance, to the extent authorized by the legislature;

(2) dividing the state into no fewer than four regions, one being the Minneapolis/St. Paul metropolitan area, for purposes of fostering the development of regional health planning and coordination of health delivery among regional health care systems and working to achieve spending limits;

(3) providing technical assistance to regional coordinating boards;

(4) monitoring and preserving the quality of health care;

(5) developing uniform billing forms and procedures;

(6) undertaking health planning activities;

(7) promoting the development of practice parameters;

(8) promoting research and experimentation;

(9) designating centers of excellence and establishing minimum standards for specialized and high-cost procedures;

(10) conducting consumer education and wellness programs;

(11) administering a data collection and analysis program; and

(12) engaging in other activities relating to affordability, quality, and accessibility of health care.

Subd. 4. Consultation with the commission. Requires the commissioner of health to consult with the Minnesota health care commission before undertaking any of the duties required in the act. If the commissioner intends to depart from the recommendations of the commission, the commissioner must inform the commission, provide a written explanation of the reasons for the departure, and give the commission an opportunity to comment. If the commissioner still intends to depart from the recommendations, the commissioner must inform the legislative oversight commission at least ten days before taking action, except in emergency situations.

Subd. 5. Appeals. Allows persons or organizations to appeal decisions of the commissioner through a contested case proceeding.

Subd. 6. Rulemaking. Requires the commissioner to adopt rules, including rules governing appeals of decisions of the state commission and regional coordinating organizations.

Subd. 7. Plan for controlling growth. Requires the Minnesota health care commission to submit a plan, with as much detail as possible, to the legislature and the governor for slowing the growth in health care spending. The goal of the plan must be to reduce the health care inflation rate by at least ten percent a year for the next five years. The commission is required to consider specific options for the cost containment plan, but is not obligated to include them in the plan.

Sec. 4. Minnesota health care commission. Establishes a 25-member Minnesota health care commission.

Subdivision 1. Purpose of the commission. The two major functions of the commission are:

(1) to make recommendations regarding statewide and regional limits and activities to address spending in excess of these limits; and

(2) to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

Subd. 2. Membership. The commission includes the following members:

(1) four members representing health plan companies, including one appointed by the Minnesota Council of HMOs, one by the Insurance Federation, one by Blue Cross and Blue Shield, and one appointed by the Governor;

(2) six members representing health care providers, including one appointed by the Minnesota Hospital Association, one by the Minnesota Medical Association, one by the Minnesota Nurses' Association, one rural physician appointed by the Governor, and two members appointed by the Governor to represent other providers;

(3) four members representing employers, including a self-insured employer and a small employer appointed by the Minnesota Chamber of Commerce, and two members appointed by the governor;

(4) five consumer members, three appointed by the governor including one representing persons over age 65, one appointed by the Senate, and one appointed by the House.

(5) three representatives of labor unions, including two appointed by the AFL-CIO and one appointed by the governor;

(6) the commissioners of commerce, employee relations, and human services.

The governor and the legislature are required to coordinate appointments to ensure gender balance and geographic balance.

Subd. 3. Financial interests of members. Prohibits members representing employers, consumers, or unions from having any personal financial interest in the health care system, except as an individual consumer. Allows health benefit plan managers to represent employers or unions.

Subd. 4. Conflicts of interest. Prohibits members of the commission from participating in commission proceedings involving providers, purchasers, patients, or activities if the commission member has a direct financial interest in the outcome.

Subd. 5. Immunity from liability. Protects members and employees of the commission from civil or criminal liability for any actions relating to their duties, if they are acting in good faith.

Subd. 6. Terms, compensation, removal, and vacancies. Makes the commission subject to existing laws governing the operation of state commissions.

Subd. 7. Administration. Requires the commissioner of health to provide the commission with office space, supplies and equipment, and technical support.

Subd. 8. Staff. Authorizes the commission to hire an executive director in the unclassified service, who may hire other employees and consultants. The attorney general provides legal services.

Sec. 5. Legislative oversight commission. Establishes a legislative commission on health care access to monitor the activities of the Minnesota health care commission and other new initiatives relating to health care access. The legislative commission includes three majority members and two minority members from each house.

Sec. 6. Regional coordinating boards. Assigns duties to regional coordinating boards and specifies membership.

Subdivision 1. General duties. Regional coordinating boards are locally controlled organizations that include providers, health plan companies, employers, consumers, and elected officials. Allows regional boards to:

(1) recommend that the state commission sanction voluntary provider agreements;

(2) make recommendations regarding major capital expenditures and the introduction of new technologies and medical practices in the region;

(3) educate the community and promote voluntary, cooperative efforts to improve access, affordability, and accessibility; and

(4) make recommendations regarding ways of improving access, affordability, and accessibility in the region and throughout the state.

Subd. 2. Membership. Each regional board includes 16 members appointed by trade associations and other organizations and by the governor and the legislature. Members represent providers, health plan companies, employers, labor unions, consumers, county commissioners, and state health programs.

Subd. 3. Establishment of regional coordinating boards and structure. Health care providers should begin formulating the appropriate structure for organizing the delivery networks or systems to accomplish cost containment objectives. When a draft plan is outlined, or during the drafting process, other entities should be included as appropriate to make sure the plan and planning process is comprehensive. The structure of regional boards may vary by region and in composition. Regions may consult with the commissioner of health and the Minnesota health care commission during planning.

Subd. 4. Financial interests of members. Prohibits members representing employers or unions, and public members from having any personal financial interest in the health care system, except as individual consumers.

Subd. 5. Conflicts of interest. Prohibits members of boards from participating in board proceedings in which they have a direct financial interest.

Subd. 6. Technical assistance. Directs the state commission to provide technical assistance to the regional boards.

Subd. 7. Terms, compensation, removal, and vacancies. The regional boards are governed by existing laws relating to boards and commissions, except that members do not receive a per diem.

Subd. 8. Sunset. The regional boards expire on July 1, 1993.

Sec. 7. Health planning. Establishes a health planning advisory committee and assigns health planning initiatives to the Minnesota health care commission.

Subdivision 1. Health planning advisory committee. Requires the state commission to convene a health planning advisory committee to make recommendations on the use of health care technology and major capital expenditures.

Subd. 2. Health planning. Directs the state commission, in consultation with the health planning advisory committee, to:

(1) make recommendations on the types of high-cost technologies, procedures, and capital expenditures for which a plan on statewide used and distribution should be made;

(2) develop criteria for evaluating new high-cost technologies, procedures, and capital expenditures that take into consideration clinical effectiveness, cost effectiveness, and health outcome;

(3) recommends statewide and regional goals for these expenditures;

(4) makes recommendations regarding centers of excellence for transplants and other specialized procedures; and

(5) recommends minimum volume requirements for certain procedures.

Sec. 8. Expenditure reporting. Requires providers to file notices of capital expenditures and spending on high-cost equipment and procedures that exceed $500,000 and requires providers whose spending decisions were not appropriate to submit to a certificate of need program.

Subdivision 1. Purpose. States the purpose of the expenditure reporting section.

Subd. 2. Definitions. Defines terms.

Subd. 3. Nursing home and hospital moratoria; nursing homes exempt. Provides that the section does not supersede or limit the nursing home and hospital moratoria. Exempts spending commitments by nursing homes or intermediate care facilities from the requirements of this section.

Subd. 4. Expenditure reporting. Requires providers spending more than $500,000 on medical equipment, capital projects, or new specialized services after April 1, 1992, to notify the commissioner of health and provide information about the expenditure. The commissioner does not have authority to deny or approve projects.

Subd. 5. Retrospective review. Requires the commissioner of health, in consultation with the Minnesota health care access commission, to retrospectively review capital expenditures and major spending commitments. The commissioner shall require providers to submit to a prospective review process for future expenditures for up to five years if:

(1) providers refuse to cooperate with state and regional attempts to coordinate health care technologies and procedures and reduce the rate of health care inflation;

(2) providers use, purchase, or perform health care technologies and procedures that are not clinically effective and cost effective and do not improve health outcomes; or

(3) providers failed to pursue collaborative arrangements.

Subd. 6. Prospective Review and Approval. (a) **Requirement.** Directs the commissioner of health to prohibit providers subject to prospective review and approval from making future major spending commitments or capital expenditures that are required to be reported under subdivision 4, for up to five years unless:

(1) the provider filed an application and provided supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the spending commitment or capital expenditure is appropriate.

Decisions on applications for approval of expenditures must be made within 60 days. The Minnesota health care commission is required to convene an expert review panel to review applications and make recommendations.

