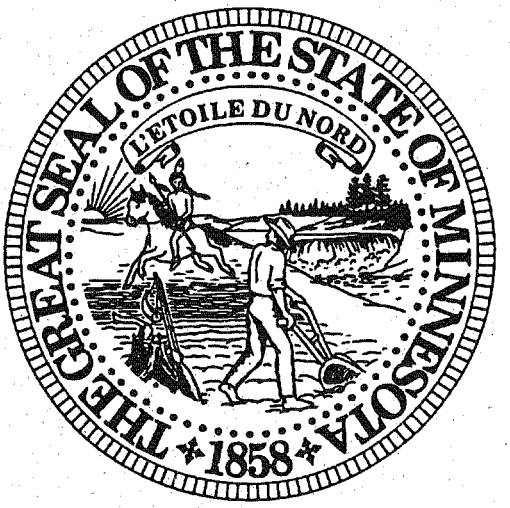
Recodification of Health Plan Law

A report to the Legislature

January, 1996



Minnesota Department of Commerce
Minnesota Department of Health

Pursuant to 1994 Minn. Laws Chap. 625
Art. 5 Sec. 5

Recodification of Health Plan Law

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Executive Summary

In 1993, the Commissioners of Health and Commerce were given joint responsibility to recodify health plan company law. The recodification initiative originated when Minnesota's health care law was being restructured around Integrated Service Networks (ISN) and the Regulated All-Payer Option (RAPO). Recodification was envisioned as a companion piece to the ISN/RAPO model.

In 1995, the Regulated All-Payer Option was repealed and the vision for Minnesota's health CARE delivery changed. A new vision replaced the ISN/RAPO model and the need for recodification was eliminated. Nevertheless, several recommendations from the recodification project continue to have value in our current environment. Those recommendations are included in this report.

I. Background

In 1994, the Minnesota Legislature gave the Commissioners of Health and Commerce joint responsibility to recodify health plan company law (1994 Minn. Laws, Ch. 625, Art. 5, §5). Staff from the Departments of Health and Commerce were assigned to the recodification project and an Advisory Task Force was appointed and consulted. This report reflects the conclusions of staff and the recommendations of the Advisory Task Force.

As required by statute, the Advisory Task Force members represented health plan companies, consumers, counties, employers, labor unions, providers, and other affected persons. Id. The diversity of membership in the Advisory Task Force provided a cross section of views and experience. **(See Appendix A).** Lois Wattman, Vice President of Public Policy for Medica, and attorney Tom Hefflefinger of Bowman and Brooke P.A. co-chaired the Task Force.

The Advisory Task Force met nine times between December 1994 and September 1995. At these meetings, staff from the Departments of Health and Commerce presented various health care topics for review, consideration and comment. The following topics, as they related to health care recodification, were addressed during the nine meetings:

- Trade Practices
- Quality Regulation
- Financial Solvency Regulation
- Contract Provisions and Disclosures
- Access to Care Regulation
- Overview of Benefits

Staff prepared comprehensive written materials which assisted the task force with their discussions. These written materials provided a concise explanation of the law for different types of health plan companies and were formatted in a manner to facilitate comparisons. **(See Appendix B).**

The Advisory Task Force meetings concluded in September, 1995, and recommendations from the Task Force were recorded in The Annual Report from the Recodification Advisory Task Force. **(See Appendix C).** The mid-year report from the Task Force is also attached. **(See Appendix D).** Since the annual report is substantively different from the mid-year report, the mid-year report has been included only to complete the record.

II. Findings in General

The 1994 statutory requirement to recodify health plan company law originated at a time when Minnesota's health care system was being structured around a Regulated All-Payer Option (RAPO) and Integrated Service Network (ISN) delivery system. The requirement to recodify health plan company law was based on the same "level playing field" concept that was suggested by the RAPO/ISN model.

During the 1995 legislative session, the state's vision for health care delivery changed dramatically. The Regulated All-Payer Option was repealed and the need for integrated service networks came under scrutiny. With the repeal of RAPO and the resulting impact on the development of integrated service networks, the concept of a "level playing field" was altered. The need for recodifying law to accommodate a repealed two-tiered system became obsolete.

Although the regulatory vision for Minnesota's health care delivery changed, the work from the recodification project was not without value. The project's research and analysis resulted in several recommendations which remain constructive in the current environment.

The recommendations which resulted from the recodification project are listed below. Summarized recommendations from the Advisory Task Force appear first. The final recommendations from the Commissioners of Health and Commerce follow.

III. Task Force Recommendations

The Recodification Advisory Task Force reached four conclusions involving the recodification of health plan company law. The Advisory Task Force recommends that the Departments of Health and Commerce consider the following:

A. Implementation of Risk-Based Capital

The Task Force recommends that the Departments of Health and Commerce continue to study the National Association of Insurance Commissioner's health organization risk-based capital formula and, as a model becomes available, determine its application to Minnesota law.

B. Consumer Protection

The Task Force recommends that quality regulation for Minnesota's health care delivery systems reflect consistent quality assurance and consumer protection standards.

C. Single Definition of Health Plan Company

The Task Force recommends the use of a single definition of "health plan company" to standardize and simplify current definitions.

D. Scope and Need for Recodification

The Task Force recommends that, due to the repeal of RAPO, the recodification of health plan company law as required under 1994 Minn. Laws, Ch. 625, Art. 5, Sec. 5, is no longer needed. The statutory requirement for recodification should be repealed.

The Task force recommends that the comparisons of health plan company law created by the Departments of Health and Commerce become a reference source for future regulatory review and reform. **(See Appendix B.)**

The complete Annual Report from the Advisory Task Force on Health Care Recodification is attached. **(See Appendix C.)**

IV. Recommendations from the Commissioners of Health and Commerce on Recodification of Health Plan Law

The following are recommendations from the Commissioners of Health and Commerce on the Recodification of Health Plan Company law. The Commissioners recommend that the Legislature consider the following:

A. Implementation of Risk-Based Capital

The National Association of Insurance Commissioners is developing a risk-based capital model for health companies. This model will accommodate the different financial risks inherent in the varied approaches to health care delivery.

The possible application of risk based capital to preferred provider organizations, provider cooperatives and other emerging methods of health care delivery should be examined. In 1997, or as soon as the NAIC completes its model formula, the Departments of Health

and Commerce should make recommendations to the legislature regarding the implementation of this risk based capital model for all Minnesota health care delivery systems.

B. Consumer Protection

The standards used by the Departments of Commerce and Health in protecting consumers in the health-care marketplace to date have served the state well. As the health-care marketplace continues to undergo significant changes, the departments will take the responsibility for monitoring these changes and make sure that the standards used to regulate consumer protection keep pace with these changes.

C. Single Definition of Health Plan Company

The recodification project identified the need for a concise, single definition of "health plan company". Existing law uses various terms for "health plan company" and the application of these terms is not consistent. A single definition, which can apply throughout health care law, will reduce the confusion and unnecessary complexity created by current statutory language. **(See Appendix E).**

The Departments of Health and Commerce should review the use of these terms and should develop a single definition which meets the existing requirements of law. The Departments should work with the revisor to assure that all statutes and rules are reviewed and recommend changes are submitted to the Legislature.

D. Scope and Need for Recodification

Language simplification and standardization are best implemented annually as new statutes and rules are added to Minnesota law. The Departments of Health and Commerce should

work with the Revisor each year and recommend to the legislature any changes that are needed to facilitate a clear and correct application of the law.

V. Conclusion

Although the need for the recodification project diminished as the direction for Minnesota's health care system changed, the recommendations which resulted from this project have value in the current environment. These recommendations from the Commissioners of Health and Commerce support the goals of high quality, cost efficient health care for all Minnesotans.

Appendix A

Members of the Advisory Task Force

Co-Chair:

Tom Heffelfinger

Bowman & Brooke, P.A.

Co-Chair:

Lois Wattman

Allina/Medica

Debbie Alexander

Consumer Activist

Debra Aune

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Jill Beed

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Michael DeRosa

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Patty Franklin

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Phil Griffin

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Bob Gunderson

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Rolf Hanson

Fairview Hospital & Health Care Services

Daniel Haugen

Neighborhood Involvement Program

Don Moersch

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Eric Netteberg

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Curt Pohl

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Roger Stearns

Stearnswood, Inc.

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Lynn Theurer

Winona County Community Health

Ghita Worcester

UCare Minnesota

Appendix B

STATUTE RESOURCE GUIDE
TRADE PRACTICES

2-16-95 Task Force

The following statutes relate to trade practices generally. All health plans are subject to provisions of chapter 72A, regulating trade practices, and that law is identified first. Additional statutes regulating similar practices are identified by subject and plan type. Universal coverage, insurance reform, risk selection and underwriting statutes are not included and will be the subject of another meeting.

I. All health plan companies are subject to the following provisions of trade practices law.
Indemnity insurers - Chapter 72A regulates the business of insurance
Fraternals - §64B.34 subject to chapter 72A except for right to determine membership
Joint self-insurance plans - §62H.04 subject to 72A.17-.32.
Nonprofit health service plans - §62C.19 subject to 72A.17 to 72A.30
HMO - §62D.12, subd. 1 subject to 72A.17 to 72A.32 except
(a) to the extent that nature of HMOs render sections clearly inappropriate
(b) enforcement by commissioner of health
CISN - 72A.17 to 72A.32 applies the same as HMO. §62N.25. §62D.12, subd. 1
ISN - §62N.03 chapter 72A applies to ISNs unless expressly provided

II. Trade Practices. Minn. Stat. §72A.17 (1994) states:

> The purpose of sections 72A.17 to 72A.32 is to regulate trade practices in the business of insurance . . . by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Minn. Stat. §72A.20 contains 31 subdivisions that prohibit specific unfair trade practices. They are:

Subd. 1. Misrepresentation and false advertising of policy contracts.

Subd. 2. False information and advertising generally.

Subd. 3. Making false, maliciously critical or derogatory statements concerning the financial condition of a competitor calculated to injure the competitor's business

Subd. 4. Boycott, coercion or intimidation resulting in an unreasonable restraint of trade

Subd. 5. Making false financial statements

Subd. 6. Making any false statement with intent to deceive any authorized examiner

Subd. 7. Promising ownership or management as an inducement to insurance
Subd. 8. [Not applicable, life insurance provision]

Subd. 9. Discrimination among individuals of the same class and hazard in amount of premiums.

Subd. 10. Inducing purchase by offering a premium rebate or any thing of value not specified in the contract of insurance.

Subd. 11. Cross references other sections of 72A and includes them as unfair trade practices. They are:
Fraudulent procurement of business by an agent
False statements in the insurance application
Unfair claims practices (will be discussed later)
Violation of Minnesota Insurance Fair Information Reporting Act at §§72A.49-.505

The Fair Information Reporting Requirements

Insurer for purposes of the act includes all health plan companies.

Act applies to all insurers. §72A.492.

