State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH SESSION

HOUSE FILE NO. 2432

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The bill was read for the first time and referred to the Committee on Health and Human Services

A bill for an act

relating to health; providing evidence-based health care guidelines; regulating provider performance evaluations; modifying voluntary purchasing pool requirements; requiring mediation therapy management care in certain situations; providing for health promotion and wellness; providing for the review of prior authorization procedures of certain entities; amending Minnesota Statutes 2006, sections 62J.60, by adding a subdivision; 62Q.17; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 145.

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

Section 1. **[62J.431] EVIDENCE-BASED HEALTH CARE GUIDELINES.**

Evidence-based guidelines must meet the following criteria:

(1) the scope and application are clear;

(2) authorship is stated and any conflicts of interest disclosed;

(3) authors represent all pertinent clinical fields or other means of input have been used;

(4) the development process is explicitly stated;

(5) the guideline is grounded in evidence;

(6) the evidence is cited and grated;

(7) the document itself is clear and practical;

(8) the document is flexible in use, with exceptions noted or provided for with general statements;

(9) measures are included for use in systems improvement; and

(10) the guideline has scheduled reviews and updating.

Sec. 2. Minnesota Statutes 2006, section 62J.60, is amended by adding a subdivision to read:

Subd. 3a. **Required statement.** An identification card issued to an enrollee by a health plan company or other entity governed by Minnesota health coverage laws must contain the following statement: "Subject to Minnesota law."

Sec. 3. **[62Q.101] EVALUATION OF PROVIDER PERFORMANCE.**

Subdivision 1. **Use of patient-paid charges.** A health plan company, or a vendor of risk management services as defined under section 60A.23, subdivision 8, shall not, in evaluating the performance of a health care provider, include patient-paid costs or charges as a factor in the performance evaluation.

Subd. 2. **Performance targets; reasonable basis and disclosure required.** A health plan company, or a vendor of risk management services as defined under section 60A.23, subdivision 8, shall, in evaluating the performance of a health care provider:

(1) conduct the evaluation using a bona fide baseline based upon practice experience of the provider group; and

(2) disclose the baseline to the health care provider in writing and prior to the beginning of the time period used for the evaluation.

Sec. 4. Minnesota Statutes 2006, section 62Q.17, is amended to read:

62Q.17 VOLUNTARY PURCHASING POOLS.

Subdivision 1. **Permission to form.** Notwithstanding section 62A.10, employers, groups, and individuals may voluntarily form purchasing pools, solely for the purpose of negotiating and purchasing health plan coverage from health plan companies for members of the pool.

Subd. 2. **Common factors.** All participants in a purchasing pool must live within a common geographic region, be employed in a similar occupation, or share some other common factor as approved by the commissioner of commerce. The membership criteria must not be designed to include disproportionately employers, groups, or individuals likely to have low costs of health coverage, or to exclude disproportionately employers, groups, or individuals likely to have high costs of health coverage.

Subd. 3. **Governing structure.** Each pool must have a governing structure controlled by its members. The governing structure of the pool is responsible for administration of the pool. The governing structure shall review and evaluate all bids for coverage from health plan companies, shall determine criteria for joining and leaving the pool, and may design incentives for healthy lifestyles and health promotion programs. The governing structure may design uniform entrance standards for all employers, except small employers as defined under section 62L.02. Small employers must be permitted to

enter any pool if the small employer meets the pool's membership requirements. Pools must provide as much choice in health plans to members as is financially possible. The governing structure may charge all members a fee for administrative purposes.

Subd. 4. **Enrollment.** Pools must have an annual open enrollment period of not less than 15 days, during which all individuals or groups that qualify for membership may enter the pool without any preexisting condition limitations or exclusions or exclusionary riders, except those permitted under chapter 62L for groups or section 62A.65 for individuals. Pools must reach and maintain an enrolled population of at least 1,000 members within ~~six months~~ one year of formation. If a pool fails to reach or maintain the minimum enrollment, all coverage subsequently purchased through the purchasing pool must be regulated through existing applicable laws and forego all advantages under this section.