(b) **Exceptions.** Provides exceptions to the retrospective/prospective review section for:

(1) replacement of existing equipment with comparable equipment

(2) medical education, medical research, and clinical trials by research and teaching institutions

(3) repair, remodeling, or replacement of existing buildings and fixtures

(4) mergers, acquisitions, and other changes in ownership that do not involve an expansion of service capacity or a change in the nature of services provided .

(c) **Appeals.** Allows providers to appeal decisions of the commissioner relating to the moratorium.

(d) **Penalties and remedies.** Allows the commissioner of health to issue fines, seek injunctions, and pursue other remedies.

Sec. 9. Submission of regional plan to commissioner. Requires each regional coordinating board to submit its plan by June 30, 1993. If a provider group or other entity in a region refuses to participate in the regional planning process, the commissioner may require the group or entity to participate or adopt rules or criteria for the group or entity. If a region does not submit a satisfactory plan, or if competing regional boards or plans exist, the commissioner may establish a public regional coordinating board to establish a regional plan. The public board is appointed by the commissioner and under the commissioner's direction.

Sec. 10. Reporting to the legislature. Requires the commissioner to report to the legislature by January 1, 1993, regarding the progress of regional coordinating boards and regional planning. If the commissioner determines that a region is not making reasonable progress or a good faith commitment towards establishing a regional board and plan, the commissioner may establish a public regional board.

Sec. 11. Participation of federal programs. Requires the state commission to seek full participation of federal health care programs in the state's cost containment system.

Sec. 12. Provider conflicts of interest. Places limits on provider conflicts of interest.

Subdivision 1. Rules prohibiting conflicts of interest. Requires the state commission to adopt rules prohibiting provider referral patterns, financial relationships, and other business and professional activities that create a potential conflict of interest. Rules must be compatible with federal rules, but may be broader and more restrictive.

Subd. 2. Interim restrictions. Requires all providers to comply with the Medicare antikickback laws, until rules are adopted. Providers who are in violation of the laws may submit a transition plan to allow time to change an activity or divest financial interests.

Subd. 3. Penalty. Allows the commissioner to assess fines for violations of this section. Fines are set at the greater of $1,000 or 110 percent of the financial benefit received by a provider as a result of a prohibited financial arrangement. (This subdivision is effective January 1, 1993.)

Sec. 13. Mandatory Medicare assignment. Provides a phase-in of mandatory Medicare assignment, with full assignment required beginning January 1, 1996. Exempts ambulance services from this requirement.

Sec. 14. Antitrust exceptions. Requires the commissioner to establish criteria and procedures for sanctioning contracts, business or financial arrangements, or other activities or practices involving providers or purchasers that might be construed to be violations of state or federal antitrust laws but which are in the best interests of the state and further the policies and goals of this chapter. Exempts the commissioner from rulemaking until January 1, 1994. Requires the adoption of permanent rules by that date.

Sec. 15. Hospital planning task force. Requires the state commission to set up a hospital planning task force to do planning and develop options and recommendations relating to cost containment, accessibility, and quality of care. Reports are due August 1, 1992 and August 1, 1993.

Sec. 16. Study on recovery of uncompensated care costs. Requires the commissioner of health to report to the legislature by January 15, 1993, on methods of recovering uncompensated care costs that are cost-shifted and no longer incurred due to the availability of the Health Right plan.

Sec. 17. Study of health care management companies. Requires the commissioners of commerce and health to study and make recommendations to the legislature by January 15, 1993 regarding the regulation of health care management companies.

Sec. 18. Study of health maintenance organization regulation. Requires to the commissioners of health and commerce to present a consensus plan to the legislature by January 15, 1993, on the division of authority over health maintenance organization regulation.

Sec. 19. Study of Medicare assignment for home medical equipment. Requires the commissioner of health to study the impact of Medicare assignment on home medical equipment suppliers, and present recommendations to the legislature by January 15, 1993.

Sec. 20. Effective date. Provides effective dates.

ARTICLE 2
SMALL EMPLOYER INSURANCE REFORM

Section 1. Citation, jurisdiction, and legislative purpose.

Subdivision 1. Popular name. Article is named Minnesota Small Employer Health Benefit Act.

Subd. 2. Jurisdiction. Provides that the article applies to any health carrier that sells health coverage to a small employer.

Subd. 3. Legislative findings and purpose. States that underwriting and rating practices in the individual and small employer markets are harmful. States that premium restrictions provided in this act reduce but do not eliminate these effects. States legislative desire to phase out remaining rating bands as quickly as possible, eliminating all rating practices based on risk by July 1, 1997.

Sec. 2. **Definitions.** Defines 28 terms. Among the most significant definitions are the following:

- Commissioner - Commissioner of health for HMOs and commissioner of commerce for other health carriers.
- Continuous coverage - No gap in coverage greater than 30 days. Incorporates term "qualifying prior coverage."
- Dependent - Includes unmarried financially dependent full-time students under the age of 25.
- Eligible employee - A person employed at least 20 hours per week. Includes sole proprietors, partners, and independent contractors under certain circumstances. Excludes seasonal employees.
- Health benefit plan - Health coverage issued by any type of health carrier to a small employer
- Health carrier - Any type of company providing health coverage to a small employer
- Index rate - The premium rate lying in the middle of a rating band.
- Late entrant - A person who enters a health benefit plan at other than at the time of initial eligibility, without one of the reasons specified in the definition.
- Preexisting condition - A condition existing during the six months prior to the beginning of health coverage.
- Qualifying prior coverage and qualifying existing coverage - Coverage under most public and private plans. This is what counts for the purpose of avoiding new preexisting condition limitations by maintaining continuous coverage.
- Small employer - A business entity of any kind with 2 to 29 employers. Allows associations of small employers to choose to be considered a small employer.
- Small employer plan - One of the two special plans permitted by this act to be sold in the small employer market.

Sec. 3. **Availability of coverage.**

Subdivision 1. Guaranteed issue and renewal. Provides that any small employer must be permitted to buy any health benefit plan available in the small employer market. Provides the same requirement for renewal. Requires health carriers that operate in the small employer market to offer

both of the small employer plans permitted by this act. Requires compliance with all underwriting and rate restrictions provided in the act.

Subd. 2. Exceptions. Permits health maintenance organizations to decline to offer coverage outside of their approved service areas. Provides exception where providing the coverage would put the health carrier in a financially impaired condition.

Subd. 3. Minimum participation. Applies guaranteed issue requirement only if small employer has 75 percent of eligible employees participating. Employees covered under another group plan (for instance, under their spouse's plan) do not count for this purpose. Permits health carriers to require that employers contribute a specified amount toward the premium, so long as the requirement is applied uniformly. Requires that health carriers require at least a 50 percent employer contribution for the two small employer plans permitted by this chapter. Does not require guaranteed issue if the employer will continue to offer another health benefit plan.

Subd. 4. Underwriting restrictions. Permits a 12 month preexisting condition exclusion. Requires credit for time covered under qualifying prior coverage, so long as coverage was continuous. Permits 18 month preexisting condition limitation or exclusion for late entrants.

Subd. 5. Cancellations and failures to renew. Prohibits cancellations, refusals to issue, and refusals to renew except for non-payment of premium, fraud or misrepresentation, failure to comply with employee participation or minimum employer contribution requirements, exit from the small employer market, or other reasons permitted by licensing laws.

Subd. 6. MCHA enrollees. Forbids carve-outs of employees into the Minnesota comprehensive health association (MCHA). Requires that present MCHA enrollees be accepted into small employer groups without underwriting. Does not require present MCHA enrollees to join their employers' groups.

Sec. 4. Compliance requirements.

Subdivision 1. Applicability of chapter requirements. Requires compliance effective July 1, 1993, or first renewal date after that. Requires termination or alternative treatment of individual coverage previously provided to a small employer group.

Subd. 2. New carriers. Requires new carriers to comply on the same basis as existing carriers.

Sec. 5. Small employer plan benefits.

Subdivision 1. Two small employer plans. Requires health carriers to offer two small employer plans permitted by this act. These small employer plans are exempted from state mandated coverages, unless the coverages are explicitly required. Provides that co-insurance and deductibles do not apply to child health supervision services and pre-natal services. Requires that maximum out-of-pocket costs be $3,000 per individual or $6,000 per family per year. Requires maximum lifetime benefit of $500,000. Would index deductible and out-of-pocket limit for inflation.