Must not obtain information in connection with an insurance transaction by 1) pretending to be someone else 2) pretending to represent someone 3) misrepresenting the true purpose of the interview 4) refusing to provide identification. §72A.493

Must provide notice explaining information practices at the time of application for insurance or delivery of policy. §72A.494

Content must state that 1) personal information may be collected from other persons 2) information may be disclosed to third persons without authorization 3) person has right to view personal records and correct misinformation 4) more detailed explanation made available upon request.

Requirements don't apply to group policy not individually underwritten. §72A.494

Information requested solely for marketing or research and not necessary for application must be disclosed. §72A.495

If insurer uses an investigative consumer report, the applicant must be informed that the report will be used, the applicant may request an interview and the report must be made available to the applicant. §72A.496

§72A.497, subd. 1. Individual must have access to personal information:

1) Inform individual of personal information possessed by insurer
2) Permit individual to see and copy personal information
3) Permit individual to obtain by mail a copy of all personal information
4) Insurer must inform individual to whom the personal information was disclosed in the previous 2 years
5) Inform individual of procedures for correcting, deleting or amending personal information
6) If credit information was obtained, provide individual with name and address of credit agency

Subd. 2 Must disclose the source of all personal information

Subd. 3 If information requested is health records, a) must also provide the name of institution and provider may provide to individual or licensed health professional designated by individual. b) If health professional who provided records to insurer indicated that the release of the record is detrimental or likely to cause physical harm to the individual, insurer can only provide records with approval of professional who created record. If approval is not obtained, records must be provided to a health professional designated by the individual. c) This section doesn't reduce patient's rights under §144.35 (access to records from providers).

§72A.498 Must respond within 30 days to request by either deleting or correcting information or informing individual why not. If information is deleted or corrected must provide notice to any person who has been supplied the erroneous information. Individual can file a statement identifying disputed information. Individual can file appeal with commissioner re: disputed information.

Subd. 4 Reasonable fee can be charged, not to exceed the cost of

copying and providing information. If information is requested as a result of adverse underwriting decision, no fee can be charged.

Subd. 5 Same obligations are imposed on agents.

Subd. 6 These rights do not apply to privileged information.

§72A.499 Must provide reasons and source of adverse underwriting decisions to individual or policyholder. Applies to group contracts only if individually underwritten.

§72A.50 Must not seek previous adverse underwriting decisions without also obtaining the reasons for the decision.

§72A.501 Authorizations to obtain information about an individual must specifically describe the purpose and are valid for a limited time.

§72A.502 Insurer must have authorization to disclose information except
1) to prevent fraud
2) to health care provider to verify coverage, medical emergency or service audits
3) to government or regulatory authority or as required by law
4) to affiliate companies
5) to a group policyholder to report claims experience or conduct audit of services and only as reasonably necessary
6) to professional peer review organization to review service or conduct of health professional
7) merger or sale of insurer
Notice must be provided to individual within 10 days of disclosure except for underwriting purposes or to insurance administrator

§§72A.503 -.504 allows private remedies.

Subd. 12. Unfair service - a business practice of:

(1) Misrepresenting pertinent facts or provisions relating to coverage

(2) Failing to acknowledge and respond promptly to claims communications

(3) Failing to adopt and implement reasonable standards for prompt claims investigation

(4) Refusing to pay claims without conducting a reasonable investigation based upon all information;

(5) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(7) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempting to settle a claim for less than the amount to which reasonable persons would have believed they were entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;

(10) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(11) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(14) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

Subd. 13 (Applies to homeowners insurance)

Subd. 14 (Applies to homeowners insurance)

Subd. 15 Excludes from discrimination:
(1) group rates based on experience and
(2) different payments to preferred provider groups

Subd. 16 Discrimination based on sex or marital status.

Subd. 17 Refusing to refund unearned premiums after termination

Subd. 18 Improper business practices including misappropriating policyholder funds or any other fraudulent or deceptive business practice

Subd. 19 Selection or underwriting practices that are not actuarially justified

Subd. 20 Terminating an agent for contacting a government agency

Subd. 21 Arbitrary, capricious or discriminatory underwriting practices

Subd. 22 (Applies to no-fault and self insured)

Subd. 23 (Applies to automobile insurance)

Subd. 24 Canceling for nonpayment without giving 30 days notice

Subd. 25 Use of information by a minor without parent's permission

Subd. 26 Failure to provide group purchaser with claims experience within 30 days of written request. Insurer, HMO or administrator may not request more than 3 years of claims experience as a condition of application for coverage.

Subd. 27 (Applies to borrowers)

Subd. 28 No fees in addition to premium for conversion.

Subd. 29 Cannot use or request HIV test results from crime or medical emergency

Subd. 30 Must retain applications, underwriting documents and policy forms for 3 years

Subd. 31 Premiums must be reasonable, adequate and not predatory.

Minn. Stat. §72A.201 regulates claims practices. Claim means a demand for services under a policy. The regulatory policy of the section is to consider all actions and circumstances, of both insurer's and insureds when determining regulatory action in response to a violation.

Subd. 4 prohibits unfair claims practice as described in 14 numbered paragraphs. They are:

(1) (excepts health insurance)

(2) failing to reply within 10 business days to a claimants communication that reasonably indicates a response is requested

(3) failing to process claims within 30 days

(4) requirements of para. (3) don't apply in case of fraud

(5) failing to notify claimant of available benefits or required documentation

(6) requiring time limits for notice of claim not contained in the policy

(7) advising claimant not to obtain the advice of attorney

(8) if insurer has received notice of claim and claimant is not represented by attorney, failing to advise claimant of expiration of statute of limitations within 60 days of expiration

(9) demanding irrelevant information

(10) refusing to settle because some one else is responsible

(11) failing to explain denial without referring to specific policy provision that supports the denial

(12) denying or reducing claim based on application that was altered or falsified by agent

(13) (applies to homeowner's insurance)

(14) (applies to estimates of repair)

Additional requirements for fair claims practice:

Subd. 4a Where preauthorization is required, must communicate decision within 10 business days of request and receipt of all necessary information

Subd. 5 Prohibits the following unfair settlement practices:

(1) making a settlement without explaining what it is for;

(2) making a settlement contingent on settling another claim

(3) refusing to pay a claim that not in dispute;

(4) threatening to cancel a policy to induce settlement;

(5) failing to pay the amount agreed upon within five business days of agreement;

(6) failing to identify the policy provisions under which payment is made;

(7)-(10) (apply to property loss)

Subd. 6 (applies to automobile insurance)

Subd. 7 Unfair settlement practices relating to releases:

(1) Requiring a release that extends beyond subject matter at issue

(2) Including language of release on settlement check or draft

Subd. 8 Unfair settlement practices relating to claim denial:

(1) stating that a claim isn't covered by the policy without reference the specific policy section that applies

(2) denying a claim without first making a reasonable investigation

(3) (applies to liability claims)

(4) (applies to liability claims)

(5) denying a claim without including the following information:
the basis for denial
the name, address and phone of a person to contact for question or complaints
the claim number and policy number

(6) (applies to property loss)

(7) chemical dependency reviewer can't deny claims unless reviewer meets certain qualifications

Subd. 8a Qualifications required of chemical dependency reviewer

(1) knowledge of chemical abuse and dependency;

(2) chemical use assessment, including client interviewing and screening;

(3) case management, including treatment planning, general knowledge of social services, and appropriate referrals, and record keeping, reporting requirements, and confidentiality rules and regulations that apply to chemical dependency clients; and

(4) individual and group counseling, including crisis intervention.

(b) The insurer may accept one of the following as adequate documentation that a chemical dependency claim reviewer is competent in the areas required under paragraph (a):

(1) the individual has at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, human services, or psychology, is a licensed registered nurse, or is a licensed physician; has successfully completed 30 hours of classroom instruction in each of the areas identified in paragraph (a), clauses (1) and (2); and has successfully completed 480 hours of supervised experience as a chemical dependency counselor, either as a student or as an employee; or

(2) the individual has documented the successful completion of the following:

(i) 60 hours of classroom training in the subject area identified in paragraph (a), clause (1);

(ii) 30 hours of classroom training in the subject area identified in paragraph (a), clause (2);

(iii) 160 hours of classroom training in the subject areas identified in paragraph (a), clauses (3) and (4); and

(iv) completion of 480 hours of supervised experience as a chemical dependency counselor, either as a student or as an employee; or

(3) the individual is certified by the Institute for Chemical Dependency Professionals of Minnesota, Inc., as a chemical dependency counselor or as a chemical dependency counselor reciprocal, through the evaluation process established by the Certification Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., and published in the Case Presentation Method Trainer's Manual, copyright 1986;

(4) the individual successfully completed three years of

supervised work experience as a chemical dependency counselor before January 1, 1988; or

(5) the individual is a licensed physician, who has 480 hours of experience in a licensed chemical dependency program.

Subd. 9 Unfair settlement practices relating to communications with regulatory agency:

(1) Failure to respond within 15 working days to an inquiry from the commissioner

(2) Failure to make claim files available

(3) failure to include all written communications and transaction in claim file

(4) failure to submit summary of complaint data

(5) failure to compile and maintain a file on complaints for four years after the date of the complaint

Minn. Stat. §72A.205 (applies to life insurance)

Minn. Stat. §72A.21 gives commissioner power to examine and investigate to determine unfair method of competition or unfair or deceptive practice.

Minn. Stat. §72A.22 gives commissioner authority to hold hearing whenever commissioner has reason to believe a person is engaged in unfair competition or unfair or deceptive act or practice defined in §72A.20 and order actions stopped.

Minn. Stat. §72A.25 gives commissioner authority to hold hearing whenever commissioner has reason to believe a person is engaged in unfair competition or unfair or deceptive act or practice not defined in §72A.20 and order actions stopped.

Minn. Stat. §72A.26 allows intervenor to bring action in district court if after a hearing the commissioner fails to charge a violation.

Minn. Stat. §72A.27 provision for appeal.

§72A.285 requires summary of qualifications of reviewer conducting review of health services in connection with a claim for benefits, must also summarize criteria used as a basis for claim decision and specific rationale for reviewer's decision.

§72A.29 provides that no order issued under this chapter affects any other liability.

§72A.30 if person is compelled to testify in hearing under this chapter in spite of claim that testimony may be self incriminating, that testimony cannot be used in criminal action.

§72A.31 and §72A.32 apply only to property insurance.

III. Additional regulations governing health plan company trade practices.

A. Agents

INDEMNITY INSURERS

§60K.02 - Persons who procure or solicit applications for insurance must be licensed by the commissioner of commerce.

§60K.14 - Prohibited and required acts of agents.
Disclosure of business of insurance and name of agent, agency and insurer
Disclosure of fees and commissions
Must make reasonable inquiry to determine the suitability of medicare supplement
Premiums held safe until forwarded to insurer
Maintain client privacy

FRATERNALS

§60K.05 - must be licensed unless devotes less than 50% of time to soliciting insurance

JOINT SELF INSURED

§62H.03 - plans can be marketed only through licensed vendors

NONPROFIT HEALTH SERVICE PLANS

§62C.17 - no solicitation except for agents licensed and qualified under 60K

HMO

§62D.22, subd. 8 - no solicitation except by agents licensed and qualified under 60K

§62D.12, subd. 17 - requires disclosure of commission before selling enrollment in HMO.

