HOUSE RESEARCH

Bill Summary

FILE NUMBER: S.F. 491 (H.F. 560) **DATE:** May 21, 2001
Version: Conference Committee Report

Authors: Goodno, Bradley, Greiling

Subject: Patient Protection

Analyst: Elisabeth M. Loehrke

Overview

This bill amends patient protection provisions that apply to health plan company enrollees. It requires part of any administrative penalty obtained from health plan companies to be distributed to certain enrollees, permits certain copayments for prescription drugs, modifies requirements governing continuity of care and obtaining standing referrals to specialists, requires studies on data collection on quality of patient care and on clinical trials, requires medical directors to be licensed in Minnesota, and makes other changes.

Section

1 **Violations and penalties.** Amends § 45.027, subd. 6. In a subdivision authorizing the commissioner of commerce to impose civil penalties for violations of law, requires the commissioner to divide 50 percent of any civil penalty imposed on a health carrier among enrollees affected by the violation, unless the commissioner certifies that distribution would be too administratively complex or that each affected enrollee would receive less than $50.

2 **Copayments for prescription drugs.** Adds § 62D.107. Permits health maintenance organizations to establish flat fee copayments for prescription drugs, as long as a copayment for a brand name prescription drug where there is a generic equivalent does not exceed $18. Provides that this section does not apply where a prescriber prescribes a drug and directs the pharmacist to dispense as written. (This allows HMOs to established tiered copayments for prescription drugs, with a lower tier for generic drugs and a higher tier for certain brand name drugs.) Makes this section effective January 1, 2002, and applicable to health plans issued or renewed on or after that date.

3 **Services associated with clinical trials.** Adds § 62D.109. Requires health maintenance contracts to cover a drug, device, treatment, or procedure associated with a clinical trial, provided that it is not experimental, investigative, or unproven according to rule and that it would otherwise be covered under the contract. Also requires an HMO to inform an enrollee

participating in a clinical trial of these coverage requirements, if the enrollee asks.

4 **Administrative penalty.** Amends § 62D.17, subd. 1. In a subdivision authorizing the commissioner of health to impose administrative penalties on health maintenance organizations for violations of law, requires the commissioner to divide 50 percent of any penalty levied among any enrollees affected by the violation, unless the commissioner certifies that distribution would be too administratively complex or that each affected enrollee would receive less than $50.

5 **Cost containment data from group purchasers.** Amends § 62J.38. In a section requiring group purchasers to submit certain cost containment data to the commissioner of health, requires expenditure data that is submitted to distinguish between costs incurred for patient care and administrative costs. Allows patient care and administrative costs to include only expenses incurred on behalf of health plan members, and prohibits inclusion of the cost of providing services for nonmembers at group purchaser-owned facilities. Specifies what must be included in administrative costs. Requires the reports of cost containment data from group purchasers to separately identify expenses for taxes, fees, and assessments, and to include payments made to acquire a health care facility, payments made pursuant to a partnership or other agreement with a health care provider, and payments made during the calendar year for these purposes. Exempts workers compensation and automobile insurance plans from complying with this paragraph.

6 **Utilization review organization.** Amends § 62M.02, subd. 21. Modifies the definition of utilization review organization to exempt from regulation as a utilization review organization, a clinic or health care system that performs utilization review activities according to a written delegation agreement with a utilization review organization. Makes the utilization review organization that contracts with the clinic or health care system accountable for any delegated utilization review activities.

7 **Licensure of medical directors.** Adds § 62Q.121. Requires all health plan companies with three percent or more of the health plan market to employ only Minnesota-licensed physicians as medical directors, for medical directors who make recommendations or decisions that affect enrollees in this state. Defines medical director. Requires all health plan companies subject to this section to provide the commissioner with names and licensure information for all medical directors, and to update this information not later than 30 days after any changes.

8 **Continuity of care.** Amends § 62Q.56. Modifies provisions governing continuity of care for enrollees when enrollees must change providers or health plans.

Subd. 1. Change in health care provider; general notification. In paragraph (a), expands the requirement that a health plan company must establish a written plan for continuity of care if a contract between the health plan company and a provider is terminated, to include specialists. In paragraphs (b) and (c) language is stricken governing referrals when the contract termination is for cause or not for cause. Paragraph (b) also specifies that termination includes nonrenewal of a contract. The language in paragraph (c) is being moved to a new subdivision 1b.

Subd. 1a. Change in health care provider; termination not for cause. Provides additional detail as to when a health plan company must authorize services with a terminated provider when the contract termination was not for cause. Paragraph (a) establishes notification requirements when a provider contract is terminated not for cause. Paragraph (b) requires authorization for services for up to 120 days if an enrollee is engaged in a current course of treatment for an acute condition, a life-threatening physical or mental illness, pregnancy after the first trimester, a physical or mental disability, or a disabling or chronic condition in an acute phase. Also requires authorization for services for the rest of an enrollee's life if the enrollee is expected to live 180 days or less. Paragraph (c) requires a health plan company to establish a process for coverage determinations for up to 120 days of continuity of care for enrollees

receiving culturally appropriate services and for enrollees who do not speak English, if the health plan company does not have an appropriate provider sufficiently close to the enrollee.