Subd. 2. Deductible - type small employer plan. Provides that one of the two required plans must pay 80 percent of covered charges, with a deductible of $500 per person and $1,000 per family per year.

Subd. 3. Co-payment - type small employer plan. Requires that one of the small employer plans pay 80 percent of covered charges, with certain co-payments.

Subd. 4. Minimum benefits. Specifies the minimum benefits that must be provided by the two small employer plans permitted by this act. The benefits are as follows:

- in-patient and out-patient hospital services, excluding chemical dependency and mental health treatment except for certain specified conditions;
- physician and nurse practitioner services;
- diagnostic x-rays and lab tests;
- ambulance transportation;
- home health care, under certain circumstances;
- private-duty registered nurse care;
- durable medical equipment, other than eyeglasses and hearing aids;
- child health supervision services up to age 18;
- maternity and pre-natal care services;
- inpatient and outpatient treatment for certain mental illnesses;
- ten hours per year of outpatient mental health treatment, except for the illnesses included in the above category;
- 60 hours per year of outpatient chemical dependency treatment;
- 50 percent of prescription drug costs, up to a separate annual maximum out-of-pocket expense of $1,000 per individual, and 100 percent of the costs above that level.

Subd. 5. Additional benefits. Prohibits supplementing the small employer plans, without satisfying all otherwise-required mandates, unless the supplemented plan differs from the two small employer plans permitted by this act only by added benefits that increase the actuarial value by no more than two percent.

Subd. 6. Choice products exception. Permits benefit coverages to vary depending upon whether providers in a primary network are used.

Subd. 7. Benefit exclusions. Permits restriction to medically necessary care.

Subd. 8. Continuation coverage. Requires the two small employer plans to comply with federal and state continuation requirements.

Subd. 9. Dependent coverage. Requires small employer plans to comply with certain coverage mandates regarding dependents, including the new definition provided in this article.

Subd. 10. Medical expense reimbursement. Permits use of existing provider contract arrangements for small employer plans.

Subd. 11. Plan design. Permits small employer plans to be offered through any otherwise-permitted provider arrangement.

Subd. 12. Demonstration projects. Provides that this act does not affect the ability of HMOs to offer demonstration projects otherwise permitted by law.

Sec. 6. Disclosure of underwriting and rating practices. Requires health carriers to disclose how premium rates are determined for a small employer.

Sec. 7. Small employer requirements.

Subdivision 1. Verification of eligibility. Requires that small employers verify the eligibility of the employer and of the employer's employees and dependents.

Subd. 2. Waivers. Requires employers to maintain records of waivers of coverage. A waiver of coverage refers to an employee's decision not to be covered by the employer's health benefit plan.

Sec. 8. Restrictions relating to premium rates.

Subdivision 1. Rate restrictions. Provides that the rate restrictions apply to all health benefit plans sold to small employers. This means that they do not apply to only the two small employer plans.

Subd. 2. General premium variations. Provides that, beginning July 1, 1993, premium rates must not vary by more than 25 percent on either side of the index rate for any type of coverage. These variations can be based only on health status, claims experience, industry of the employer, and the length of time that the small employer has been covered.

Subd. 3. Age-based premium variations. Provides that, beginning July 1, 1993, premium rates for small employers may vary by no more than 50 percent on either side of the index rate, based on the age of persons covered. This variation is in addition to the variation permitted by subdivision 2.

Subd. 4. Geographic premium variations. Permits geographic premium variations of no more than 20 percent, with the approval of the commissioner. Does not permit rural premium rate to exceed Twin Cities metro rate. Permits three regions, one being Twin Cities metro area.

Subd. 5. Gender-based rates prohibited. Provides that, beginning July 1, 1993, gender may not be used to determine premium rates.

Subd. 6. Rate cells permitted. Permits charging a different rate for individual and family coverage.

Subd. 7. Index and premium rate development. Permits a health carrier to consider, in setting premium rates, only the following actuarially valid differences: benefit designs, rating factors permitted in subdivisions 2 and 3, and geographic variations.

Subd. 8. Filing requirement. Requires filing index rates and explanation of rating factors that will be used and how they will be used to arrive at premium rates with the relevant commissioner annually.

Subd. 9. Effect of assessments. Provides that reinsurance assessments or premiums do not affect compliance with this section.

Subd. 10. Rating report. Requires an annual report from the commissioners of health and commerce on existing rating restrictions and possible additional reform.

Sec. 9. Cessation of small employer business.

Subdivision 1. Notice to commissioner. Requires 180 days advance notice to commissioner by health carrier that decides to leave the small employer market. Provides that certain activities do not constitute cessation of small employer business.

Subd. 2. Notice to employers. Requires health carriers that plan to leave the small employer market to notify their policyholders (employers) 120 days in advance.

Subd. 3. Re-entry prohibition. Provides that health carriers that leave the small employer market may not return for five years. Provides exception for HMOs that cease doing business only in particular service areas.

Subd. 4. Continuing assessment liability. Provides that health carriers that leave the small employer market are still liable for reinsurance assessments.

Sec. 10. Supervision by commissioner.

Subdivision 1. Reports. Requires health carriers in the small employer market to file annual actuarial opinion with the relevant commissioner, certifying compliance with this act.

Subd. 2. Records. Requires health carriers to keep complete records of their rating practices and the actuarial justifications for them.

Subd. 3. Submissions to commissioner. Permits commissioner to request additional information, which is classified as non-public data.

Subd. 4. Review of premium rates. Requires the commissioner to regulate premium rates, as provided in section 62A.02, which is amended in Article 3 of this bill.

Subd. 5. Transitional practices. Requires the commissioner to disapprove rates made possible by unfair practices entered into during the transitional period between passage of this bill and the effective date of the insurance reforms. Requires filing information on all small employers dropped during the transition period. Forbids dropping small employers to evade effects of this chapter.

Sec. 11. Penalties and enforcement.

Subdivision 1. Disciplinary proceedings. Permits commissioner to take action against a health carrier's license or certificate of authority and impose a monetary penalty for violation of this article. Provides for hearing, appeal, and judicial review procedures.

Subd. 2. Enforcement powers. Makes available under this chapter the enforcement powers available to the commissioners of health and commerce under other chapters.

Sec. 12. Prohibited practices.

Subdivision 1. Prohibition on issuance of individual policies. Prohibits providing health coverage to a small employer through the use of individual policies.

Subd. 2. Exceptions. Provides several exceptions to subd. 1.

Subd. 3. Agent's licensure. Provides penalties for agents who violate subd. 1.

Subd. 4. Employer prohibition. Prohibits employers from carving-out certain employees.

Subd. 5. Sale of other products. Prohibits health carriers from tying the sale of health benefit plans to other products.

Secs. 13 through 22. Health coverage reinsurance association. These sections establish a private reinsurance association, through which health carriers may transfer and share risks. Only risks associated with the benefits included in the two small employer plans permitted by this bill may be shared or transferred through the reinsurance association. Permits health carriers to choose not to participate in the reinsurance association. Provides for assessment against members, if reinsurance premiums are not sufficient to cover costs.

Sec. 23. Loss ratio standards. Provides that all health benefit plans sold to small employers are subject to the new loss ratio provision contained in Article 3 of this bill. That provision requires a 75 percent loss ratio, increasing by one percent per year until it reaches 80 percent, for coverage sold to small employers.

Sec. 24. Commissioner of commerce study. Requires the commissioner of commerce to study and make recommendations to the legislature regarding the effects of this bill on the small employer market. Requires analysis of the desirability and feasibility of ending all rating practices based on risk be July 1, 1997, based upon a phase-out of the rating bands on a scheduled basis. Report is due December 1, 1994.

Sec. 25. Effective dates. Sections 1 to 12 and 23 effective July 1, 1993. Sections 13 to 22 (reinsurance pool) effective immediately, to permit reinsurance association to be ready to provide coverage by July 1, 1993.

ARTICLE 3
INSURANCE REFORM: INDIVIDUAL MARKET AND MISCELLANEOUS

Section 1. Private Employers Insurance Program.

Subdivision 1. Intent. Intent of new PEIP (private employers insurance program) is to provide private employers with access to the purchasing power of a large pool.

Subd. 2. Definitions. Defines terms.

Subd. 3. Administrative. Administered by commissioner of employee relations.

Subd. 4. Advisory committee. Requires commissioner to establish advisory committee comprised of employers and employees.

Subd. 5. Employer eligibility. Coverage is sold for a two-year term. Employers ineligible if five percent or more of their workers work outside of Minnesota, but they may then enroll just Minnesota-based employees. Private employers must have two or more employees. Requires 75 percent minimum employee participation and 50 percent minimum employer contribution. Permits enrollment cap if necessary due to limited reserve capacity.