CISN

§62D.22, subd. 8 - same as HMO, solicitation by licensed agent

§62D.12, subd. 17 - requires disclosure of commission before selling enrollment

ISN

§62N.22 - seller must disclose commission, no licensing requirement

B. Cancellation Rights

INDEMNITY INSURER, FRATERNALS, NONPROFIT HEALTH SERVICE PLAN, HMO, ISN

§§72A.51-.52 allows individual to cancel within 10 days of date of purchase

CISN, JOINT SELF-INSURED

Doesn't apply

ALL HEALTH PLAN COMPANIES

62Q.16 MID-MONTH TERMINATION PROHIBITED.
For coverage issued or renewed on or after January 1, 1995, coverage must continue until the end of the month in which coverage was terminated. Does not apply to individual plans.

C. Other Prohibited Practices

HMO, CISN

§62D.12 - Prohibited practices.

subd.2 - No cancellation or fail to renew except for
- a) failure to pay premium
- b) termination of plan
- c) moving out of service area
- d) failing to make copayments
- e) with 30 days notice

subd.3 - No use of words descriptive of insurance

subd.4 - No payment to enrollee except
- a) to refund payments made by or on behalf of enrollee
- b) for payment made for emergency or out of area services

subd.5 - Participating providers have no recourse against enrollees for amounts other than copays. HMOs have no recourse against enrollees for amounts other than prepayment.

subd.6 - Rates must be based on accepted actuarial principles.

subd.8 - No discrimination against medicaid or medicare recipients.

subd.9 - All funds must be used for nonprofit purposes of providing comprehensive health care. Allows only authorized expenses.

subd.9b - No contracts with hospitals assuming financial risk for services not subject to the control of the hospital

subd.10 - No reduction in benefits for receipt of disability or worker's compensation

subd.11 - charge for dental services must be computed and stated separately.

subd.12 - No reduction in benefits because of receipt of MA or court or county services

subd.13 - Cannot refuse to provide or renew coverage because enrollee is eligible for worker's comp coverage

subd.14 - must establish telephone no. for provider questions and respond within 24 hours.

subd.15 - no retaliatory action against provider for explaining provisions of provider agreement that limit care
subd.17 - must disclose commissions

INDEMNITY INSURERS

§62A.18 - No group or individual policy shall reduce benefits due to an increase in disability or worker's comp benefits.

§62A.22 - Cannot refuse to provide or renew health coverage because insured has option is eligible to receive worker's comp.

ALL HEALTH PLANS EXCEPT ISNs AND CISNs

§62A.306 - No premium rates or underwriting decisions based on gender.

Quality Assurance Worksheet

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans	Recommendations
	HMOs, ISNs, CISNs, HSPC (Blues), Fraternals, Traditional Indemnity Insurer, PPOs, Co-ops, Self Insured, HPCs (All Health Plan Companies)		-Do we need to regulate? -How strong is the need to regulate? (1-5) -Is uniform application of this statute desirable? -Is uniform application of this statute possible?	Considerations: -Level Playing Field? -Accountability? -Cost Containment? -Flexibility? -Improved Quality? -Accessibility?	-Universal Application? -Standardization? -Simplification? -Inconsistencies? -Duplication? -Vague or Ambiguous?
I. Quality Assurance Process Required.	ISNs, HMOs, CISNs Insurer's offering Medicare Select policies.	Provider and Payer are one or are affiliated in a managed care plan. Incentives to decrease level of care exist.	Quality evaluation of delivery system involves multiple layers of providers. Quality should not be solely evaluated at the provider level. Less consumer choice as other entities move towards managed care.	Not applying this law would: Decrease administrative costs to plan. Decrease regulation.	Recommend that all health plan companies have some type of q.a. process in place, but allow plans flexibility in designing a process appropriate to their business structure.
II. Must Report Quality Assurance Process.	All Health Plan Companies via the action plans, HMOs must also file annual q.a. workplans.	Public Accountability Flexibility in determining how to utilize quality data.	Quality is an important issue to all consumers. Increase consumer information. Regulatory purposes.	Currently, some non-managed care plans can "opt" out by indicating that they have no quality assurance process in place.	Recommend that all health plan companies report on their q.a. process through the filing of action plans.
III. Data Reporting Requirements.	HMOs (very detailed reporting requirements), All health plan companies (details to be set forth in rules).	Regulatory purposes. Information for consumers.	Consumer Information. Regulatory purposes. Increased accountability.	Not applying this law would: Decrease administrative costs to plan. Decrease regulation.	Recommend that one set of reporting requirements be established and that such information be submitted on a specified basis.

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans	Recommendations
IV. Dispute Resolution processes must be in place.	All health plan companies.	Accountability.	Increased accountability. Increased focus on quality. Decreased litigation.	Not applying this law would: Decrease administrative costs to plan. Decrease regulation.	Recommend that all plans establish a dispute resolution process to receive/ respond to complaints, and that all plans offer ADR.
V. Must establish Office of Consumer Services.	ISNs	"Seamless Accountability" for ISNs.	Accountability for all health plans. Centralized control over complaint procedures and quality assurance.	Not applying this law would: Decrease administrative costs to plan. Decrease regulation.	Recommend that all plans have a centralized location or office for consumer inquiries and complaints.
VII. Specific Quality Evaluation Steps outlined by statute.	HMOs, CISNs	Identification of problem areas; inclusiveness.	Standardized q.a. programs. Comprehensive q.a. evaluation.	Not applying this law would: Decrease administrative costs to plan. Decrease regulation. Increase flexibility.	Recommend that this requirement be eliminated.
VII. (Continued) Must conduct Focused Studies.	HMOs	Identification of specific or potential problem areas.	Standardized q.a. programs. Comprehensive q.a. evaluation.	Not applying this law would: Decrease administrative costs to plan. Decrease regulation. Increase flexibility.	Recommend that this requirement be eliminated.
VIII. Subject to Consumer Satisfaction/ Quality Report Card Surveys.	All Health Plan Companies.	Accountability.	Accountability. Regulatory purposes.	Issues regarding confidentiality and a lack of comparable data would need to be addressed. Not applying this might decrease administrative costs to plan.	Recommend that all health plan companies submit data for consumer satisfaction surveys and report card data.

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans	Recommendations
IX. Contractual requirements requiring providers to comply with the plan's q.a. process, etc.	HMOs, CISNs	Provider is held to same standard as plan. Provider is the most likely person to convey message of quality to the consumer.	Assurance that q.a. program is followed. Increased focus on quality.	Seems too obvious; possibly an unnecessary statute. Increased flexibility. Decreased regulations and costs.	Recommend that these requirements be eliminated.
X. Explicit Statute allowing revocation of license if conducting business in a manner contrary to statue, fraudulently, harmful to members, etc.	Fraternals, HMOs, CISNs, traditional insurers,	Enforcement authority.	Enforcement authority. Clearer interpretation of statute. Consistency.	Not applying this law would decrease regulation.	Recommend that a general enforcement provision applicable to all health plan companies be established.
X. (Continued) Explicit statute allowing the commissioner to conduct onsite examinations.	HMOs, CISNs	Enforcement authority.	Enforcement authority. Clearer interpretation. Consistency.	Not applying this law would decrease regulation.	Recommend that a general enforcement provision applicable to all health plan companies be established.
X. (Continued) Explicit statute allowing commissioner to order payment or provide services.	HMOs, CISNs, (ISNs, All-payer insurers if benefit is within the universal standard benefit set.)	Enforcement authority. Rapid resolution of urgent situations.	Enforcement authority. Rapid resolution of urgent situations.	Not applying this law would decrease regulation.	Recommend that a general enforcement provision applicable to all health plan companies be established. Authority and Powers of the Commissioner will be addressed in more detail at future meeting.

Prepared for Recodification Task Force 2-16-95
Minnesota Department of Health
Catherine Moore

Financial Solvency Work Sheet

4/20/95

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans or reasons for applying to NO health plans	Preliminary Recommendations
	HMOs, CISNs, HSPCs, Fraternals, Insurers, HPCs (All Health Plan Companies)		-Do we need to regulate? -How strong is the need to regulate? -Is uniform application of this statute desirable? -Is uniform application of this statute possible?	Considerations: -Level Playing Field? -Accountability? -Cost Containment? -Flexibility? -Improved Quality? -Accessibility?	-Universal Application? -Standardization? -Simplification? -Inconsistencies? -Duplication? -Vague or Ambiguous?

Minimum Net Worth/ Risk Based Capital	**Insurance - 60A.07** **HMO - 62D.042** **CISN - 62N.28** **HSPC - 62C.09**	**Protect consumer from the risk of their health plan's insolvency.** **Promote continuity of health care.**	**Any health carrier that makes a health coverage promise to consumers should be monitored to assure that they have the necessary capital to provide or pay for the covered health care.**	**Appropriate minimum net worth requirements will differ for insurers and other health plan companies.**	**1. Adopt Risk based capital model law for all health plans;** **2. Require $1.5 million start-up capital for all new organizations, regardless of form. This figure should be periodically updated to account for inflation. Commissioners should have discretion to require additional start-up capital if deemed necessary. No change in insurance laws.** **3. Require all companies to maintain a fixed minimum capital level at all times.**

Maximum Net Worth	HMO - 62D.042 CISN - 62N.28 HSPC - 62C.09	Cost containment - an attempt to have cost savings resulting from managed care passed on to the consumer in the form of lower premiums or better care.	Applying to all companies would create a more equal competitive environment.	Insurance carriers domiciled and/or operating in other states are subject to those states' solvency standards. Questionable impact on cost containment, hinders competition and growth, discourages efficiency, difficult to enforce, fails to recognize level of risks undertaken, impractical to implement for multi-state or multi-line carriers.	1. Consider this topic now only as it impacts on solvency. For solvency purposes, the commissioners of health and commerce recommend no maximum net worth requirement until RBC impact is known. 2. Consider this topic in later discussion of rates and cost containment.
Deposits	Insurance - 60A.10 HMO - 62D.041 CISN - 62D.041 HSPC - 60A.10	All companies - deposits are intended to be used to pay for certain costs of rehabilitation or liquidation. HMO and CISN - deposits are also intended to promote continuity of care and to protect enrollees from liability for certain health care expenses.	Deposits are necessary and appropriate for any company which may need to be liquidated or rehabilitated by the commissioner. The amount could vary based on the size of the company.	Companies domiciled in other states have funds on deposit with their own state commissioners.	1. Develop a consistent deposit structure which will apply to managed care organizations and HSPCs. Should include a fixed deposit plus some additional amount based on health care expenditures. No change to insurance laws.

