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Information Brief

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# MinnesotaCare 1993

## Summary of Major Provisions

This information brief provides an overview of the MinnesotaCare legislation of 1993 (Chapter 345; H.F. 1178/S.F. 900). The act incorporates many elements of the cost containment plan prepared by the Minnesota Health Care Commission, and also amends many provisions of the MinnesotaCare Act of 1992. This publication summarizes only the major provisions of the act; for more detailed information, refer to the act itself or to the House Research Department section by section act summary.

### Article 1

## Integrated Service Networks

**This article creates integrated service networks (ISNs), which are networks of health care providers that agree to provide health care for a fixed annual fee.**

**Starting date and regulation.** ISNs can begin operation July 1, 1994. The Commissioner of Health will regulate all ISNs. (Sections 1 and 5)

**Details of ISN organization.** ISNs may be operated by separate nonprofit corporations or cooperatives, or by units of local government. A nonprofit health carrier may establish an ISN without forming a separate corporation if certain conditions are met. (Section 7)

**1994 session.** The Commissioner of Health, in consultation with the Minnesota Health Care Commission, must recommend to the 1994 Legislature specific statutory language needed to regulate and facilitate the development of ISNs. (Section 1)

Article 2

# Regulated All-payer System

**This article requires the Commissioner of Health to develop an all-payer system to govern the provision of health care services outside of ISNs. Health carrier expenditure limits and health care provider revenue limits are established for the transition period prior to full implementation of the all-payer system.**

**Development of the all-payer system.** The Commissioner of Health, in consultation with the Minnesota Health Care Commission, must present recommendations for an all-payer system to the legislature by January 1, 1994. The all-payer system will control health care costs and utilization for services provided outside of ISNs. (Section 3)

**Phase-in of the all-payer system.** The act phases in the all-payer system over a two year period beginning July 1, 1994, with full implementation by July 1, 1996. During the transition period, the health carrier expenditure limits and health care provider revenue limits described immediately below apply. (Section 3)

**Expenditure and revenue limits.** The act requires the Commissioner of Health to establish limits on health carrier expenditures and health care provider revenues, for calendar years 1994 and 1995. These limits must be the same as the limits on the annual rate of growth in overall health care spending set by the commissioner in Article 3. The commissioner must monitor and enforce compliance with the limits. Health carrier reserves will also be monitored, and health carrier premium rates must be approved by the appropriate commissioner. (Sections 4 and 5)

Article 3

# Data Collection

**This article limits the overall rate of growth in health care spending, creates a data institute to collect encounter level data, and amends existing provisions related to data collection.**

**Growth limits.** The act sets limits on the annual rate of growth in health care spending for Minnesota residents for calendar years 1994 to 1997. The limits are based on the regional consumer price index for urban consumers, plus additional percentage points. (Section 2)

**Data institute.** The act establishes a public/private data institute to collect encounter level data from group purchasers, health care providers, and state agencies. (Section 15)

Article 4

# Technology Advisory Committee

## This article renames the Health Planning Advisory Committee and modifies the duties of the committee.

**Role of the Health Technology Advisory Committee.** This committee (formerly the Health Planning Advisory Committee) will conduct evaluations of existing research and technology assessments conducted by other entities and submit preliminary and final reports. (Various sections)

Article 5

# Miscellaneous

## This article contains miscellaneous provisions related to health care cost containment and other issues.

**Rate disclosure.** The act regulates disclosures by health carriers to policyholders regarding effects of statutory changes on premium rates. If a health carrier says that a new law has caused a rate increase, the health carrier must distinguish between increases caused by statutory changes and increases caused by medical inflation. (Section 4)

**Commission disclosure.** The act requires health insurance agents, including sellers of HMO coverage, to disclose their commission to prospective purchasers. (Sections 3 and 6)

**Generic drug substitution.** The act requires a pharmacist to dispense an equivalent less expensive generic drug if available, unless the prescriber specifically requires the prescription to be dispensed as written or unless the purchaser objects. (Section 10)

**Prohibiting gifts to practitioners.** The act prohibits any drug manufacturer or wholesale drug distributor from offering or giving any gift of value ($50 per calendar year) to a practitioner, with certain exceptions. (Section 11)

Article 6

## Cost Containment Amendments

**This article establishes procedures for obtaining exemptions from antitrust law and modifies cost containment provisions of the MinnesotaCare Act of 1992.**

**Antitrust applications.** This article outlines the criteria and procedures for reviewing and authorizing contracts and other business arrangements involving providers or purchasers that might be construed as violations of state and federal antitrust laws. (Sections 14-24)

Article 7

## Small Employer Insurance Reform

**This article amends certain provisions of the MinnesotaCare Act of 1992 that affect the small employer insurance market.**

**Participation and contribution requirements of employers.** This article amends and clarifies the effects of the contribution and participation requirements in the small employer market. These requirements determine whether an employer is guaranteed coverage in that market. (Section 4)

**Rate phase-in.** The act requires a phase-in over the next two policy years of rate changes due to MinnesotaCare statutory changes affecting the small employer insurance market. (Section 15)