Subd. 6. Individual eligibility. Permits employers to set eligibility rules for their employees and dependents. Permits waivers of coverage and permits commissioner to require 18-month preexisting condition exclusion for late entrants.

Subd. 7. Coverage. Coverage starts July 1, 1993. Requires annual bidding invitations to health carriers. Requires that coverage be provided through carriers where reasonable. Coverage must emphasize managed care. Provides for coordination with Medicare. Provides that coverage should be modeled after coverage available to state employees, but must be separate from that offered to state employees. Requires that benefits include benefit mandates. Permits dental as optional coverage. Requires compliance with chapter 62L underwriting limitations.

Subd. 8. Premiums. Permits commissioner to determine premiums and rating methods, which must at least comply with Article 2 of this bill. Requires that premiums fully reflect ongoing administration costs and reserves. Requires repayment of loan for administrative start-up costs and for initial reserve within five years. Premiums paid to program exempt from premium tax. Premiums paid by program to insurance companies are not exempt from existing premium tax.

Subd. 9. Trust fund. Creates trust fund to receive premium payments, pay claims, and maintain reserves.

Subd. 10. Program status. Makes program subject to state insurance laws, including payment of MCHA assessments. Provides that program is not an insurance company.

Subd. 11. Evaluation. Requires December 15, 1995 report to legislature.

Sec. 2. Definitions. Defines "health carrier" and "health plan" for purposes of chapter 62A.

Sec. 3. Filing. Expands current language requiring filing of all health coverage forms and rates with the relevant commissioner prior to use.

Sec. 4. Approval. Gives commissioner a 60-day period to approve or disapprove proposed forms or rates. Permits use of forms or rates at end of 60-day period unless disapproved.

Sec. 5. Standards for disapproval. Requires commissioner to disapprove proposed forms or rates, unless the health carrier meets its burden of proving that the rate is actuarially justified and not excessive or inadequate. Requires commissioner to review related administrative contracts and other agreements. Prohibits use of rates and forms disapproved by the commissioner. Provides that the commissioner's 60 day period to review forms and rates does not begin until all relevant material has been filed. Provides that a proposed rate will be denied if requested supporting data is not filed within 30 days after the commissioner requests it.

Sec. 6. Withdrawal of approval. Permits the commissioner to withdraw, at any time, a previously granted approval of forms and rates. Permits the commissioner to request additional data to evaluate previously-approved rates. Provides that the approval must be withdrawn if the additional information is not provided timely.

Sec. 7. Hearing. Permits hearing prior to withdrawal of approval.

Sec. 8. Health care policy rates.

Subdivision 1. Loss ratio standards. Requires at least a 75 percent loss ratio on health benefit plans sold in the small employer market. Provides that the loss ratio increases by one percent each year, until it reaches 80 percent. For individual coverage, the loss ratio is 65 percent, increasing by one percent each year, until it reaches 70 percent. Requires commissioner to annually make public information on premium rates. Provides that sale of a policy that does not meet the loss ratio standards is subject to enforcement under certain sections of chapter 72A. Requires certain noncomprehensive health policies, such as specific disease or fixed indemnity plans, to retain the loss ratio presently required for that type of coverage.

Subd. 2. Compliance audit. Permits commissioner to audit all health carriers to enforce compliance with this section.

Sec. 9. Coverage of dependents. Requires that all health plans use the definition of dependent required in the small employer market.

Sec. 10. Prohibition; severing of groups. Prohibits "carve-outs" of bad health risks in employer plans of any size.

Sec. 11. Medicare supplemental plans. Clarifies that health service plan corporations, such as Blue Cross Blue Shield, are covered by existing regulation of Medicare supplemental plans. Makes all Medicare-related plans provided by HMOs subject to the "six-month window rule" already applicable to other health carriers. This rule requires that Medicare supplement plans be issued with no medical underwriting during a person's first six months of eligibility for Medicare. Also requires community rating for all medicare-related coverage January 1, 1993.

Sec. 12. Individual market regulation.

Subdivision 1. Applicability. Provides that the section applies to all types of health carriers selling individual coverage. Exempts MCHA, Medicare supplement, and long-term care coverage.

Subd. 2. Guaranteed renewal. Requires that renewal of individual policies be available at rates that do not take into account health conditions that were not present when the policy was issued.

Subd. 3. Premium rate restrictions. Provides that premium rates in the individual market are subject to all of the rating restrictions applicable to the small employer market in Article 2. This includes the plus or minus 25 percent band for certain rating factors, the plus or minus 50 percent band for age, and a possible plus or minus 20 percent band for geographic region.

Subd. 4. Gender rating prohibited. Prohibits rating based on gender in the individual market.

Subd. 5. Portability of coverage. Provides that coverage in the individual market is portable without preexisting condition exclusions or limitations, with some exceptions. A person may be subjected to a one-time 12 month preexisting condition exclusion when the person first enters the individual market. If the person previously had group coverage, the carrier that provided the group coverage must issue an individual policy with no new preexisting condition exclusion. Continuous coverage is required for these provisions.

Subd. 6. Guaranteed issue not required. Provides that this section does not require guaranteed issue in the individual market, except that gender cannot be used to deny coverage and individual coverage must be issued by a carrier that provided group coverage to the same person.

Sec. 13. MCHA contributing members. Makes multiple employer welfare arrangements (MEWAs) and the PEIP program (private employers portion only) contributing members of MCHA. This would subject them to assessments to fund MCHA deficits.

Sec. 14. MCHA members. Makes MEWAs and PEIP members of MCHA.

Sec. 15. MCHA special assessments. Makes conforming change in MCHA special assessment language to accommodate MEWAs and PEIP as contributing members.

Sec. 16. MCHA funding. Provides that the MCHA deficit may be partly or completely funded from the health care access account, beginning January 1, 1994, subject to appropriation. Provides that any portion of the assessment not funded in that manner will be funded by assessments on health carriers, as is done now.

Sec. 17. Inclusion in employer-sponsored plan. Provides that persons eligible to enroll in employer plans are not eligible for MCHA. This section does not apply to persons enrolled in MCHA as of June 30, 1993. This section is a companion to a section in Article 2, which prohibits employers from carving out certain employees and enrolling them in MCHA.

Sec. 18. Joint self-insurance employee health plans. Clarifies that multiple employer welfare arrangements (MEWAs) are subject to state law. Extends state regulation to MEWAs comprised of only two employers.

Sec. 19. Request for ERISA exemption. Requires commissioner of commerce to request federal legislation exempting Minnesota from certain restrictions imposed by the federal ERISA law. Requires consultation with legislative oversight commission established in Article 1 of this bill.

Sec. 20. Commissioner of commerce study. Requires the commissioner of commerce to study and make recommendations on certain aspects of the individual market, including the elimination of rating practices based on risk, the possibility of a guaranteed issue requirement, and the future of MCHA.

Sec. 21. Review of standardized policy forms. Requires commissioner of commerce to study and make recommendations to the legislature regarding standardized health insurance policy forms for health carriers under that commissioner's jurisdiction.

Sec. 22. Study of healthy lifestyle premium reductions. Requires the commissioner of commerce to study and make recommendations to the legislature regarding possible premium discounts for healthy lifestyles. This could apply in the individual and small employer market.

Sec. 23. Repealer. Repeals two existing subdivisions that are replaced in earlier sections of this article.

Sec. 24. Effective date. Various effective dates. Rating reform is effective July 1, 1993, except in medicare supplement market, where rating reform is effective July 30, 1992 and January 1, 1993.

ARTICLE 4
CHILDREN'S HEALTH PLAN EXPANSION

Section 1. Reports and implementation. Requires the commissioner of human services and other commissioners to undertake initiatives related to the health right plan and the federal health insurance credit.

Subdivision 1. Wellness component. Requires the commissioners of human services and health to recommend to the legislature, by January 1, 1993, methods to incorporate wellness discounts into the health right plan sliding scale. Beginning October 1, 1992, requires the commissioner of human services to inform enrollees of the future availability of this discount and encourage enrollees to adopt healthy lifestyles.

Subd. 2. Federal health insurance credit. Requires the commissioners of human services and revenue to apply, by October 1, 1992, for federal waivers and approvals needed to allow the federal health insurance credit to be assigned to the state.