Guaranteeing Organizations	**HMO - 62D.042-043** **CISN - 62D.042-043** **ISN - proposed**	**Guarantees assist new or smaller organizations in meeting their minimum net worth requirements. They are monitored to assure the enforceability of the guarantee and financial strength of the guaranteeing organization.**	**Guarantees could help any company meet its minimum net worth requirement.**	**Guarantees are not traditionally used in the insurance industry. There are difficulties in monitoring the ability to perform under the guarantee and a guarantee is not as good as having the capital in the company.**	**Allow all companies, except insurers and health service plan companies, to use guarantees. Develop strict standards to assure guaranteeing organizations are solvent and guarantees are enforceable.**
Phase-In or Waiver	**CISN - 62N.28** **ISN - waiver proposed by the departments of health and commerce**	**Phase-in/waiver allows new organizations to begin operating without the minimum required net worth in cases where public policy goals of competition and access outweigh the need for sound financial solvency.**	**Phase-in/waiver could be useful to any new organization, except insurers, regardless of its form of organization.**	**Risks inherent in allowing a phase-in dictate that phase-in be allowed only when necessary to increase access or competition.**	**Allow no phase in or waiver of minimum net worth requirements for any companies.**

Financial Reporting and Examination	Insurance - 60A.13/60A.031 Fraternal - 60A.031 and 64B.30 HMO/CISN - 62D.08/62D.14 Minn. Rules 4685.1910-2800 HSPC - 62C.11	Enables the commissioners to monitor the financial viability of companies.	All companies with a net worth requirement could easily be subject to the same type of financial reporting requirements, while the specific content of reports may vary according to differences in operations of companies. The NAIC has established forms by type of entity.		All health plan companies should file appropriate NAIC blanks, with supplements as required by the commissioners and be subject to periodic financial examinations.
Investment Restrictions	Insurance - 60A.11-60A.112; 61A.28-61A.315 Fraternal - 64B.21 HMO - 62D.045 CISN - 62D.045 HSPC - 62C.10-11	Promote financial solvency of companies.	Investment restrictions are currently very similar for all companies, however, there are differences between life and property and casualty insurers.	Investment focuses are different depending on the type of business written.	All companies should be subject to the investment restrictions currently in place for domestic life insurers. HSPCs, ISNs, CISNs, and HMOs will have provisions for real estate which is used in the direct delivery of health care.
Working Capital	HMO - 62D.042 CISN - 62D.042 ISN Proposed	Assure that companies are able to meet day to day obligations and provide uninterrupted health care.	All companies need to meet current obligations regardless of the form of organization.	Insurance companies use an unclassified balance sheet so they do not calculate working capital as traditionally defined.	Require all companies, except insurers and HSCPs, to maintain positive working capital at all times.

Rehabilitation/ Liquidation	**Insurance - 60B** **HMO/CISN - 62D.18, 60B** **HSPC - 60B** **Fraternal - 60B**	**Provide for orderly rehabilitation or liquidation of troubled company, with maximum protection of enrollees.**	**Level playing field, consumer protection.**	**Companies currently not defined as "domestic insurance companies" may be subject instead to federal bankruptcy law. Companies domiciled in other states are subject to their laws.**	**Minn. Stat. Sec. 60B should apply to all domestic health plan companies.**
Insolvency Funding	**CISN - 62N.33**	**Protect consumers and other creditors in the event of insolvency.**	**Consumer protection, level playing field.**	**Differences in requirements for hold harmless clauses may require different levels of insolvency funding.**	
Guaranty Association	**Insurance - 61B and 60C** **HSPC - 61B**	**Protect consumers in the event of insolvency.**	**Consumer protection, level playing field, strength of association.**	**See insolvency funding.**	

Contract Pro\ ons & Disclosures Worksheet

Topic	Currently Applicable To:	Type of Provision Is this a fundamental consumer right; a provision applicable to all health plan company consumers; or applicable only to those consumers of specific types of health plan companies?	Preliminary Recommendations
Provisions directly related to the contract itself:			
1. Plan member is entitled to evidence of coverage.	HMO: 62D.07(3), 62D.09(3) Insurers (Medicare): 62A.31(1e) ISN: 62N.11(1) HSPC: 62C.14	All health plan company consumers should be entitled to this.	Universal application.
2. Contract must clearly outline what services are and are not covered, and what procedures must be followed to obtain services.	HMO: 62D.07(3), 62D.09(4) Insurer: (long term care) 62A.50(2) HSPC: 62C.14	All health plan company consumers should be entitled to this.	Universal application.
3. Contract must clearly show which providers plan member may obtain treatment from.	HMO: 62D.09(5)	All health plan company consumers should be entitled to this.	Universal application.
4. Contract may be cancelled within a specified number of days from receipt without penalty.	HMO: 62D.07(3) (ten days) Insurer: 62A.50 (2) (long term care) (thirty days)	All health plan company consumers should be entitled to this.	Universal application.
5. A grace period is allowed for payment of premium.	HMO: 62D.07(3) Insurer: 62.04(2)(3)	All health plan company consumers should be entitled to this.	Universal application.
6. The plan member must be clearly informed of the terms under which a contract may be terminated by the health plan company and/or limitations or restrictions regarding cancellation.	HMO: 62D.07(3) Insurer/Medicare: 62A.31(1c) HSPC: 62C.14 Insurer: 62A.04	All health plan company consumers should be entitled to this.	Universal application.
7. Thirty day notice of changes in benefits or fees required.	HMO: 62D.07(3)	All health plan company consumers should be entitled to this.	Universal application.
8. Contract must contain number of Department of Health and/or Commerce.	HMO: 62D.07(3)	All health plan company consumers should be entitled to this.	Universal application.

Topic	Currently Applicable To:	Type of Provision Is this a fundamental consumer right; a provision applicable to all health plan company consumers; or applicable only to those consumers of specific types of health plan companies?	Preliminary Recommendations
9. Contract & any changes or additions must be approved by the commissioner.	HSPC: 62C.14(9), 62C.14(10) HMO: 62D.07	All health plan company consumers should be entitled to this.	Universal application.
10. Contract and all riders, endorsements, etc. constitute entire contract between plan and purchaser.	HSPC: 62C.14(6) Insurer: 62A.040	All health plan company consumers should be entitled to this.	Universal application.
11. Contract must conform with the laws of Minnesota/shall be construed pursuant to Minnesota law.	HSPC: 62C.14(13) Insurer: 62A.04	All health plan company consumers should be entitled to this.	Universal application.
12. Contract shall be reinstated following nonpayment of premiums.	Insurer: 62.04(2)(5)	All health plan company consumers should be entitled to this.	Universal application.
13. Contract must contain a name, address, and telephone number & description of internal complaint process.	HMO: 62D.09(8), 62D.07(5)	All health plan company consumers should be entitled to this.	Universal application.
14. Contract must clearly disclose that all expenses may not be covered.	Insurer: (Long term care): 62A.50(2), 62A.50(8) HMO: 62D.09 (in marketing materials)	All health plan company consumers should be entitled to this.	Universal application.
15. Contract must include a statement outlining all out of pocket expenses, deductibles, etc. for which the insured/enrollee may be held responsible.	Insurer: (Long term care): 62A.50(6) HMO: 62D.09 (marketing materials)	All health plan company consumers should be entitled to this.	Universal application.
16. Contract must contain statement of renewal provisions, including any rights of the insurer to change premiums.	Insurer: (Long term care) : 62A.50(3), 62A.50(7)	All health plan company consumers should be entitled to this.	Universal application.
17. Contract must contain a "hold harmless /no personal liability" clause for those services covered by contract.	HSPC: 62C.14 (8), 62C.18 HMO: 62D.123	All health plan company consumers should be entitled to this.	HSPS/HMO/ISN/INSURER?
18. Contract may not offset any social security benefits received.	HSPC: 62C.14(15)	?	?

Topic	Currently Applicable To:	Type of Provision Is this a fundamental consumer right; a provision applicable to all health plan company consumers; or applicable only to those consumers of specific types of health plan companies?	Preliminary Recommendations
19. "Misstatements" or omissions on application cannot be used to deny coverage or void policy after a specified time period.	Insurer: 62A.04(2)	?	?
20. Contract must specify that payment must be made within a reasonable time period.	Insurer: 62.04(2)(8)	All health plan company consumers should be entitled to this.	Universal application.
Required Disclosures to consumers:			
21. Plan member must be made aware of continuation & conversion rights.	HMO: 62D.07(3) HSPC: (continuation for dependent child): 62C.14(5)	All health plan company consumers should be informed of this.	Universal application.
22. Plan member is entitled to an annual financial summary of the health plan company.	HMO: 62D.09(3)	All health plan company consumers should be informed of this.	Universal application; change requirement to provision upon request.
25. Plan member is entitled to an annual description of the health plan company.	HMO: 62D.09(3)	All health plan company consumers should be informed of this.	Delete this item; the action plan requirements already fulfill this requirement.
26. Each plan member must be given information on how to obtain a referral if a referral is required for coverage.	HMO: 62D.09(7)	All health plan company consumers should be informed of this.	Universal application.
27. Each plan member must be given information on how to properly obtain a second opinion if a second opinion is required for coverage.	HMO: 62D.09(7)	All health plan company consumers should be informed of this.	Universal application.
28. Each plan member must be given information on how and when to obtain a prior authorization if such authorization is required for coverage.	HMO: 62D.09(7)	All health plan company consumers should be informed of this.	Universal application.

Topic	Currently Applicable To:	Type of Provision Is this a fundamental consumer right; a provision applicable to all health plan company consumers; or applicable only to those consumers of specific types of health plan companies?	Preliminary Recommendations
29. Each plan member must be given instructions on how to obtain authorization for emergency care if such authorization is required for coverage.	HMO: 62D.09(8)	All health plan company consumers should be informed of this.	Universal application.
23. Plan member must be made aware of his or her right to file a grievance with the health plan company.	HMO: 62D.07(3) Inpatients: Chapter 144	All health plan company consumers should be informed of this.	Universal application.
30. The plan member must be informed of his right to file a grievance with the commissioner of health and/or commerce.	HMO: 62D.07(3)	All health plan company participants should be entitled to this information.	Universal application.
31. Each plan member must receive a copy of consumer information/enrollee rights annually.	HMO: 62D.09(3) ISN: 62N.12 Inpatients: Chapter 144	This provision is applicable only to those entities for which a "Bill of Enrollee" Rights has or will be established. Enforceable only in those entities in which the provider/patient/payer relationship is intertwined.	Applicable to managed care entities.
32. Each plan member must informed of his or her right to available and accessible services, including emergency services, 24 hours a day, 7 days a week.	HMO: 62D.07(3)	Plan specific provision.	Applicable to managed care entities.
"Fundamental Health Care Rights":			
33. The right to privacy of medical and financial records.	HMO: 62D.07(3) Inpatients: Chapter 144	Fundamental consumer right.	Universal application
34. The right to be informed of health problems and received information regarding treatment and risks.	HMO: 62D.07(3) Inpatients: Chapter 144	Fundamental consumer right.	Universal application