Article 8

## Individual Market Reform; Miscellaneous

**This article amends provisions of the MinnesotaCare Act of 1992 that affect the individual insurance market or other insurance-related matters.**

**Loss ratios.** The act increases the loss ratio requirement by increasing loss ratios for two additional years, at a rate of one percent per year, resulting in a loss ratio of 82 percent for the small employer market in the year 2000, and 72 percent in the individual market in the year 2000. (Section 2)

**Rate phase-in.** The act requires a phase-in over the next two policy years of rate changes due to MinnesotaCare statutory changes affecting the individual insurance market. (Section 6)

## Article 9
# MinnesotaCare

**This article modifies covered services and eligibility requirements for the subsidized health insurance program administered by the Department of Human Services and established as part of the MinnesotaCare Act of 1992.**

**MinnesotaCare covered services.** The act makes the following changes:

- removes coverage for adult, non-preventive dental services;
- expands coverage for outpatient mental health services by removing the dollar cap and adding day treatment, partial hospitalization, and medication management by a physician[1] as covered services;
- adds hospice care as a covered service;
- removes the hour limit for alcohol and drug dependency services; and
- adds inpatient mental health and inpatient hospital and residential chemical dependency treatment as covered services. (Section 3)

**Eligibility for reduced MinnesotaCare premiums for children.** An annual premium of $48 per child is charged (rather than the standard sliding scale premium) for children age one and older who are from families with incomes that do not exceed 150 percent of poverty and who meet other eligibility requirements. (Sections 4 and 7)

**Persons potentially eligible ("bridging the gap").** Persons potentially eligible for Medical Assistance (MA) are allowed to enroll in MinnesotaCare for 60 days, but must apply for MA within this time period or face disenrollment. (Section 6)

**MA eligibility expansion to 275%.** The MA income eligibility standard for pregnant women and infants up to age one is raised from 185 percent to 275 percent of the federal poverty guidelines. (Section 11)

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[1]Medication management was added as a covered service in a separate technical corrections bill, chapter 366.

**MinnesotaCare budget.** Further enrollment in MinnesotaCare and hiring of additional staff by the Departments of Human Services and Health are prohibited unless a plan to balance the MinnesotaCare budget for the 1996-1997 biennium is approved by the 1994 Legislature. (Section 2)

### Article 10
## Rural Health Initiative

**This article amends provisions of the MinnesotaCare Act of 1992 related to programs to assist rural hospitals.**

**Rural hospital planning and transition grants.** The act reduces the maximum grant amount for this program (to allow more grants to be awarded). (Section 1)

### Article 11
## Health Professional Education

**This article establishes several new initiatives designed to increase the number of health care professionals practicing in rural areas and modifies provisions of the MinnesotaCare Act of 1992 related to health professional education.**

**Modifications to existing programs.** The act makes changes in loan forgiveness programs for physicians and nurses, and in the summer health care intern program. (Various sections)

**New initiatives.** The act establishes a physician loan forgiveness program based on the federal National Health Services Corps program, a grant program to establish rural clinical sites for nurse practitioner education, nurse practitioner promotion teams, and a physician loan forgiveness program for underserved urban areas. (Various sections)

### Article 12
## Data Research Initiatives

**This article modifies provisions of the MinnesotaCare Act of 1992 related to the Department of Health's responsibilities for data collection and research.**

**Definition of practice parameter.** This definition is modified to add parameters adopted by specific organizations. (Sections 1, 6)

**Data collection advisory committee.** The duties of this committee are transferred to the data institute by July 1, 1994. (Section 4)

## Article 13
# Financing

**This article modifies the gross revenues tax that finances MinnesotaCare. Its primary effect is to narrow or reduce the tax base.**

**Medical assistance (MA) reimbursement for drugs.** The article increases MA's reimbursement for prescription drugs by two percent. This will allow pharmacies to recover the wholesale drug distributor tax from the MA program. (Section 1)

**Exemptions.** This article adds new exemptions to the gross revenues tax:

- Ambulance services provided by organizations that only use volunteer attendants
- Medicare copayments, coinsurance, and deductibles, including payments made by Medicare supplemental insurance
- MinnesotaCare copayments, coinsurance, and deductibles
- Payments for patient services incidental to providing research
- Community mental health services. (Sections 13 and 14)

**Health maintenance organizations (HMOs).** The act eliminates HMOs as taxpayers under the gross revenues tax. Only "staff model health carriers," HMOs with providers as staff or employees, will pay the tax on the services their staff providers deliver. Other HMOs will be treated like insurance companies, as payers for health services, rather than as providers. (Sections 3, 4, and 9)

**Pharmacies.** This article imposes the provider tax on pharmacies' sales of medical supplies, appliances, and equipment. (Laws 1993, Special Session, Chapter 6, sections 19 to 30)

**Deduction for medical research.** Nonprofit and governmental hospitals and providers may deduct expenditures for qualifying research programs from their taxable gross revenues. (Section 17)