Subd. 3. Coordination of medical assistance and the health right plan. Requires the commissioner of human services to develop and implement a plan to combine MA and health right plan application and eligibility procedures, and seek any necessary federal approvals or law changes. Requires a progress report to the legislature by January 1, 1993.

Subd. 4. Plan for managed care. Requires the commissioner of human services to present to the legislature, by January 1, 1993, a plan to provide all MA and health right plan services through managed care arrangements.

Subd. 5. Report on purchases at full cost. Requires the commissioner to present two reports to the legislature on the impact on overall health right premium costs of allowing families and individuals not eligible for a subsidy to purchase coverage through the plan at full cost.

Sec. 2. Definitions. Strikes several definitions for the children's health plan (these are reinstated in modified form as new language later in the bill). Makes a change in terminology consistent with the expansion of the children's health plan into the health right program.

Sec. 3. **Plan administration.** Requires a reserve equal to five percent of the expected cost of premium subsidies. Requires quarterly assessments of expected expenditures to cover the remainder of the fiscal year and the following two fiscal years. Specifies adjustments in premiums and enrollment that the commissioner shall make to ensure that expenditures remain within the limits of available revenues. Allows the commissioner of human services to adopt emergency rules that remain in effect for 720 days.

Sec. 4. **Covered health services.** Expands benefits for the health right plan.

(a) **Covered services.** Reinstates the children's health plan definition of covered services as the services initially covered by the health right plan. Covers outpatient mental health services, subject to annual limits of $1,000 for adults and $2,500 for children. Exempts medication management from the dollar limit on outpatient mental health services. States that covered services are to be expanded as provided in this section.

(b) **Alcohol and drug dependency.** Adds outpatient treatment of alcohol and drug dependency as a covered service beginning October 1, 1992. Coordinates benefits with the consolidated chemical dependency treatment fund.

(c) **Inpatient hospital services.** Adds inpatient hospital services as a covered service beginning July 1, 1993, subject to a $10,000 annual benefit limit for adult enrollees not eligible for MA. Requires enrollees to be notified of this benefit.

(d) **Emergency medical transportation services.** Adds emergency medical transportation services as a covered service beginning July 1, 1993.

(e) **Federal waivers and approvals.** Direct the commissioner to coordinate the provision of inpatient hospital services with the MA spend-down and apply for any necessary federal waivers or approvals.

(f) **Copayments and coinsurance.** Establishes the following copayments and coinsurance requirements:

(1) ten percent for inpatient hospital services for adult enrollees not eligible for MA, subject to annual out-of-pocket maximums of $2,000 per individual and $3,000 per family;

(2) 50 percent for adult, non-preventive dental services;

(3) $3.00 per prescription for adult enrollees; and

(4) $25.00 for eyeglasses for adults.

States that enrollees who are eligible for MA are financially responsible for the coinsurance amount up to the spenddown limit, in order to become eligible for MA.

Sec. 5. **Eligible persons.** Expands eligibility for the health right plan.

(a) **Children.** Reinstates the children's health plan definition of eligible persons (children one to 18 with family incomes under 185 percent of poverty who are not eligible for MA and who are

uninsured) as the initial group eligible for the health right plan. States that eligibility is to be expanded as provided in paragraphs (b) to (e). Requires parents enrolling under these expansions to enroll their children and dependent siblings. Requires all parents or all children to enroll. Defines dependent sibling.

(b) Families with children. Allows parents and dependent siblings of children eligible under paragraph (a) to enroll, beginning October 1, 1992. Allows enrollment for these individuals to continue without regard to age, place of residence, or presence of children in the household.

(c) Continuation of eligibility. Beginning October 1, 1992, allows persons already enrolled under paragraphs (a) and (b) to remain eligible even if their incomes after enrollment exceed 185 percent of poverty, subject to any premium requirement and as long as other requirements are met.

(d) Families with children; eligibility based on percentage of income paid for health coverage. Beginning January 1, 1993, allows all children, parents and dependent siblings residing in the same household who are not eligible for MA to enroll in the plan. Requires these individuals to pay a premium for coverage. Prohibits individuals and families with incomes higher than the plan limit from enrolling. Allows individuals initially enrolled under this paragraph to continue enrollment without regard to age, place of residence, or presence of children in the household.

(e) Addition of single adults and households with no children. Beginning July 1, 1994, allows all families and individuals who are not eligible for MA to enroll. Requires these individuals to pay a premium for coverage. Prohibits individuals and families with incomes higher than the plan limit from enrolling.

Sec. 6. Application procedures. Establishes methods for administering the program. These include: requiring use of social security numbers; requiring random audits; allowing data sharing with other agencies; and requiring use of cost avoidance techniques. Provides that benefits are available only after discharge if an enrollee is hospitalized on the first day of coverage.

Sec. 7. Enrollment and premium fee. Requires payment of enrollment and premium fees.

(a) Enrollment fee. Requires payment of the enrollment fee used in the Children's health plan until October 1, 1992.

(b) Premium payments. Beginning October 1, 1992, requires enrollees to pay a premium based on a sliding scale. Allows persons whose applications are received by September 30, 1992 to continue to pay the enrollment fee until July 1, 1993.

(c) Administration. Requires the commissioner to develop procedures to require reporting of changes in income, adjust sliding scale premiums based on changes in income, and disenroll persons who do not pay required premiums. Establishes methods for premium payment.

Sec. 8. Eligibility for subsidized premiums based on sliding scale. Sets eligibility requirements for premium subsidies.

(a) General requirements. States that families and individuals enrolling after October 1, 1992 are eligible for subsidized premium payments only if the requirements in paragraphs (b) to (c) are met. Exempts persons already enrolled as of September 30, 1992 from these requirements, as long

as continuous coverage is health right or MA is maintained. Allows individuals and families whose incomes rise above the plan limit to continue enrollment and pay the full cost of coverage.

(b) Must not have access to employer-subsidized coverage. To be eligible for subsidized premiums, requires that a family not have access to subsidized health coverage provided by an employer, and not have had access to such coverage through the current employer for 18 months prior to application.

(c) Period insured. Requires families and individuals to have been uninsured for at least four months prior to application. Exempts persons entering the plan from MA, GAMC, or specified demonstration projects from this requirement. Allows the commissioner to change this requirement without rulemaking to remain within the limits of available appropriations.

Sec. 9. Premiums. Sets general criteria for premiums based on a sliding scale.

(a) Requires each individual and family enrolled to pay a premium determined according to a sliding fee based on the cost of coverage as a percentage of gross family income.

(b) Directs the commissioner to establish sliding scales to determine the percentage of gross family income that households at different income levels must pay to obtain coverage. Requires separate sliding scales for individuals, two-person households, and households of three or more.

(c) Requires the sliding scale to begin with a premium of 1.5 percent of gross family income for individuals with incomes below 133-1/3 percent of the AFDC payment standard with premium percentages increasing with evenly spaced income matched to income limits. Requires a separate set of premiums for the period preceding the coverage of inpatient hospital services.

(d) Provides that an individual or family whose gross monthly income is above the specified limit is not eligible for the plan.

(e) Allows premiums to be collected through wage withholding with the consent of the employer and employee.

(f) Exempts the sliding fee scale and percentages from the requirements of chapter 14.

Sec. 10. Residency. Requires families and individuals to be permanent residents of Minnesota, in order to be eligible for coverage under the health right plan. Provides a definition of a permanent Minnesota resident that includes a 180-day residency requirement. Provides specific severability language.

Sec. 11. Appeals. Makes changes in terminology.

Sec. 12. No asset test for children. Requires MA eligibility for persons under age 21 to be determined without regard to asset standards.

Sec. 13. Participation required for reimbursement under other state health care programs. Requires providers of health care under state employee health insurance plans, the public employees insurance plan, workers' compensation, and MCHA to participate in MA, GAMC, and the health right plan.

Sec. 14. **Provider payment increase.** Increase hospital outpatient reimbursement, physician reimbursement, and dental reimbursement under MA. Makes this increase contingent on the appropriation of sufficient money to the commissioner.

Sec. 15. **Coordination of state health care purchasing.** Requires the commissioner of administration to convene an interagency task force to develop a plan for coordinating state and local government health care programs, in order to improve the efficiency and quality of health care delivery and make effective use of the state's market leverage and contracting expertise. Requires the commissioner to present recommendations to the legislature by January 1, 1994.

Sec. 16. **Study on premiums and benefits.** Requires the commissioner of commerce to study health right premiums and subsidies in relation to the benefits provided, and report to the legislative commission on health care access by January 15, 1993.