Access to Care Worksheet

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans	Preliminary Recommendations
	HMOs, ISNs, CISNs, HSPC (Blues), Fraternals, Traditional Indemnity Insurer, PPOs, Co-ops, Self Insured, HPCs (All Health Plan Companies)		-Do we need to regulate? -How strong is the need to regulate? (1-5) -Is uniform application of this statute desirable? -Is uniform application of this statute possible?	Considerations: -Level Playing Field? -Accountability? -Cost Containment? -Flexibility? -Improved Quality? -Accessibility?	-Universal Application? -Standardization? -Simplification? -Inconsistencies? -Duplication? -Vague or Ambiguous?
Provider contracts **Required** **Permitted**	CISNs: 62N.25, Subd.8 HMOs: 62D.03, Subd.4 (f),(g) ISNs: 62N.05 HPCs: 62Q.19 PPOs: 72A.20, Subd.15 Traditional Indemnity Insurer:62A.64 HSPC: 62C.13 Co-ops: 62R.06	Ensure sufficient network capacity and ability to provide all contracted services to enrollees. Contracts spell out the obligations of each party, reducing misunderstanding and enhancing cooperation.	All health plans that establish provider networks use contracts.	Mandating provider contracts adds administrative costs and reduces flexibility. Provider contracts are not applicable to insurers absent a provider network.	If a health plan company establishes a provider network, then it should be required to contract with these network providers.
Exclusive relationships **Prohibited** **Permitted**	HPCs: 62Q.09 Co-ops: 62R.06, Subd. 2, 62R.08 (c) Employees: 62Q.09	Unfair advantage to some providers and plans. Prevents providers and plans from expanding into new regions of state. Protects employer-employee relationship.	Prohibition promotes level playing field and facilitates expansion by health plans and providers into new areas of the state.	Plans that employ providers should not be treated the same as plans that contract with independent providers.	Plans that employ providers, such as staff model plans, should be allowed to sign full time employees to exclusive contracts. Otherwise, exclusive contracting should be prohibited.

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans	Preliminary Recommendations
Hold Harmless Provision	CISNs: 62N.25, Subd.8 HMOs: 62D.12, 62D.123 HSPC: 62C.16,62C.18 Subd.2, 62C.18, Subd.1	Protect enrollees from being billed if the health plan's payment to the provider is late, disputed, etc. Puts the risk of late payment on the provider.	Hold harmless provision is appropriate in all cases in which there is a contractual relationship between the health plan and the provider. Places risk of late payment on the provider, not the enrollee.	Not appropriate in cases in which there is no contractual relationship between the health plan and the provider. In these cases, the provider should be able to bill the enrollee for unpaid charges.	Hold harmless provision should be required for HMOs, CISNs, ISNs, PPOs and 62Cs.
Provider risk sharing	CISNs: 62N.28,Subd. 6, 62N.31 HMOs: 62D.03,Subd.4.(f), 62D.12 Subd. 9b, ISNs: 62N.02 subd. 12	To allow providers to assume some part of the risk of providing services. To limit the amount of risk so that fiscal stability of the provider is maintained.	All providers should be permitted, but not required, to share risk.	Risk sharing is appropriate only to contracted providers and only if care is managed. Risk sharing can be addressed by contract so legislation is not needed.	All network providers should be permitted, but not required, to share risk.
Expanded provider network (Any willing provider) **Revised 5/18/95**	HPC: 62Q.095	To allow qualified midlevel and allied providers to participate in health plan networks. To give enrollees greater choice of allied and midlevel providers within health plan networks.	To the extent that networks are limited, any willing provider laws provide additional choice to enrollees and network access to providers who may otherwise be excluded.	Establishing an expanded provider network adds administrative costs. Access to these providers is only available to enrollees who pay an additional premium. Undermines the ability of health plans to choose providers and manage enrollees health care.	Already applies to all health plan companies. Keep statute as currently written, no recodification needed.

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans	Preliminary Recommendations
Credentialing	HPC: 62Q.07, Subd.2, 62Q.095, Subd.1, 62Q.10 HMOs and CISNs: M.R.4685.1110,Subp.11 ISNs: 62N.05,Subd.2(16)	To ensure that providers are qualified to provide services to network enrollees. To inform enrollees and potential enrollees about the plan's standards for provider credentialing.	All enrollees and potential enrollees need this information to make informed choice of health plan.	All health plans do their own credentialing to the extent that they contract with providers or limit or restrict enrollees ability to choose their own providers. Credentialing is an integral part of risk management and there is no need to require this by statute.	All health plan companies that establish provider networks should be allowed to establish credentialing standards, which must be reported in the action plans.
Service Area	HMOs: 62D.03, Subd.4 (m), 62D.121,Subd. 7 4685.0100,Subp.9 and 11 4685.1010,Subp.1.B., Subp.3, Subp. 4, 4685.3300, Subp.9 HPC: 62Q.19, Subd. 4 CISNs: same as HMOs	To ensure that health plans sell products only in areas in which they can provide contracted services.	To the extent that a health plan limits enrollees to a provider network, this is necessary to ensure that such plans are only marketed in areas in which network services are available.	Limits ability of health plans to expand to underserved parts of Minnesota. Limits choice of health plans to some Minnesota residents.	Service area approval should be required for all health plan companies that establish provider networks.
Utilization Review	HPCs: 62M, 62Q.12	To provide procedural consistency in utilization review practices. To provide procedures that ensure that enrollees and providers receive timely notice of UR decisions. To provide for timely appeals of denials of services.	To the extent that health plans practice utilization review of prospective or concurrent care, enrollees and providers are protected against arbitrary UR procedures.	While statute provides procedural safeguards and consistency, it does not provide substantive protection against adverse UR decisions.	Statute working well, should be retained as is.

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans	Preliminary Recommendations
Free choice of provider within a class of providers	HSPCs: 62C.05, Subd. 2, 62C.14, Subd. 3	To protect the provider-patient relationship against interference by the health plan	To protect all patient-provider relationships, no matter which health plan company	This would undermine the ability of a health plan to establish a provider network and control costs.	Only applicable to health plans that do not establish provider networks.
Adequacy of Network	HMOs: 4685.1010,Subp. 6, Subp. 8, 62D.08,Subd. 5	To ensure that medically necessary health services are available to network enrollees on a continuing basis, consistent with accepted professional practice. To require the health plan to continually monitor network capacity and take corrective actions when necessary to maintain capacity.	To the extent that a health plan limits enrollees to a network of providers, this law is needed to ensure network capacity.	To the extent that a health plan does not limit its enrollees to a network of providers, this law is unnecessary.	State law should require all health plan companies that establish provider networks to ensure that services are available at convenient locations and within professionally established time limits. However, this is currently only required for HMOs (and PPOs informally) and seems to go beyond recodification.

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans	Preliminary Recommendations
Allied and Midlevel Providers	**Insurers: 62A.03,Subd. 1; 62A.15 HPCs: 62Q.07 (Action plans); 62Q.10 (Non-discrimination)**	**To provide enrollees with the services of allied and midlevel providers. To prevent health plan discrimination against allied and midlevel providers.**	**To the extent that health plans limit network participation, this law is needed to ensure that allied and midlevel providers can join the network.**	**By requiring use of allied and midlevel providers, the ability of a health plan to choose its provider network is compromised. Health plans will choose to utilize allied and midlevel providers based on factors such as cost, efficiency, availability and enrollee requests. There is no need for the state to require this by statute.**	**Since 62Q.07 and 62Q.10 apply to all health plan companies, no recodification is needed.**
Facilities	**Insurers: 62A.044, 62A.081, 62A.153 HMOs: 62A.044 HSPCs: 62A.081, 62A.153**	**To provide coverage for health care services provided by or in appropriate outpatient facilities and facilities operated by local, state or federal government.**	**To prevent health plan discrimination against outpatient facilities or facilities operated by local, state or federal government.**	**This compromises the ability of a health plan to choose its providers based on its own standards and needs.**	**Statute provides additional choice of providers for consumers, and prevents discrimination against certain types of providers. Therefore, should be applied to all health plan companies and put into 62Q.**

Topic	Currently Applies To:	Reasons for Current Regulation	Reasons for applying this to ALL Health plans	Reasons for NOT applying this to all health plans	Preliminary Recommendations
Essential Community Providers	**HPCs: 62Q.19**	**To ensure continued access to certain providers for high risk and special needs enrollees of health plans.**	**All health plans will have some high risk and special needs enrollees who want or need continuing access to providers who have experience caring for such persons.**	**Health plans are required to adopt and report policies and procedures for enrolling and serving high risk and special needs populations. It is preferable in terms of cost and coordination of care that services to high risk and special needs enrollees be provided by plan providers, rather than by non-plan providers.**	**Since this is a transitional statute, leave it as is.**
Cooperatives **Health care network coop** **Health provider coop**	**62R.03, Subd. 2** **62R.03, Subd. 3**				

MANDATED BENEFITS

5/8/95 rev.	Accident and Health Insurance/Fraternal Benefit Societies	Nonprofit Health Service Plan Corporations	Health Maintenance Organizations/CISNs	Health Plans as defined in 62A.011, Subd. 3 and 62N.02, Subd. 7
Maternity benefits. No discrimination against unmarried women and minor female dependents and their dependent children. Individual policies can exclude all maternity benefits.	62A.041 Individual and group coverage	62C.14 Subd. 5a Individual and group contracts	62A.041 Individual and group contracts 62C.14 Subd. 5b	

Coverage of Newborn Infants for illness, injury, congenital malformation or premature birth Requires coverage for inpatient or outpatient treatment for cleft lip and cleft palate up to age 18 including oral surgery and orthodontic care	62A.042 Individual family policies and group policies with family or dependent coverage	62C.14, Subd. 14 Individual family policies and group contracts with family or dependent coverage	62A.042 Individual family policies and group policies with family or dependent coverage	
Coverage for surgical and nonsurgical treatment of TMJ disorder and CMJ disorder. Coverage the same as that for treatment to any other joint in the body, if administered or prescribed by a physician or dentist.	62A.043	62A.043	62A.043	

Children's Health Supervision Services and Prenatal Care Services with no deductible, copayment or other coinsurance or dollar limitation. Child health supervision services means pediatric preventive services, immunizations, developmental assessments and laboratory services from birth to age 6. Prenatal care services means the comprehensive package of medical and psychosocial support provided throughout the pregnancy.	62A.047	62A.047	62A.047 MR 4685.0801, Subd. 8 Child health supervision to age 18	

Coverage for treatment of alcoholism, chemical dependency or drug addiction: in a licensed hospital or licensed residential treatment program, must cover at least 20% of the total patient days allowed by the policy and no less than 28 days per year. In a nonresidential treatment program approved or licensed by the state, must cover at least 130 hours per year.	62A.149 Mandated for group policies. Optional for individual policies (this benefit may be refused in writing in exchange for a reduction in premiums) Group and individual policies	62A.149 Mandated for group policies. Optional for individual policies (this benefit may be refused in writing in exchange for a reduction in subscriber charges) Group and individual policies	4685.0700 Subp. 3 (N) (4) In a licensed hospital or licensed residential treatment program, must cover at least 20% of the total patient days allowed by the policy and no less than 28 days per year. Not required	

