1.1 A bill for an act
1.2 relating to health; specifying certain aspects of prepaid health plan contracts
1.3 entered into by the commissioner of human services or county-based purchasing
1.4 plans; requiring use of certain accounting procedures; providing health care
1.5 providers and others a right to audit under those contracts; providing for
1.6 resolution of disputes; amending Minnesota Statutes 2008, section 256B.69,
1.7 subdivisions 5i, 9, by adding a subdivision.

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

1.9 Section 1. Minnesota Statutes 2008, section 256B.69, subdivision 5i, is amended to
1.10 read:

1.11 Subd. 5i. **Administrative expenses.** (a) Managed care plan and county-based
1.12 purchasing plan administrative costs for a prepaid health plan provided under this section
1.13 or section 256B.692 must not exceed by more than five percent that prepaid health plan's
1.14 or county-based purchasing plan's actual calculated administrative spending for the
1.15 previous calendar year as a percentage of total revenue. The penalty for exceeding this
1.16 limit must be the amount of administrative spending in excess of 105 percent of the actual
1.17 calculated amount. The commissioner may waive this penalty if the excess administrative
1.18 spending is the result of unexpected shifts in enrollment or member needs or new program
1.19 requirements.

1.20 (b) Expenses listed under section 62D.12, subdivision 9a, clause (4), are not
1.21 allowable administrative expenses for rate-setting purposes under this section, unless
1.22 approved by the commissioner.

1.23 (c) A prepaid health plan must meet a loss ratio of not less than 93.5 percent,
1.24 calculated as specified in this paragraph. The loss ratio consists of a numerator consisting
1.25 only of direct expenses of providing patient care to persons covered under the program,

2.1 excluding administrative expenses. The denominator consists of the total amount paid by
2.2 the commissioner to the prepaid health plan, after subtraction of taxes and other mandatory
2.3 government assessments directly attributable to the plan's participation as a provider in
2.4 the program being reported on. Payments by the prepaid health plan to unaffiliated third
2.5 parties or to providers or other entities that own, are owned by, or are under common
2.6 control with the plan must be divided into patient care expenses and administrative
2.7 expenses and included in the appropriate category for determination of the loss ratio.
2.8 (d) A bid submitted by a prepaid health plan may include a provision obligating the
2.9 bidder to provide free services to uninsured, low-income persons as specified in the bid
2.10 if necessary to meet the required loss ratio, to the extent that the loss ratio for that year
2.11 would otherwise not reach 93.5 percent.
2.12 (e) Nothing in this subdivision requires the minimum loss ratio to be applied to any
2.13 plan's business other than that business awarded by the commissioner, unless the plan fails
2.14 to keep a separate and distinct accounting of funds received from the commissioner.

2.15 **EFFECTIVE DATE.** This section is effective January 1, 2011.

2.16 Sec. 2. Minnesota Statutes 2008, section 256B.69, subdivision 9, is amended to read:
2.17 Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as
2.18 required by the commissioner, including data required for assessing client satisfaction,
2.19 quality of care, cost, and utilization of services for purposes of project evaluation. The
2.20 commissioner shall also develop methods of data reporting and collection in order to
2.21 provide aggregate enrollee information on encounters and outcomes to determine access
2.22 and quality assurance. Required information shall be specified before the commissioner
2.23 contracts with a demonstration provider.
2.24 (b) Aggregate nonpersonally identifiable health plan encounter data, aggregate
2.25 spending data for major categories of service as reported to the commissioners of
2.26 health and commerce under section 62D.08, subdivision 3, clause (a), and criteria for
2.27 service authorization and service use are public data that the commissioner shall make
2.28 available and use in public reports. The commissioner shall require each health plan and
2.29 county-based purchasing plan to provide:
2.30 (1) encounter data for each service provided, using standard codes and unit of
2.31 service definitions set by the commissioner, in a form that the commissioner can report by
2.32 age, eligibility groups, and health plan; and
2.33 (2) criteria, written policies, and procedures required to be disclosed under section
2.34 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used
2.35 for each type of service for which authorization is required.

3.1 (c) All financial reporting, including reporting of administrative expenses, under this
3.2 section must be reported in compliance with generally accepted accounting principles.
3.3 If the commissioner believes this paragraph would violate federal regulations, the
3.4 commissioner shall promptly seek a federal waiver to permit the state to comply with
3.5 this paragraph. The commissioner may accept donations to cover the cost of the waiver
3.6 application.

3.7 **EFFECTIVE DATE.** This section is effective January 1, 2011.

3.8 Sec. 3. Minnesota Statutes 2008, section 256B.69, is amended by adding a subdivision
3.9 to read:

3.10 Subd. 9c. **Rights to audit related to the loss ratio.** (a) Within 90 days after the
3.11 end of each calendar year, each managed care plan used by the commissioner to provide
3.12 services under this section shall furnish to each provider that furnished services during
3.13 the calendar year under a contract with the plan a Web-based statement in reasonable
3.14 detail setting forth the computation of the total costs and expenses used in the calculation
3.15 of the minimum loss ratio as well as the amount of administrative expenses incurred in
3.16 the prior calendar year.

3.17 (b) Any provider or group of providers may, at its expense and after 14 days' written
3.18 notice, audit and inspect all records of the managed care plan relating to the costs and
3.19 expenses which are used in the calculation of the minimum loss ratio, provided that at
3.20 the end of 24 months following the end of any calendar year the plan's records shall be
3.21 deemed to be conclusive, and the providers have no further rights to audit and inspect
3.22 them with regard to that calendar year.

3.23 (c) In the event that an audit or inspection determines that a plan failed to satisfy the
3.24 93.5 percent loss ratio requirement, the following shall apply:

3.25 (1) the plan shall make a payment to the commissioner equal to the amount by which
3.26 the plan failed to satisfy the minimum loss ratio, to be deposited in the fund from which the
3.27 payments to the plan were made, as determined by the commissioner. If the commissioner
3.28 cannot specify the fund, the payment shall be deposited in the health care access fund; and

3.29 (2) if the plan falls two percentage points or more short of satisfying the 93.5
3.30 percent minimum loss ratio, the plan shall reimburse the provider or group of providers
3.31 for reasonable costs incurred for the audit or inspection.

3.32 (d) No plan used by the commissioner may require any provider to waive this right
3.33 to audit as a condition of participation with the plan. No plan may retaliate against any
3.34 provider for exercising any rights related to the audit described in this subdivision.

4.1 (e) If a plan and a provider or group of providers disagree regarding the result of
4.2 an audit or inspection of records conducted under this subdivision, the commissioner
4.3 shall refer the dispute to the attorney general for resolution. Each party shall pay its own
4.4 expenses in connection with the process of resolving the dispute.

4.5 (f) An enrollee or group of enrollees has the right to conduct an audit and inspection
4.6 of a plan's records on the same basis granted under this subdivision to health care providers.

4.7 (g) The commissioner shall describe the requirements of this subdivision in any
4.8 request for proposal for services to which this subdivision applies.

4.9 **EFFECTIVE DATE.** This section is effective January 1, 2011.