HOUSE RESEARCH

Bill Summary

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Subject: Patient Protection

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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, modifies requirements governing continuity of care and obtaining standing referrals to specialists, requires a study on data collection on quality of patient care, 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 **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.

3 **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. Specifies what constitutes administrative costs. Requires the reports to separately identify expenses for taxes, fees, and assessments, and to include payments made to acquire a health care facility and other payments made pursuant to a partnership or other agreement with a health care provider.

4 **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.

5 **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. 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. Specifies that termination includes nonrenewal of a contract.

Paragraph (b) provides additional detail as to when a health plan company must authorize services with a terminated 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 condition, 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.

Paragraph (d) allows health plan companies to require medical records and supporting documentation to be submitted, and requires health plan companies to explain the criteria used to deny an authorization and how continuity of care will be provided if authorization is granted.

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 for up to 120 days. Requires authorization for services if an enrollee is engaged in a current course of treatment for an acute condition, a life-threatening physical or mental condition, 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.

Paragraph (c) allows health plan companies to require medical records and supporting documentation to be submitted, and requires health plan companies to explain the criteria used to deny an authorization and how continuity of care will be provided if authorization is granted.

Subd. 2a. Limitations. Makes the requirements in subdivisions 1 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. 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.

6 **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 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.

7 **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.

8 **Effective date.** Establishes the following effective dates:

sections 1 and 2 are effective for violations committed on or after August 1, 2001;2001;

section 3 is effective beginning with the report for the 2001 calendar year;year;

sections 4 and 7 are effective the day following final enactment; andand

sections 5 and 6 are effective for health plans issued or renewed on or after JanuaryJanuary 1, 2002.