Inpatient treatment for mental and emotional conditions			4685.0700 Subp. 3 (N)(4) Must provide coverage for inpatient treatment for mental and emotional conditions of at least 30 days in each contract year	
Benefits for the treatment of emotionally handicapped children in a licensed residential treatment facility, on the same basis as inpatient hospital medical coverage	62A.151 Group policies only	62A.151 Group policies only	62A.151 Group policies only	

Benefits for ambulatory mental health services First 10 hours of outpatient treatment over a 12 month period, prior authorization for additional hours for serious or persistent mental or nervous disorders	62A.152 Group policies which provide benefits for at least 100 certificate holders who are residents of MN or groups of which more than 90% are residents of MN	62A.152 Group policies which provide benefits for at least 100 certificate holders who are residents of MN or groups of which more than 90% are residents of MN	62D.102 Group contracts only	
Outpatient medical and surgical services on the same basis as if provided inpatient	62A.153	62A.153		

Benefits for DES related conditions Cannot exclude, reduce or otherwise limit coverage, solely to conditions attributable to DES or exposure to DES unless diagnosis of DES-related cancer prior to effective date of coverage	62A.154	62A.154	62A.154	
Coverage for services provided to a ventilator dependent person Up to 120 hours of interpreter service by a private duty nurse or personal care assistant in the hospital	62A.155	62A.155 Group contracts only	62A.155	

Reconstructive surgery incidental to or following surgery resulting from injury, sickness or other diseases of the involved part, or when performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect	62A.25	62A.25 Group contracts only	62A.25	
Coverage for special dietary treatment for phenylketonuria when recommended by a physician	62A.26	62A.26 Group contracts only	62A.26	

Coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata. Subject to copayments of policy and limited to maximum of $350 in any benefit year, exclusive of any deductible	62A.28	62A.28 Group contracts only	62A.28	
Coverage for diagnostic procedures for cancer, including mammograms and pap smears, in accordance with the standard practice of medicine	62A.30	62A.30	62A.30	
Coverage for elimination or maximum feasible treatment of port-wine stains	62A.304	62A.304	62A.304	62A.304

Prohibited exclusion, reduction or limitation on benefits solely because the covered person has been diagnosed as having fibrocystic breast condition	62A.305	62A.305	62A.305	62A.305
Coverage for equipment and supplies for diabetes	62A.45	62A.45	62A.45	62A.45
Second opinion related to chemical dependency and mental health, paid for by the HMO and provided by an independent qualified health care professional			62D.103	

Coverage for prescription drugs			4685.0700 Subp. 3 (M) Limitations on coverage are permitted but coverage cannot be excluded	
Coverage for inpatient hospital care			4685.0700 Subp. 3 (N) Minimum of 365 days per period of confinement, group contracts Minimum of 90 days per period of confinement, individual contracts Minimum of 60 days per year out of service area	

Diagnosis and referral to sources of care for outpatient treatment of mental and emotional conditions and alcohol and other chemical dependency			4685.0700 Subp. 3 (L) No limitation	
Emergency care			4685.0700 Must cover in-area and out-of-area emergency care	
Preventive health services			4685.0700	
Comprehensive health maintenance services: emergency care; inpatient hospital care; inpatient physician care; outpatient health services; preventive health services			62D.02 Subd. 7 4685.0100 Subp. 5 4685.0700	

Emergency ground ambulance transportation			62D.02 Subd. 7	

Appendix C

FINAL RECOMMENDATIONS OF THE ADVISORY TASK FORCE ON HEALTH CARE RECODIFICATION

As authorized by Minnesota Statutes, The Advisory Task Force on Health Care Recodification consulted with the Departments of Health and Commerce on the recodification of health plan company law. The Task Force met on nine occasions between December 1994 and September 1995. At each of these meetings, the Departments of Health and Commerce presented information and assisted with discussion on the issues involved in recodification.

At the September meeting, the Task Force reached several conclusions involving recodification of health plan company law. The following paragraphs summarize those conclusions:

I. Implementation of Risk Based Capital

The Department of Commerce presented the Task Force detailed, educational information on risk based capital formulas. These formulas are designed to accommodate the varying levels of insolvency risk inherent in different methods of health care delivery. The Task Force recommends that the Departments of Commerce and Health continue to study health related risk based capital formulas and, as models become available, determine their

application to Minnesota law. The Task Force recommends that the Departments of Health and Commerce work with the legislature to apply risk based capital as soon as the National Association of Insurance Commissioners has finalized the model law.

The Task Force recognizes the current differences in the financial solvency requirements of the health plan companies. The Task Force recommends that the existing requirements remain in place until risk based capital formulas can be applied.

II. Single Definition of Health Plan Company

The Task Force recognizes a need for recodification of all references to "health plan company." The various terminologies and provisions referring to health plan companies should be reviewed, simplified and consolidated. The current references should be revised into a single definition that can be applied throughout the health plan chapters of law. The Task Force suggests that the Revisor be responsible for this recodification.

III. Consumer Protection

The Departments of Health and Commerce presented information comparing the consumer protection regulation of health plan companies. Based on this information, the

Task Force recommends that consumer protection regulation be consolidated and applied consistently to all health plan companies where appropriate. The Task Force believes that consistent, minimum levels of consumer protection should be assured regardless of the product or delivery system selected. Standardization in this area is needed.

IV. Scope and Need for Recodification

The Task Force believes that the need for recodification of health plan company law has altered dramatically. The recodification project was initially intended to compliment a new regulatory framework based on a regulated all payor option and integrated service networks. The 1995 repeal of RAPO necessitated a change in the scope of recodification. Recodification should now involve only technical corrections and this Task Force is no longer needed.

V. Staff Research Material

The Task Force believes that the comparisons of health plan company law created by the Departments of Health and Commerce should be a source of reference for future regulatory reform. These comparisons clearly identify the similarities and differences in health plan company law. While the purpose of recodification was altered significantly by

the 1995 Legislature, the broad issues raised during the recodification project remain relevant for future regulatory reform. The comparisons created by the Departments can assist with that reform.

MEMBERS OF THE ADVISORY TASK FORCE ON RECODIFICATION:

Tom Heffelfinger, Co-Chair
Lois Wattman, Co-Chair

Debbie Alexander
Debra Aune
Jill Beed
Joan Delich
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Phil Griffin
Bob Gunderson
Patty Franklin
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Appendix D

Preliminary Recommendations of the Advisory Task Force on Health Plan Recodification

June 1995

Minnesota Department of Health and
Minnesota Department of Commerce

RECODIFICATION PROJECT

This report is the Preliminary Recommendations of the Advisory Task Force on Recodification and Reform of Regulatory Requirements of Health Plan Companies.

The Health Plan Company Recodification project was authorized in Laws of Minnesota 1994 Chapter 625, Article 5, Section 5 (1994 MinnesotaCare law). That law recognized that Minnesota's health plan market is regulated by many statutory chapters. Some of these chapters apply to all types of health plan companies while others apply to only one type.

In an effort to simplify regulations and eliminate unnecessary regulations among types of health plan companies, the Advisory Task Force recommends standardizing many of the requirements. However, the Task Force also recommends that some differences remain between plans where necessary to recognize different consumer protection needs.

This report summarizes the initial work of the Recodification Advisory Task Force. It has met monthly since December, 1994 and will continue to meet until December of 1995. The Task Force is comprised of 22 members representing insurance companies, health service plan companies, HMOs, PPOs, consumers, counties, employers, labor unions and providers. A list of the membership is attached as Appendix A.

These Preliminary Recommendations are a direct result of the comments from Task Force members during discussion of the first five topical areas of health plan company regulations. Staff of the Departments of Health and Commerce have provided background materials and initial recommendations to the Task Force. This report focuses on the five topics which the task force has discussed thus far: trade practices, quality, financial solvency, access and contracts.

These recommendations are preliminary and are subject to change by the Task Force at any time up until its concluding meeting in December of 1995. Also, the proposed legislation which the Commissioners of Health and Commerce are required to draft and submit to the Legislature by January 1, 1996 may not be identical to these recommendations. This report is intended solely to provide information and to stimulate further discussion and is not necessarily reflective of current or future policy of the two Departments.

Future topics may include: continuation/conversion, eligibility/open enrollment, licensing/company structure and rates/cost containment.

PART I
TRADE PRACTICES

A. CROSS REFERENCING

In order to promote a more "user friendly" health care code, trade practices should be cross referenced in appropriate locations in health care law.

- **Therefore, it is recommended that health plan company law be reorganized to include cross references, where appropriate, to 72A.**

B. LICENSING

In order to provide a fair competitive environment and assure the highest levels of consumer protection, agent licensing requirements should be applied uniformly to all sales of health plan company products.

- **Therefore, it is recommended that all persons who procure or solicit applications for insurance shall be licensed by the Commissioner.** *From 60K.02 (insurers), 62C.17 (HSPCs), 62D.22, Subd.8 (HMOs, CISNs). This represents a substantial change for fraternals (60K.05) and an addition to ISNs (62N.22).*

C. RIGHT TO CANCEL

In order to promote consumer protection interests in health plan company sales, the ten day "right to cancel" provision should be extended to CISNs and ISNs.

- **Therefore, it is recommended that all health plan company product sales be subject to a consumer's ten day right to cancel.** *From 72A.51 and 72A.52. This represents a clarification for ISNs and CISNs.*

D. COMMISSION DISCLOSURE

In order to clearly standardize the application of commission disclosure requirements, all health plan companies should be subject to commission disclosure requirements.

- **Therefore, it is recommended that all health plan companies be subject to commission disclosure requirements.** *From 62D.12, Subd. 8 (HMOs and CISNs) and 62N.22 (ISNs) and 60K.14, Subd.7 (insurers).*

PART II
Quality of Care

A. WRITTEN QUALITY PROGRAM

Under current law, only HMOs, CISNs, insurers offering Medicare select policies and ISNs are required to have a quality assurance process in place. This emphasis on managed care stems from managed care's early development years. With the evolution of health service plan companies, the need for quality programs now extends to Non-Profit Health Service Plan Corporations (HSPCs).

- **Therefore, it is recommended that the legislature require HMOs, ISNs, CISNs, Health Service Plan Corporations, and health carriers offering Medicare Select polices to have a written quality program which shall include quality assessment, assurance, and improvement. The existing rules shall be amended where inconsistencies may exist.**

  Each written quality program shall :

  - **include the oversight of a governing body which shall be the board of directors or a committee of senior management.**

  - **include an identifiable structure with an identified supervisor for performing the quality program.**

  - **require the health plan to monitor the quality program. Information shall be documented and communicated to appropriate individuals in the health plan company for the purpose of improving quality.**

  - **include requirements for the credentialing and recredentialing of providers.**

  - **require all providers to participate in the plan's quality program.**

If any part of the quality program is delegated to an entity other than the health plan, the health plan shall remain accountable for the delegated functions. *From 62N.25(7) (CISN), 64B.23 (Fraternals). Impacts Chapters 62A, 62C, 62D, 62N, Minn. R.4685.1100. See also, 1995 Minn. Laws Ch. 234, Art. 1, Sec. 26 relating to Integrated Service Networks. Regarding credentialing standards, see* 62Q.07, Subd.2, 62Q.095, Subd.1, 62Q.10 (HPC), M.R.4685.1110, Subp. 11 (HMO and CISN) and 62N.05, Subd. 2(16) (ISN). *See also 1995 Minn. Laws 234, Art. 1, Sec. 10-11 (ISNs). This would represent a substantial change for HSPCs.*

B. ACTION PLANS

Many quality requirements must be reported to the Commissioner in Action Plans under Minn. Stat. 62Q.07. These requirements include credentialing, provider data, quality improvement processes, high risk and special needs policies and any plans for expanding rural health care availability. Currently some health plans may elect not to complete specific portions of the action plan, including the information on quality. Because public accountability is best served when quality reporting occurs, all HMOs, CISNs, ISNs and HSPCs should report on quality through the action plan.