Sec. 17. **Phase-out of the children's health plan.** Requires the commissioner to continue to accept enrollments in the children's health plan until July 1, 1993, using the eligibility and coverage requirements in effect prior to October 1, 1992, until FY 1993 funding is exhausted.

Sec. 18. **Impact of health right on children's health plan enrollees.** Requires the commissioner of human services to examine the impact of health right premium costs on continued access to care for children's health plan enrollees, and report to the legislature by February 15, 1993.

Sec. 19. **Instruction to revisor.** Requires the revisor to change the name "children's health plan" to "health right plan" in Minnesota Statutes, and to recodify the health right plan statutes.

Sec. 20. **Effective date.** Provides an October 1, 1992 effective date for section 13.

ARTICLE 5
RURAL HEALTH INITIATIVES

Section 1. **Invoice errors; department of human services.** Requires DHS to notify hospitals of all invoice errors, within 30 days of discovery of the errors.

Sec. 2. **Political subdivision salary limit.** Allows political subdivisions to pay salaries to doctors of osteopathy that are higher than the cap of 95 percent of the salary of the governor (current law allows this to be done only for medical doctors).

Sec. 3. **Participating providers.** Prohibits health plan companies from excluding, as participating providers, physicians who are not board certified or have not completed a residency, as long as other requirements are met.

Sec. 4. **Definition.** Eliminates the requirement that hospitals have experienced net income losses in at least two of the three most recent consecutive hospital fiscal years, in order to be eligible for the rural hospital planning and transition grant program.

Sec. 5. **Consideration of grants.** Requires the commissioner of health to take into account the financial condition of a hospital, in awarding rural hospital planning and transition grants.

Sec. 6. Allocation of grants. Amends language related to rural hospital planning and transition grants to make this grant program ongoing (current law limits grants to FY 1991). Strikes language referring to the number of grants to be awarded.

Sec. 7. Rural health advisory committee. Establishes a rural health advisory committee and specifies membership and duties.

Subdivision 1. Establishment; membership. Directs the commissioner of health to establish a 15-member rural health advisory committee. Specifies committee membership.

Subd. 2. Duties. Requires the advisory committee to:

(1) Advise the commissioner of health and other state agencies on rural health issues.

(2) Provide a systematic and cohesive approach toward rural health issues and rural health care planning, at a local and statewide level.

(3) Develop and evaluate mechanisms to encourage greater cooperation among rural communities and providers.

(4) Recommend and evaluate approaches to rural health issues that are sensitive to the needs of local communities.

(5) Develop methods of identifying individuals who are underserved by the rural health care system.

Subd. 3. Staffing; office space; equipment. Directs the commissioner to provide the advisory committee with staff, office space, and access to office equipment and services.

Sec. 8. Office of rural health. Lists duties for the office. Allows the office to enter into contracts and provide grants.

Subdivision 1. Duties. Requires the office of rural health to:

(1) establish and maintain a clearinghouse for rural health issues, research findings, and innovative approaches for delivering rural health care;

(2) coordinate state rural health activities, in order to avoid duplication;

(3) identify federal and state rural health programs, and assist public and nonprofit entities in participating in these programs;

(4) assist rural communities in improving the delivery and quality of health care, and in recruiting and retaining health professionals; and

(5) carry out the duties assigned in section 9.

Subd. 2. Contracts. Allows the office to enter into contracts and provide grants to perform these duties.

Sec. 9. Rural health initiatives. Directs the commissioner of health, through the office of rural health, and consulting as necessary with other state agencies, to:

(1) Develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing referral networks among rural health care providers.

(2) Develop recommendations for a program to assist rural communities in establishing community health centers.

(3) Administer a program of financial assistance for rural hospitals in isolated areas of the state.

(4) Develop recommendations for health education and training programs in rural areas.

(5) Develop a coordinated, statewide strategy for health care personnel recruitment and maintain a health care personnel data base.

(6) Provide rural communities with technical assistance in service delivery and health personnel recruitment.

(7) Study and recommend changes in the regulation of health care personnel, to address rural health personnel shortages.

(8) Support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas.

(9) Support efforts to secure higher Medicare and medical assistance reimbursement for rural health care providers.

(10) Coordinate the development of a statewide plan for emergency medical services.

(11) Carry out other activities necessary to address rural health problems.

Sec. 10. Rural hospital financial assistance grants. Makes grants available to rural hospitals in isolated areas of the state, and to hospitals in danger of closing due to the hospital tax in Article 9.

Subdivision 1. Sole community hospital financial assistance grants. Directs the commissioner to award financial assistance grants to rural hospitals in isolated areas of the state that are eligible to be classified as sole community hospitals, have had net income losses in the two most recent fiscal years, have 20 or fewer beds, and have exhausted local sources of support.

Subd. 2. Grants to at-risk hospitals to offset the impact of the hospital tax. Directs the commissioner to award financial assistance grants to hospitals with 50 or fewer beds not located in a city of the first class that would otherwise close as a direct result of the hospital tax in Article 9.

Sec. 11. Data base on health personnel. Directs the commissioner of health to develop and maintain a data base on health services personnel, in order to assist communities and government units in developing plans to recruit and retain health care personnel.

Sec. 12. Rural community health centers. Directs the commissioner to develop and implement a program to establish community health centers in rural areas of the state that are underserved by health care providers.

Sec. 13. Nonprofit corporation powers. Allows government entities owning or operating a hospital or hospital district to expend funds, including public funds in any form, or devote the resources of the hospital or hospital district, to recruit or retain physicians. Allowable uses of funds and resources include retirement of medical education debt, payment of one-time amounts for services rendered or to be rendered, payment of recruitment expenses, and payment of moving expenses. Requires expenditures to be reasonable under the facts and circumstances of the situation. Strikes two provisions allowing expenditures of funds under more limited conditions.

Sec. 14. Emergency medical services fund. Eliminates, as an allowable use of money in the emergency medical services system fund, the undertaking of special projects of statewide significance. Allows fund money to b used for the providing of discretionary grants for EMS projects with potential regionwide significance. Requires 93-1/3 percent of the money in the fund to be distributed annually to the eight regional emergency medical services systems. Strikes language allocating 13-1/3 percent of fund money for special projects with potential statewide significance.

Sec. 15. Reduces the minimum number of cities or towns needed in order to create a hospital district from four to two.

Sec. 16. Changes a reference to the number of cities or towns, in order to be consistent with the change made in the previous section.

Sec. 17. Special studies. Requires the commissioner of health, through the office of rural health, to conduct studies on advanced telecommunications technologies, access to perinatal services, and midlevel practitioner reimbursement, and report to the legislature.

Sec. 18. Report on rural hospital financial assistance grants. Directs the commissioner of health to examine eligibility criteria for the rural hospital financial assistance grants, and report any needed modifications to the legislature by February 1, 1993.

Sec. 19. Study of basic and advanced life support reimbursement. Directs the commissioner of human services, in consultation with the commissioner of health, to study medical assistance reimbursement mechanisms for advanced and basic life support ambulance and special transportation service calls. Requires a report to the legislature by February 1, 1992.

Sec. 20. Study of ambulance subscription plans. Requires the commissioners of commerce and health to study issues related to prepaid ambulance service plans. Requires a report to the legislature by January 1, 1992.

Sec. 21. Repealer. Repeals section 3, effective July 1, 1995 or one year after the date a quality assurance and certification program becomes operational, whichever occurs first.

Sec. 22. Effective date. States that section 1 is effective July 1, 1992 or on the implementation date of the MMIS upgrade, whichever is later. States that section 7, creating the rural health advisory committee, is effective January 1, 1993.

ARTICLE 6
HEALTH PROFESSIONAL EDUCATION

Section 1. Eligibility. Clarifies requirements related to submitting letters of interest and signing contracts for the physician loan forgiveness program.

Sec. 2. Loan forgiveness. Makes changes in the physician loan forgiveness program that allow physicians to be placed in rural areas more quickly. Allows the higher education coordinating board to accept up to eight fourth year medical students, eight first year residents, and eight second year residents prior to June 30, 1992. Allows the board to accept up to eight fourth year medical students per fiscal year between July 1, 1992 to June 30, 1995. Clarifies that the board will pay back one year of qualified loans for each year of service in a designated rural area. Provides additional loan forgiveness to residents who substitute for rural physicians under specified circumstances.

Sec. 3. Midlevel practitioner education account. Establishes a loan forgiveness program for midlevel practitioners.

Subdivision 1. Definitions. Defines terms.

