Overview

This bill modifies provisions governing patient protections for health plan company enrollees. It requires the commissioners of health and commerce to divide half of any penalties obtained from health carriers or HMOs to affected enrollees, and it modifies provisions governing access to specialty care and continuity of care. Also, it requires coverage of patient costs for treatment provided in medical clinical trials.

1 **Violations and penalties.** Amends § 45.027, subd. 6. In a subdivision authorizing the commissioner of commerce to impose civil penalties for violations of laws, specifies that if the commissioner imposes a civil penalty on a health carrier, the commissioner must divide half of the penalty obtained among policy or certificate holders affected by the violation.

2 Amends § 62D.17, subd. 1. In a subdivision authorizing the commissioner of health to impose administrative penalties on a health maintenance organization for violations of laws, requires the commissioner to divide half of the penalty obtained among enrollees affected by the violation.

3 **Cost containment data from group purchasers.** Amends § 62J.38. In a section requiring group purchasers to submit specified cost containment data to the commissioner of health, requires expenditure data (one type of data that must be submitted) to distinguish between expenditures for patient care and expenditures for administrative costs. Also specifies what costs are considered administrative costs.

4 **Uniform explanation of benefits document.** Amends § 62J.51, by adding subd. 19a. Defines "uniform explanation of benefits document" as the document explaining the details of a group purchaser's claim adjudication, which is sent to a patient.

5 **Uniform remittance form advice report.** Amends § 62J.51, by adding subd. 19b. Defines "uniform remittance form advice report" as the document explaining the details of a group purchaser's claim adjudication, which is sent to a provider.

6 **Uniform billing form HCFA 1450.** Amends § 62J.52, subd. 1. Requires institutional and
noninstitutional home health services to be billed using the uniform billing form HCFA 1450, and adds certain home care services to the list of services that must be billed using that form.

7 **Uniform billing form HCFA 1500.** Amends § 62J.52, subd. 2. Removes certain home care services from the list of services that must be billed using the HCFA 1500 form.

8 **State and federal health care programs.** Amends § 62J.52, subd. 5. Requires personal care attendant and waivered services billed under fee-for-service to state and federal health care programs to use either the HCFA 1450 or the HCFA 1500 form, as designated by DHS. Strikes a reference to forms for child and teen checkup services.

9 **Standards for Minnesota uniform health care reimbursement documents.** Adds § 62J.581. Requires group purchasers and payers to provide a uniform remittance advice report to health care providers and a uniform explanation of benefits document to health care patients, and specifies standards for their use. States that the standards become effective 12 months after the date of required compliance with standards for the electronic remittance advice transaction under federal law, and apply regardless of when the health care service was provided.

10 **Minnesota health care identification card.** Amends § 62J.60, subd. 1. Exempts group purchasers from the requirement that they issue health care identification cards, if the requirements in § 62A.01, subdivisions 2 and 3 are met.

11 **Continuity of care.** Amends § 62Q.56. Modifies provisions governing the continuity of care.

   **Subd. 1. Change in health care provider.** Further specifies the conditions and procedures under which a health plan company must provide, upon request, a referral to a terminated provider for up to 120 days. This requirement applies in the case of treatment for an acute condition, a life-threatening mental or physical illness, pregnancy beyond the first trimester, or a disabling or chronic condition in an acute phase. The requirement also applies if the enrollee is receiving culturally appropriate services or does not speak English, and certain conditions related to lack of provider availability are met.

   **Subd. 2. Change in health plans.** Further specifies the conditions and procedures under which a health plan company must provide, upon request by an enrollee subject to a change in health plans, a referral to the enrollee's current provider for up to 120 days. This requirement applies in the case of treatment for an acute condition, a life-threatening mental or physical illness, pregnancy beyond the first trimester, or a disabling or chronic condition in an acute phase. The requirement also applies if the enrollee is receiving culturally appropriate services or does not speak English, and certain conditions related to lack of provider availability are met.

   **Subd. 2a. Limitations.** States that subdivisions 1 and 2 apply only if the health care provider agrees to accept the health plan company's payment rate as payment in full, adhere to prior authorization requirements, and provide the health plan company with necessary medical information. Also states that the section does not require a health plan company to provide coverage for a service or treatment not covered under the enrollee's health plan.

   **Subd. 3. Disclosure.** Requires information on enrollee rights under this section to be included in contracts or certificates of coverage, and provided upon request.

12 **Access to specialty care.** Amends § 62Q.58. Modifies the procedures under which an enrollee can apply for and receive a standing referral to a health care provider.

   **Subd. 1. Standing referral.** Requires the procedure for requesting a standing referral to specify the managed care review and approval an enrollee must obtain before such a referral is permitted.

   **Subd. 1a. Mandatory standing referral.** Specifies the conditions under which a health plan company must give an enrollee a standing referral to a specialist. This requirement applies if benefits for the treatment are provided under the health plan and the enrollee has an acute
condition, a life-threatening mental or physical illness, pregnancy beyond the first trimester, or a disabling or chronic condition in an acute phase.

**Subd. 2. Coordination of services.** Allows an enrollee with a standing referral to request that the specialist become the enrollee’s primary care provider, and allows the specialist to authorize tests and services and make secondary referrals.

**Subd. 3. Disclosure.** Requires information regarding referral procedures to be provided in direct marketing materials.

**13 Medical clinical trials.** Adds § 62Q.75. Requires coverage of patient costs for certain clinical trials.

**Subd. 1. Definitions.** Defines "patient cost" as the cost of a medically necessary health care service covered and provided by the health plan that would normally be provided to or be available to the patient, whether or not the patient participated in a clinical trial. Excludes specified costs from this definition.

**Subd. 2. Coverage required.** Requires a health plan company to cover patient costs incurred in a clinical trial for the treatment of a life-threatening condition or prevention, early detection, and treatment of cancer if: (1) the treatment is being provided or studies are being conducted as part of a phase III or phase IV clinical trial; (2) the clinical trial is approved by specified entities; (3) the proposed treatment has been reviewed and approved by a qualified institutional review board; and (4) the facility and personnel are providing treatment within their scope of practice, experience, and training.

**Subd. 3. Participating providers; cost sharing.** Allows a health plan company to require that a qualified individual participate in the trial through a participating provider, and allows the health plan company to apply cost-sharing requirements and other limitations.

**14 Quality of patient care.** Requires the commissioner of health to evaluate the feasibility of collecting data on the quality of patient care provided in health care facilities, and requires the commissioner to examine public and private sector roles and the need for risk adjustment. Requires the evaluation to consider mechanisms to identify the quality of nursing care and requires the plan to address issues related to the release of data to the public.

**15 Effective date.** States that sections 1 to 3 and 11 to 14 are effective for all new policies, contracts, or health benefit plans issued or renewed on or after January 1, 2001.