Subd. 1b. Change in health care provider; termination for cause. Requires a health plan company to notify enrollees of a change in health care provider and to transfer enrollees to a participating provider if the provider's contract was terminated for cause. (This subdivision is existing law and is being moved from subdivision 1.)

Subd. 2. Change in health plans. When an enrollee is subject to a change in health plans, paragraph (a) provides additional detail as to when the enrollee's new health plan company must authorize services with the enrollee's current provider. Requires authorization for services for up to 120 days if an enrollee is engaged in a current course of treatment for an acute condition, a life-threatening physical or mental illness, pregnancy after the first trimester, a physical or mental disability, or a disabling or chronic condition in an acute phase. Also requires authorization for services for the rest of an enrollee's life if the enrollee is expected to live 180 days or less.

Paragraph (b) requires a health plan company to establish a process for coverage determinations for up to 120 days of continuity of care for enrollees receiving culturally appropriate services and for enrollees who do not speak English, if the health plan company does not have an appropriate provider sufficiently close to the enrollee.

Subd. 2a. Limitations. Makes the requirements in subdivisions 1, 1a, 1b, and 2 apply only if the enrollee's health care provider will accept either the health plan company's reimbursement rate or the provider's regular fee, whichever is lower; follow the health plan company's preauthorization requirements; and give the health plan company all necessary medical information regarding the care provided. Specifies that this section does not require a health plan company to cover a service or treatment not covered under the enrollee's health plan.

Subd. 2b. Request for authorization. Allows a health plan company to require submission of medical records and other supporting documents with a request for authorization. If the authorization is denied, requires the health plan company to explain the criteria used for its decision, and if the authorization is granted, requires the health plan company to explain how continuity of care will be provided.

Subd. 3. Disclosure. Requires information on an enrollee's right to continuity of care to be included in member contracts or certificates of coverage and to be provided, upon request, to an enrollee or prospective enrollee.

9 **Access to specialty care.** Amends § 62Q.58. Modifies provisions governing standing referrals to specialists.

Subd. 1. Standing referral. Requires health plan companies to grant standing referrals to specialists if appropriate. Also requires health plan company procedures for obtaining a standing referral to specify the managed care review and approval that must be obtained before a standing referral will be granted.

Subd. 1a. Mandatory standing referral. Requires health plan companies to grant standing referrals, upon request, to any enrollee with one of the following conditions: a chronic health condition, a life-threatening physical or mental illness, pregnancy after the first trimester, a degenerative disease or disability, or any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist. Specifies that this section does not affect a separate law permitting direct access to obstetricians and gynecologists.

Subd. 2. Coordination of services. Strikes language making a primary care provider responsible for coordinating the care of an enrollee with a standing referral, and prohibiting a specialist from making referrals without prior approval of the primary care provider. Permits a

specialist to whom an enrollee has a standing referral, in agreement with the enrollee and primary care provider, to authorize tests and services and make secondary referrals. Allows the health plan company to limit the primary care services, tests, and secondary referrals made by the specialist to those related to the condition for which the standing referral was made.

Subd. 3. Disclosure. No changes made to this subdivision.

Subd. 4. Referral. If a standing referral is authorized or mandatory, requires a health plan company to provide a referral to a reasonably available participating specialist or to a nonparticipating specialist, at no additional cost to the enrollee beyond what the enrollee would otherwise pay, if the health plan company does not have a reasonably available participating specialist.

10 **Coverage of clinical trials.** Requires the commissioners of health and commerce, in consultation with the commissioner of employee relations, to convene a work group to study health plan coverage of clinical trials. Specifies who must be included in the work group and what the work group must address. Requires the commissioners to submit findings and recommendations to the chairs of the health policy and finance committees in the Senate and House by January 15, 2002. Makes this section effective the day following final enactment.

11 **Quality of patient care.** Requires the commissioner of health to evaluate the feasibility of collecting data on the quality of patient care provided in hospitals, outpatient surgical centers, and other facilities, and requires distribution of a written report on the subject by January 15, 2002.

12 **Effective date.** Establishes effective dates:

sections 1 and 4 are effective for violations committed on or after August 1, 2001;2001;

section 5 is effective beginning with the report for the 2001 calendar year;year;

sections 3, 6 and 11 are effective the day following final enactment; andand

sections 8 and 9 are effective January 1, 2002 and apply to health plans issued oror renewed on or after that date.