Subd. 2. Creation of account. Establishes a midlevel practitioner education account and directs the higher education coordinating board to use the money in the account to establish a loan forgiveness program for midlevel practitioners agreeing to practice in designated rural areas.

Subd. 3. Eligibility. Describes the application process and requires prospective midlevel practitioners accepted into the program to sign a contract to serve at least two of the first four years following graduation in a designated rural area.

Subd. 4. Loan forgiveness. Allows the higher education coordinating board to accept up to eight applicants a year. Requires applicants to secure their own loans. Allows applicants to designate, for each year of midlevel practitioner study, up to two years, an agreed upon amount up to $7,000, as a qualified loan. Directs the board to repay one-half a qualified loan for each year served in a designated rural area.

Subd. 5. Penalty for nonfulfillment. Requires participants to pay back 100 percent of the amount paid by the board, plus interest, for failure to fulfill the required service commitment. Directs the board to deposit this money in the midlevel practitioner education account, and allows the board to waive the penalty for emergency circumstances.

Sec. 4. Education and training of primary care physicians. Requires the board of regents to comply with the duties assigned in sections 4 to 6, if it accepts the funding provided. Defines primary care. Requests the regents of the University of Minnesota, through the medical school, to implement initiatives to increase the number of graduates of residency programs who practice primary care by 20 percent, over an eight year period. Requests the board to seek non-state grants for the initiatives, and requires annual progress reports.

Sec. 5. Medical school initiatives. Requests the medical school to: (1) modify its selection process to increase the number of graduates choosing careers in primary care; (2) make curriculum changes to provide greater exposure to primary care; and (3) develop a program to provide students with clinical

experiences in primary care settings in rural communities and Twin Cities community health clinics and HMOs.

Sec. 6. Residency and other initiatives. Requests the medical school to: (1) provide increased opportunities for residents to serve rotations in primary care settings; (2) establish a rural residency training program in family practice; (3) develop community-based continuing medical educations programs for primary care physicians.

Sec. 7. Education account for nurses who agree to practice in a nursing home. Establishes a loan forgiveness program for these nurses.

Subdivision. 1. Creation of account. Establishes an education account in the general fund for a loan forgiveness program for nurses who agree to practice in a nursing home.

Subd. 2. Eligibility. Describes the application process and requires prospective registered nurses and licensed practical nurses to sign a contract to serve at least one of the first two years following graduation in a nursing home.

Subd. 3. Loan forgiveness. Allows the higher education coordinating board to accept up to ten applicants a year. Requires applicants to secure their own loans. Allows applicants to designate, for each year of nursing education, up to two years, an agreed upon amount up to $3,000, as a qualified loan. Directs the board to repay one year of qualified loans for each year served in a nursing home.

Subd. 4. Penalty for nonfulfillment. Requires participants to pay back 100 percent of the amount paid by the board, plus interest, for failure to fulfill the required service commitment. Directs the board to credit this money to the account established in subdivision 1. Allows the board to waive the penalty for emergency circumstances.

Subd. 5. Rules. Directs the board to adopt rules to implement this section.

Sec. 8. Study of obstetrical access. Directs the commissioner of health to study access to obstetrical services in Minnesota and report to the legislature by January 1, 1993.

Sec. 9. Grant program for midlevel practitioner training. Allows the higher education coordinating board to award grants to Minnesota schools and colleges, to establish and administer midlevel practitioner training programs in rural Minnesota.

Sec. 10. Grants for continuing education. Directs the higher education coordinating board to establish a competitive grant program to develop continuing education programs for nurses working in rural areas. Requires two grants to be awarded for the fiscal year ending June 30, 1993.

ARTICLE 7
DATA COLLECTION AND RESEARCH INITIATIVES

Section 1. Health care analysis unit. Directs the commissioner of health to establish a health care analysis unit. Specifies duties for the unit.

Subdivision 1. Definition. Defines "practice parameter" and "outcome research."

Subd. 2. Establishment. Requires the commissioner of health to establish a health care analysis unit.

Subd. 3. General duties; implementation date. Directs the commissioner, through the health care analysis unit, to:

1. conduct applied research using existing and new data bases, and promote research applications;

2. establish a condition-specific data base;

3. develop and implement data collection procedures that ensure a high level of provider and health plan cooperation;

4. work with health plans and health care providers to promote improvements in health care efficiency and effectiveness.

5. participate in private initiatives that promote publicly disseminated applied research;

6. provide technical assistance to health plan and health care purchasers;

7. develop outcome-based practice parameters; and

8. provide technical assistance as needed to the health planning advisory committee and regional coordinating boards.

Subd. 4. Criteria for unit initiatives. Lists criteria for the general data and research initiatives of the health care analysis unit.

Subd. 5. Criteria for public sector health care programs. Lists criteria for the data and research initiatives of the unit that relate to public sector health care programs.

Subd. 6. Data collection procedures. Requires the unit to collect data in the most cost-effective manner. Allows the unit to require health care providers and health carriers to cooperate with the data collection process.

Subd. 7. Data classification. Classifies data collected through the large-scale data base initiatives of the health care analysis unit as private data or nonpublic data. Allows this data to be released only to researchers and individuals purchasing health care for health plan companies and groups. Allows summary data to be released. Requires the commissioner to adopt rules related to data access, and to provide notice to organizations of data release.

Subd. 8. Data collection advisory committee. Directs the commissioner to convene a data collection advisory committee to evaluate methods of data collection.

Subd. 9. Federal and other grants. Directs the commissioner to seek non-state sources of funding for unit initiatives.

Subd. 10. Contracts and grants. Allows the commissioner to contract with or provide grants to private sector entities. Requires data privacy provisions to be observed.

Subd. 11. Rulemaking. Allows the commissioner to adopt permanent and emergency rules.

Sec. 2. Large-scale data base. Directs the health care analysis unit to establish a large-scale data base for a limited number of health conditions. Provides criteria for selecting health conditions, and requires certain information to be collected. Requires the health care analysis unit to negotiate with private sector organizations to obtain required data in a cost-effective manner. Directs the unit to establish linkages between private and public sector data bases in order to reduce administrative costs.

Sec. 3. Analysis and use of data collected through the large-scale data base. Sets requirements for the analysis and use of data.

Subdivision 1. Data analysis. Directs the health care analysis unit to analyze the data collected using existing and newly researched medical practice parameters. Also allows the unit to use the data collected to develop new practice parameters.

Subd. 2. Educational efforts. Requires the unit to disseminate medical parameters and research findings for specific medical conditions to all medical practitioners.

Subd. 3. Peer review. Allows the unit to require peer review by the Minnesota Medical Association, the Minnesota Chiropractic Association, or the appropriate licensing board when practice in all or part of the state deviates from practice parameters, or when there is large variation within the state in the method or frequency of treatment.

Subd. 4. Practice parameter advisory committee. Requires the commissioner to convene this committee. Requires the committee to present recommendations on the adoption of practice parameters and provide technical assistance.

Sec. 4. Technical assistance for purchasers. Directs the unit to provide technical assistance to health plan and health care purchasers. Requires the commissioner to publicize information about health plans and services in an easily understandable format.

Sec. 5. Outcome-based practice parameters. Allows the health care analysis unit to conduct activities related to practice parameters. Allows the commissioner to approve these practice parameters. Establishes adherence to a practice parameter as a defense in malpractice cases.

Subdivision 1. Practice parameters. Allows the health care analysis unit to develop, adopt, revise, and disseminate practice parameters, and disseminate research findings. Lists duties related to practice parameters.

Subd. 2. Approval. Allows the commissioner of health to approve practice parameters. Exempts the commissioner from chapter 14 when approving certain nationally recognized parameters.

Subd. 3. Medical malpractice cases. Provides that adherence to a practice parameter approved by the commissioner is an absolute defense against allegations that a provider did not comply with accepted standards of practice in the community. Specifies that this applies to claims

arising on or after August 1, 1993, or 90 days after the date the commissioner approves the applicable practice parameter.

Sec. 6. Modifies the definition of review organization, to include as functions the review of association membership and the review of a provider's professional practice at the request of the health care analysis unit. Gives review organizations greater flexibility in addressing disputes between licensing boards and health care providers licensed by these boards.

Sec. 7. **Provider data.** Provides that data related to the denial, restriction, or termination of clinical privileges that is disclosed through discovery is not admissible in other judicial proceedings.

Sec. 8. **Data collection; health care provider tax.** Requires the various health boards to assist state agencies in data and tax collection activities. Requires boards to take disciplinary action against regulated persons for failure to provide required data or to pay the health provider tax.