- **Therefore, it is recommended that all HMOs, CISNs, ISNS and HSPCs be required to report on their quality program activities through the action plan. When indemnity insurers, including fraternals, choose to have a quality program, the information from such programs shall be required to be reported in the action plan.** *From 62Q.07 (g) which will be amended and 64B.23 (fraternals). See also 1995 Minn. Laws Ch. 234, Art. 2, Sec. 18-19 for modifications to the action plan requirement.*

C. DISPUTE RESOLUTION

Dispute resolution is employed to resolve disputes surrounding services and coverage. Although disputes surrounding coverage arise in all forms of health plans including insurers, current dispute resolution requirements apply only to managed care companies. Since disputes involving coverage extend beyond managed care, the law of dispute resolution should be standardized and extended to all health plan companies.

- **Therefore it is recommended that the dispute resolution process apply to all health plan companies and that current law be amended to eliminate duplications and inconsistencies.** *From 62Q.105, contained in the 1995 MinnesotaCare bill, which outlines the complaint resolution process, 64B.23 (fraternals), 62D.11 (HMO) and 62N.13 (ISN). See also 1995 Minn. Laws Ch. 234, Art. 2 Sec. 1, 21-24 for new requirements relating to dispute resolution.*

D. OFFICE OF CONSUMER SERVICES

In order to increase public accountability and to assure the highest levels of quality, Minnesota Care required ISNs to establish an office of consumer services. This office is responsible for dealing with all enrollee complaints and inquiries. Under current law only managed care companies are regulated for complaint procedures, although all health plan companies are involved in complaints.

As part of recodification's standardization, all health plan companies should join ISNs in providing a source for centralized handling of complaints and enquiries.

- **Therefore, it is recommended that the legislature require all health plan companies to have a source for the centralized handling of complaints and inquiries.**

PART III
FINANCIAL SOLVENCY

A. RISK BASED CAPITAL

In order to refine and improve solvency regulation and apply methodologies which reflect state of the art regulatory oversight, the risk based capital framework should be studied as it is developed.

The National Association of Insurance Commissioners (NAIC) risk based capital model law for insurance companies became law in Minnesota during the 1995 legislative session. See, 1995 Minn. Laws Ch. 253. A working group of the NAIC, which includes staff from the Department of Commerce, is currently developing modifications to the life insurance risk based capital formula and model law. These modifications will make the formula and model law applicable to all types of health plan companies.

Once these modifications have been completed, the commissioners of health and commerce will recommend adopting the new "health organization" risk based capital model law with any modifications deemed necessary to reflect conditions unique to Minnesota companies.

- **Therefore, it is recommended that the commissioners of health and commerce make recommendations to the legislature in 1996 for adoption of the health organization risk based capital model law with any necessary modifications.**

B. NET WORTH

The financial solvency risk of health plan company start ups can be accommodated by a strong net worth requirement. Due to the maturing of the managed care marketplace, there is no longer a need for differences in required start-up capital. The ongoing minimum net worth requirement, however, must offer a floor of security. This floor may be modified upward by the application of risk based capital should an entity's risk profile indicate the need for additional capital.

- **Therefore, it is recommended that:**

1. **All health plan companies have a minimum start-up net worth of 1.5 million dollars.** *This is the current requirement for integrated service networks as outlined in 1995 Minn. Laws, Ch. 234, Art. 1, Sec. 14, insurance companies authorized to write only the coverage defined in 60A.07 Subd. 5(a) clause (5e), and HMOs as found in 62D.042 Subd. 2(a). This recommendation would represent a substantive change for Non-Profit Health Service Plan Corporations regulated under Chapter 62C (HSPCs) and CISNs. This general provision may apply to all companies and may replace net worth requirements currently found in sections 62C.09, 62N.28, and 62D.042. If an insurance company is authorized to write additional lines more capital may be required pursuant to Section 60A.07.*

2. **No health plan company shall be permitted to have net worth at any time below $1 million dollars.** *This ongoing minimum requirement is based on existing requirements found in sections 60A.07 Subd. 5a clause (5a)(insurers), 62D.042 Subd. 1(b) (HMOs) and 62N.28 Subd. 1 (CISNS). See also, 1995 Minn. Laws Ch. 234, Art. 14 relating to integrated service networks. This recommendation would represent a substantive change for health service plan companies and could replace requirements currently found in Section 62C.09.*

3. **All health plan companies, except insurance companies regulated under Chapter 60A and Non-Profit Health Service Plan Corporations (HSPCs) regulated under Chapter 62C, should be permitted to satisfy 50% of net worth requirements through guarantees from an outside organization. Guarantees should be governed under restrictions similar to those currently found in section 62D.043.** *This is based on the new law pertaining to integrated service networks, 1995 Minn. Laws, Ch. 234, Art. 1, Sec. 18. This would be a substantive change for HMOs and CISNs which are now allowed to satisfy up to 100% of their minimum requirement by means of a guarantee (see sections 62D.042 Subd. 5 and 62N.29) Health service plan companies are currently not permitted to use guarantees.*

4. **The law should provide for periodic adjustments to the net worth and deposit requirements every five years to account for inflation.** *This recommendation is not found in current law.*

5. **The sections of law which provide for limited maximum net worth and phasing in of net worth be deleted.** *Repeal these provisions found in sections 62D.042 (HMO), 62N.28 (CISN) and 62C.09 (HSPC).*

C. DEPOSITS

Deposit requirements allow regulators an ability to assist in a required health care company restructuring. Due to an increased understanding and agreement on appropriate deposit amounts, a uniform deposit calculation is now appropriate for managed care organizations which do not participate in a guarantee association -- HMOs, ISNs, and CISNs.

A minimum deposit should be standardized for all health plan companies regardless of their participation in a guarantee association. This standardization will provide consumers uniform protection in the event of an insolvency of their health plan. The deposit regulation for insurers has functioned successfully, however, and should not be changed.

- **Therefore, it is recommended that**

  1. **All HMOs, CISNs, ISNs, and non-profit health service plan corporations be required to have a deposit which consists of cash or direct obligations of the United States government.** *This is based on the 1995 ISN legislation and would represent a slight change for all health plan companies. See, 1995 Minn. Laws, Ch. 234, Art. 1, Sec. 15.*

  2. **Require all deposits for HMOs, CISNs, ISNs, and Non-Profit Health Service Plan Corporations (HSPCs) to be held in a custodial account acceptable to the commissioner.** *This recommendation is based on the HMO requirement found in section 62D.041 and this year's ISN legislation, 1995 Minn. Laws, Ch. 234, Art. 1, Sec. 15.*

3. **Require HMOs, CISNs, ISNs and HSPCs to deposit a minimum of $300,000 before receiving a certificate of authority.** *This recommendation is based on the 1995 ISN legislation, 1995 Minn. Laws, Ch. 234, Art. 1, Sec. 15. This would represent a downward change for HMOs and CISNs.*

4. **Require HMOs, CISNs, and ISNs, after their first full calendar year of operation, to maintain on deposit of $300,000 plus 25% (three months) of their annual uncovered expenditures incurred in the previous calendar year.** *This would slightly change the current HMOs and CISNs requirements found in Section 62D.041 as well as the requirement for ISNs as found in the 1995 MinnesotaCare Act, 1995 Minn. Laws, Ch. 234, Art. 1, Sec. 15. There would be a small increase for smaller organizations. See definition of "uncovered expenditures" below.*

5. **Define uncovered expenditures as the costs of health care services and supplies that are covered by an HMO, CISN, or ISN for which an enrollee would also be liable in the event of an insolvency and that are not guaranteed, insured or assumed by a person other than the health plan company. Uncovered expenditures should include the cost of covered health care services and supplies received by enrollees from providers who are not employed by, under contract with, or otherwise affiliated with such health plan company.** *This definition combines the current definitions of uncovered expenditures in 62D.04 Subd.1(a) and supplemental benefit expenses in 62D.05 Subd.6(a). This definition appears in the current ISN legislation, 1995 Minn. Laws, Ch. 234, Art. 1, Sec. 13.*

D. INVESTMENT RESTRICTIONS

Life insurers have served well as a model for investment restrictions for health plan companies. There are some differences, however, between life and health companies that must be recognized. One significant difference is real estate holdings.

- **Therefore, it is recommended that all health plan companies, except insurance companies regulated under chapter 60A, be required to invest their admitted assets in securities and property designated in Section 61A.28 for investment by domestic life insurance companies. A managed care company may invest up to 60% of its admitted assets in any combination of real estate and equipment which is used for the accommodation of its business.** *All of these companies are already required to follow the investment restrictions for life insurers: see sections 64B.21 (fraternal benefit societies), 62D.045 (HMOs), 1995 Minn. Laws, Ch. 234, Art. 1, Sec. 17 (integrated service networks) and 62C.10 (non-profit health service plan corporations). The real estate provision is based on, but is slightly more restrictive than, the real estate provisions for HMOs found in Section 62D.045.*

E. WORKING CAPITAL

Positive working capital reflects the liquidity position of a health plan company. In order to foster a consistent regulatory environment, HMOs, CISNs and ISNs should be required to have positive working capital.

- **Therefore, it is recommended that all HMOs, CISNs, and ISNs have positive working capital.** *This recommendation is based on the HMO requirement found in Section 62D.042 as well as the 1995 ISN legislation, 1995 Minn. Laws, Ch. 234, Art. 1, Sec. 16.*

F. GUARANTEE ASSOCIATION

The Commissioners will continue to study guaranty association coverage for all health plan companies. Currently insurance companies and health service plan companies are members of the life and health guaranty association. Prior to expanding guaranty association coverage to other health plan companies, the following issues will be addressed;

* The need for risk based capital methodology to be fully implemented as to the standard approach to solvency regulation for all types of health plan companies;
* A comparison of the costs of insurer and HMO insolvencies;
* The need for an equitable method of making assessments to the different types of entities; and

* The effectiveness of hold harmless agreements in the event of an insolvency.