Subd. 5. **Members.** The governing structure of the pool shall set a minimum time period for membership, which must be no less than five years. Members must stay in the purchasing pool for the entire minimum period to avoid paying a penalty. Penalties for early withdrawal from the purchasing pool shall be established by the governing structure.

Subd. 6. **Employer-based purchasing pools.** Employer-based purchasing pools must, with respect to small employers as defined in section 62L.02, meet all the requirements of chapter 62L. The experience of the pool must be pooled and the rates blended across all groups. Pools may decide to create tiers within the pool, based on experience of group members. These tiers must be designed within the requirements of section 62L.08. The governing structure may establish criteria limiting movement between tiers. ~~Tiers must be phased out within two years of the pool's creation.~~

Subd. 7. **Individual members.** Purchasing pools that contain individual members must meet all of the underwriting and rate restrictions found in the individual health plan market.

Subd. 8. **Reports.** Prior to the initial effective date of coverage, and annually on July 1 thereafter, each pool shall file a report with the ~~information clearinghouse and the~~ commissioner of commerce. ~~The information clearinghouse must use the report to promote the purchasing pools.~~ The annual report must contain the following information:

(1) the number of lives in the pool;

(2) the geographic area the pool intends to cover;

(3) the number of health plans offered;

(4) a description of the benefits under each plan;

(5) a description of the premium structure, including any co-payments or deductibles, of each plan offered;

(6) evidence of compliance with chapter 62L;

(7) a sample of marketing information, including a phone number where the pool may be contacted; and

(8) a list of all administrative fees charged.

Subd. 9. **Enforcement.** Purchasing pools must register prior to offering coverage, and annually on July 1 thereafter, with the commissioner of commerce on a form prescribed by the commissioner. The commissioner of commerce shall enforce this section and all other state laws with respect to purchasing pools, and has for that purpose all general rulemaking and enforcement powers otherwise available to the commissioner of commerce. The commissioner may charge an annual registration fee sufficient to meet the costs of the commissioner's duties under this section.

Subd. 10. **No effect on certain arrangements.** Nothing in this section precludes groups of employers, including businesses of one, from forming a multiple employer welfare arrangement under chapter 62H or a purchasing alliance under chapter 62T, or precludes such groups from using a combination of chapters 62H and 62T for joint pooling purposes. Those types of group arrangements are not subject to this section.

Sec. 5. **[62Q.676] MEDICATION THERAPY MANAGEMENT CARE.**

A pharmacy benefit manager that provides prescription drug services must provide medication therapy management services for enrollees taking four or more prescriptions to treat or prevent two or more chronic medical conditions. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a Minnesota licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(2) communicating essential information to the patient's other primary care providers; and

(3) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications.

Nothing in this section shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

Sec. 6. **[145.985] HEALTH PROMOTION AND WELLNESS.**

Community health boards as defined in section 145A.02, subdivision 5, shall work with schools, health care providers, and others to coordinate health and wellness programs

in their communities. In order to meet the requirements of this section, community health boards shall:

(1) provide instruction, technical assistance, and recommendations on how to evaluate project outcomes;

(2) assist with on-site health and wellness programs utilizing volunteers and others addressing health and wellness topics including smoking, nutrition, obesity, and others; and

(3) encourage health and wellness programs consistent with the Centers for Disease Control and Prevention's Community Guide and goals consistent with the Centers for Disease Control and Prevention's Healthy People 2010 initiative.

Sec. 7. **PRIOR AUTHORIZATION.**

Health plan companies and third party administrators, in cooperation with health care providers, shall review prior authorization procedures administered by utilization review organizations and health plan companies, to ensure the cost-effective use of prior authorization and minimization of provider, clinic, and central office administrative burden.