Sec. 9. **Study of administrative costs.** Requires the unit to study costs incurred by health carriers, group purchasers, and providers that are related to the collection and submission of information to government, insurers, and other third parties. Requires the unit to recommend to the commissioner, by January 1, 1994, any needed reforms.

ARTICLE 8
MEDICAL MALPRACTICE

Section 1. **Expert witnesses.** Requires affidavits submitted by attorneys listing expert witnesses to include the signatures of the expert witnesses. Requires the court to set a deadline for parties to answer requests for information about expert witnesses.

Sec. 2. **Medical malpractice cases.** Requires uniform interrogatories and consideration of alternative dispute resolution.

Subdivision 1. Discovery. Requires attorneys to use uniform forms for requesting answers to questions about expert witnesses and other evidence to be used in malpractice cases. Parties are limited to ten "interrogatories" in addition to the uniform forms, unless all parties agree to allow additional interrogatories.

Subd. 2. Alternative dispute resolution. Requires parties to discuss alternative ways to resolve the case without a trial.

Subd. 3. Uniform interrogatories. Sets forth uniform forms to be used for "interrogatories" in medical malpractice cases. Interrogatories are written questions that are submitted by one party to a lawsuit to the other party during the "discovery" phase of the lawsuit. "Discovery" is the pretrial process for attorneys to exchange factual information that will be used as evidence during the trial.

ARTICLE 9
FINANCING

Section 1. **Health care fund.** Creates a health care access fund in the state treasury.

Secs. 2 and 3. Premiums tax, HMOs and nonprofit health service corporations. Impose the insurance premiums tax on nonprofit health service corporations (Blue Cross and Delta Dental) and health maintenance organizations. This tax is imposed at one percent rate, beginning January 1, 1996. The premiums tax rate imposed under present law on commercial insurers is two percent.

Premiums under the health right, children's health plan, and Minnesota comprehensive health insurance programs are exempted from the insurance premiums tax.

Sec. 4. Income tax deduction, self employed. Allows self-employed taxpayers to deduct the entire amount paid for health insurance under the state income tax (effective beginning tax year 1993).

Sec. 5. Definitions. Defines terms for purposes of the gross revenues tax on hospitals, health care providers, and wholesale drug distributors.

Commissioner is the commissioner of revenue.

Gross revenues are in- and out-patient revenues of a hospital and revenues of health care providers received for health care services.

A **health care provider** is a licensed provider of a type that qualifies to receive medical assistance reimbursement (regardless of whether the provider actually serves MA patients). Health maintenance organizations are included, but hospitals and pharmacies are excluded.

A **health maintenance organization or HMO** is an HMO licensed and operating under chapter 62D.

Home health services are those defined under medical assistance rules or provided in the recipient's residence (other than a nursing home, hospital or intermediate care facility).

A **hospital** is a licensed hospital or a surgical center.

A **nonresident health care provider** is a health care provider whose principal place of business is not in Minnesota.

A **nonresident hospital** is a hospital located outside of Minnesota.

A **pharmacy** is a licensed pharmacy that does not provide other health care services.

A **resident health care provider** is a health care provider whose principal place of business is located in Minnesota.

A **surgical center** is as defined under the Health Department rules.

A **wholesale drug distributor** is a licensed wholesale drug distributor.

Sec. 6. Minimum contacts to tax. Establishes nexus rules determining when a health care provider or hospital has sufficient contacts with Minnesota to be required to pay the provider tax. An entity is subject to the tax, if it

- has a Minnesota office

- has employees or representatives in Minnesota
- regularly sells taxable services to individuals in Minnesota
- regularly solicits business in Minnesota
- regularly performs services the benefits of which are consumed in Minnesota
- owns or leases property in Minnesota
- receives medical assistance payments from Minnesota.

Regular solicitation is presumed if a provider or hospital sells to 20 Minnesota customers.

Sec. 7. Provider tax. Imposes a two percent gross revenues tax on hospitals, health care providers, and wholesale drug distributors. The hospital tax takes effect on January 1, 1993. The tax on health care providers and wholesale drug distributors takes effect on January 1, 1994.

A use tax is imposed on prescription drugs that were not subject to the wholesale drug distributor tax.

Sec. 8. Exemptions, special rules. Exempts from the hospital and health care provider taxes:

- Medicare payments (but not copayments and deductibles)
- medical assistance payments
- nursing home and supervised care services
- home care services
- general assistance medical care payments
- health right payments
- payments received from another hospital or health care provider that was subject to tax for that provider.

In addition, providers may deduct amounts paid to wholesale drug distributors that were subject to the wholesale drug tax.

HMOs are permitted to deduct:

- contributions to reserves, but not to exceed 25 percent of annual revenues
- MCHA assessments
- claims administration and underwriting expenses as determined by Health Department rules.

The tax cannot be itemized on bills provided to individual patients.

Sec. 9. Credit for tax paid to other state. Allows a credit for taxes paid by a Minnesota hospital or health care provider for gross receipts taxes paid to another state for the same service that was subject to tax in Minnesota.

Sec. 10. Payment. Requires the hospital tax to be paid in monthly installments of estimated tax by the 10th of the month after the revenues are received.

The health care provider and wholesale drug taxes must be paid in quarterly installments by the 15th of the following month (e.g. April 15th for the first quarter). The estimated payments must equal, at least, the lesser of 90 percent of one-quarter of the tax for the year or the tax for the quarter's receipts.

Taxpayers with liabilities of $500 or less or that receive grants for rural hospitals are not required to make estimated payments.

Taxpayers with quarterly liabilities of $60,000 or more in any quarter are required to pay with electronic funds transfer under the rules applicable to other state taxes.

An annual return must be filed by March 15 of the following year. The commissioner of revenue will prescribe the forms.

Sec. 11. Sales tax rules. Provides that the enforcement and administrative rules under the sales tax apply to the hospital, health care provider, and wholesale drug taxes.

Sec. 12. Deposit of revenues. Requires revenue from the hospital, health care provider, wholesale drug, and insurance premiums tax on the HMOs and nonprofit health service corporations be deposited in the health care access fund.

Sec. 13. Severability. Provides any part of the tax is severable if it is found to be invalid.

Sec. 14. Cigarette tax increase. Increases the cigarette tax by 5 cents to 48 cents per pack of twenty cigarettes.

Sec. 15. Cigarette tax discount. Reduces the discount on cigarette tax stamps to reflect the increase in the tax rate. The discount compensates cigarette distributors for the cost of stamping cigarettes with tax stamps and collecting the tax.

Sec. 16. Cigarette floor stocks tax. Imposes a floor stocks tax on cigarettes held by distributors, retailers and other sellers of cigarettes on the day the cigarette tax increases goes into effect. A floor stocks tax ensures that new tax rate applies to all cigarette sales after its effective date. The floor stocks tax prevents a retailer or distributor from purchasing large quantities of cigarettes before the rate increase goes into effect to avoid the tax increase.

Sec. 17. Cigarette tax revenue. Provides that the revenue attributable to the cigarette tax increase will be deposited in the health care access fund for the period July 1, 1992 through January 1, 1994.

Sec. 18. Transition provision, hospitals. Provides that hospitals are not allowed the deduction for payments received from providers and amounts paid for prescription drugs in calendar year 1992, since the health care provider and wholesale drug tax is not in effect until 1993.

Sec. 19. Pass through rules. Allows hospitals to pass through the tax by assessing charges on third-party contracts. The charges may not exceed 2 percent of the revenues paid under a contract. Third-party contractors must pay the charges in addition to payments due under a contract. Hospitals may also recover their tax obligation through other methods. This authority expires January 1, 1994.

Sec. 20. Study of drug tax. Directs the commissioner of revenue to report to the legislature by November 1, 1992 on the impact of the wholesale drug tax and health care provider tax on pharmacies. If the commissioner determines the taxes are not equitable or effective, she is to recommend alternative methods of taxing drugs.

Sec. 21. Federal waiver; Medicaid provider tax rules. Directs the commissioner of human services to apply for a waiver from the new federal law restricting the use of health care related taxes that are not "broad based."

Sec. 22. Effective dates.

ARTICLE 10
APPROPRIATIONS

Section 1. Appropriations. Appropriates money to various state agencies for articles 1 to 9.

Sec. 2. Transfer. Allows the commissioner of finance to transfer money from the health care access fund to the general fund.

Sec. 3. Effective date. Provides an effective date of July 1, 1992 for the appropriations in section 1. Allows a portion of the appropriation to the commissioner of human services to be available for fiscal year 1992.