    - **Therefore, it is recommended that the commissioners of health and commerce shall report to the legislature recommendations to create a single guaranty association after the risk based capital methodology is fully implemented. This report shall address comparison in an equitable method of making assessments and the effectiveness of hold harmless agreements in the event of insolvency.**

PART IV
Access to Care

A. SERVICE AREAS

In order to promote consumer choice and create additional opportunities to serve rural Minnesota's health care needs, the commissioners should have authority to grant waivers of statutory service area requirements. The statutory requirements for service areas should apply uniformly to HMOs, CISNs, ISNs, HSPCs and insurers with networks to assure competitive equality and waivers should be granted by the Commissioner only as needed.

The 1995 MinnesotaCare legislation defines "managed care organization" as any HMO, ISN, CISN, and any other company which delivers health care through a preferred provider organization or network of selected providers.

- **Therefore, it is recommended that the service area requirements for HMOS, CISNs and HSPCs be standardized and uniformly applied to all "managed care organizations" as defined in the 1995 MinnesotaCare legislation, 1995 Minn. Laws 234, Art. 2, Sec. 5, and that the Commissioner be granted authority to waive the statutory requirements when such waiver better serves the consumer.** *From 62D.03, subd.4(m), 62D.121, Subd. 7, 4685.0100, Subp. 9 and 11, 4685.1010, Subp.1B, Subp. 3, Subp.4, 4685.3300 and 62q.19,Subp.4 (HPC). See also the ISN recommendations in the 1995 MinnesotaCare law, 1995 Minn. Laws 234, Art. 1 Sec. 24. This would represent a substantial change for HSPCs and insurers with PPOs.*

B. ADEQUATE NETWORKS

Consumer interests have been well served by the current HMO requirements which assure the adequacy of HMO networks. As new managed care delivery systems emerge and are recognized, a consistent application of network requirements is needed to provide the same levels of consumer protection to all

managed care consumers.

- **Therefore, it is recommended that the HMO requirements found in M.R. 4685.1010, Subp. 6, Subp. 8 apply to all managed care organizations as defined in the 1995 MinnesotaCare legislation, 1995 Minn. Laws Art. 2 Sec. 5. ISN access rules for network adequacy are currently being developed and will allow greater flexibility. (see 1995 Minn. Laws, Art. 1 Sec. 24).** *From M.R. 4685.1010, Subp.6, Subp. 8, 62D.08, Subd.5 and 62A.318(medicare select).*

C. PROVIDER CONTRACTING

Provider contracting gives consumers assurance that they will have access to providers. All network providers should be required to contract with their health plan company to provide the greatest level of assurance that providers will be available..

- **Therefore, it is recommended that all health plan companies that establish provider networks (managed care organizations as defined in the 1995 MinnesotaCare legislation) be required to contract with those network providers.** *From 62N.25, Subd.8 (CISNs), 62D.03, subd.4 (f)(G) (HMOs), 62N.05, Subd. 17 (ISNs) and 62C.13 (HSPCs) . This represents a substantial change for PPOs (72A.20, subd. 15), traditional indemnity insurers (62A.64), HSPC (62c.13) and Co-ops (62R.06).*

PART V
Standard Contract Provisions and Disclosures

A. CONSUMER PROTECTION DISCLOSURES

To further and more effectively promote the public interests, all health plan companies shall communicate certain contract provisions which are essential to the consumer's understanding of the benefits provided. Health Plan marketing materials shall include information on how to access the health plan's office of consumer services., continuation and conversion rights and procedures or references for referrals, prior authorizations, second opinions and emergency care. The Commissioner shall be granted authority to review the plan's communications on these topics and make recommendations to the health plan regarding their effectiveness.

- **Therefore, it is recommended that all health plan companies, through marketing materials, clearly disclose information to purchasers on:**

  1. how to access the plan's office of consumer services;
  2. continuation and conversion rights; and
  3. necessary procedures or references for referrals, prior authorizations, second opinions and emergency care.

  It is further recommended that the Commissioner be granted authority to review the plan's disclosures and to make recommendations regarding their effectiveness. ***See Sections 62D.07, 62D.09, and 62D.03 (HMO); 62C 14 (HSPC); and 62A.50 and Chapter 144 (Insurers).***

B. CONTRACT STANDARDIZATION

Health plan company law is often a mirror image of common and contract law. Some health plan statutes codify common and contract law. These statutes should be applied to all health plan companies in a standardized fashion.

- **Therefore, it is recommended that health plan law involving evidence of coverage, covered services, contract cancellation rights, premium payment grace periods and notice of change in premiums or benefits be standardized to apply to all health plan companies wherever this existing law reflects common and contract law.** *From evidence of coverage 62D.07(3), 62D.09(3) (HMO), 62A.31(1e), 62A.04(16) (Insurers), 62N.11(1) (ISN) and 62C.14 (HSPC); covered services 62D.07(3), 62D.09(4) (HMO), 62A.50(2) (insurer) and 62C.14 (HSPC), 62A.50(8) (insurer), 62D.09 (HMO) and 62A.50(6) (insurer) ; contract cancellation rights 62D.07(3) (HMO), 62A.50(2) (insurer) and 72A.51, 72A.52 (trade practices) 62A.31(1c) (insurer), 62C.14 (HSPC) and 62A.04 (insurer); premium payment grace periods 62D.07(3) (HMO) and 62.04(2)(3), 62A.04(2)(5) (insurer) and 62A.50(3), 62A.50(7), 62A.03(5) (insurer); change in premiums or benefits 62D.07(3) (HMO), 62C.14(9), 62C.14(10) (HSPC), 62D.07 (HMO), 62A.02(2) (insurer), 62C.14(6) (HSPC), 62A.040 (insurer), 62C.14(13) (HSPC) and 62A.04 (insurer).*

C. DISCLOSURES CONCERNING THE COMPLAINT PROCESS

In order to improve the quality of care provided through health plan companies, each health plan should be required to disclose the name, address and telephone number of their office of consumer services, the internal grievance process and the right to file a grievance against the health plan with the Commissioner. Knowledge and appropriate utilization of the complaint process will improve future quality of care.

- **Therefore, it is recommended that all health plan companies notify their consumers of the name, address and telephone number of their office of consumer services and that all purchasers be informed of the plan's internal grievance process and the right to file a grievance against the plan with the Commissioner of health or Commerce.** *From 62D.07(3) (HMO), 62D.09(8), 62D.07(5) (HMO).*

Appendix E

62Q.01 Subd. 4. **Health Plan Company.** "Health plan company" means:
(1) a health carrier as defined under section 62A.011, subdivision 2;
(2) an integrated service network as defined under section 62N.02 subdivision 8;
(3) an all-payer insurer as defined under section 62P.02; or
(4) a community integrated service network as defined under section 62N.02 subdivision 4a.

62A.011 Subd. 2. **Health Carrier.** "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H.

62L.02 Subd. 16. **Health Carrier.** "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; and a multiple employee welfare arrangement, as defined in United States Code title 29, section 1002(40), as amended. For purposes of sections 62L.01 to 62L.12, but not for purposes of sections 62L.13 to 62L.22, "health carrier" includes a community integrated service network or integrated service network licensed under chapter 62N. Any use of this definition in another chapter by reference does not include a community integrated service network or integrated service network unless otherwise specified. For the purpose of this chapter, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one health carrier, except that any insurance company or health service plan corporation that is an affiliate of a health maintenance organization located in Minnesota, or any or any health maintenance organization located in Minnesota that is an affiliate of an insurance company or health service plan corporation, or any health maintenance organization that is an affiliate of any other health maintenance organization in Minnesota, may treat the health maintenance organization as a separate health carrier.

62J.03 Subd. 10. **Health Plan Company.** "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4.

62N.02 Subd. 6a. **Health Carrier.** "Health carrier has the meaning given in section 62A.011.

62R.18 Subd. 2. **Health Carrier.** "Health carrier has the meaning provided in section 62A.011.

Appendix F

Resource Material Changes

The information below reflects clarifications and 1995 law changes to the resource materials which are included in this appendix. Changes are noted in italics.

TRADE PRACTICES:

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Minn. Stat. §72A.201 Subd. 4
(1) *acknowledge receipt of notification of the claim within 10 days*
(3) failing to process claims within 30 days *(including health insurance)*

CONTRACT PROVISIONS AND DISCLOSURES:

starting on page 34
#1 currently applicable to: HMO Minn. Stat. §§ 62D.07(3), 62D.09(3), Insurers (Medicare Supplement) Minn. Stat.§ 62A.31(10), ISN Minn. Stat. §62N.11(1), HSPC Minn. Stat.§§ 62C.14 *and 62A.10 Subd.2(2)*

#2 currently applicable to: HMO Minn. Stat.§§ 62D.07(3), 62D.09(4), Insurers (long term care) Minn. Stat.§62A.50(2), HSPC Minn. Stat.§§62C.14 *and 62A.03, Subd.1(6)*

#4 currently applicable to: HMO Minn. Stat.§62D.07(3)(ten days), Insurer Minn. Stat. §§ 62A.50(2)(long term care)(thirty days), *and 62A.04 Subd.3(8), 72A.51-52*

#6 currently applicable to: HMO Stat.§ 62D.07(3), Insurer/Medicare Supplement Minn. Stat.§ 62A.31(1c), HSPC 62C.14, Insurer 62A.04 *and 60A.085, 62A.04 Subd.3(8), 62A.03 Subd.1(5), 62A.65 Subd.2*

#7 currently applicable to : HMO 62D.07(3) *and 62A.023*

#9 currently applicable to : HSPC 62C.14(9), 62C.14(10), HMO 62D.07 *and 62A.02 Subd. 2*

#10 currently applicable to : 62C.14(6) *delete 62A.040 and add 62A.04 Subd. 2(1)*

#14 currently applicable to : Insurer (long term care) 62A.50(2), 62A.50(8) HMO 62D.09 (in marketing materials) *and 62A.03 Subd. 1(6)*

#16 currently applicable to : Insurer (long term care) 62A.50(3), 62A.50(7) *and 62A.03 Subd. 1(4)*

#18 currently applicable to : HSPC 62C.14(15) *and 62A.18*

#21 currently applicable to : HMO 62D.07(3), HSPC (continuation for dependent child), 62C.14(5) *and 62A.145-.146, 62A.147-.148, 62A.16-.17, 62A.20, 62A.21, 62A.65 Subd. 5(h)*

#29 currently applicable to : HMO 62D.09(8) *and 62A.049*

MANDATED BENEFITS

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Add Diabetic Equipment and Supplies

Accident and Health and Fraternal Benefit: 62A.45
NHSPC: 62A.45
HMO: 62A.45
Health Plans: 62A.45

Add Mental Health and Chemical Dependency

Accident and Health and Fraternal Benefit: 62Q.47
NHSPC: 62Q.47
HMO: 62Q.47
Health Plans: 62Q.47

Add Hospital and Anesthesia for Dental Procedures

Accident and Health and Fraternal Benefit: 62A.308
NHSPC: 62A.308
HMO: 62A.308
Health Plans: 62A.308

Add Breast Cancer

Accident and Health and Fraternal Benefit: 62A.309
NHSPC: 62A.309
HMO: 62A.309
Health Plans: 62A.309