percentage pursuant to section 2 of this article, shall be added to the cash metering system, according to Minnesota Statutes, section 124.195, after January 15, 1985, and shall be paid in a manner consistent with the percentage specified in that section.

Sec. 12. **CASH FLOW EVALUATION.**

The commissioner of finance, in cooperation with the commissioner of education and the Minnesota association of school business officials, shall evaluate the impact on school districts of the cash flow provisions of Minnesota Statutes, chapter 124. The commissioner shall report the findings, along with recommendations, to the education committees of the legislature by February 15, 1985.

Sec. 13. **REPEALER.**

Minnesota Statutes 1982, sections 124.246, subdivision 5; 124.26, subdivision 5; 124.572, subdivision 8a; 124.573, subdivision 6; and 124.574, subdivision 8, are repealed. Minnesota Statutes 1983 Supplement, sections 124.225, subdivision 12; and 124.271, subdivision 6, are repealed.

Sec. 14. **APPROPRIATION.**

The appropriation for payment of support services for hearing impaired persons, according to Laws 1983, chapter 314, article 3, section 19, subdivision 8, for fiscal year 1985 is increased by $6,000, from $37,000 to $43,000.

Sec. 15. **EFFECTIVE DATE.**

Sections 1 and 9 are effective the day following final enactment. Section 3 is effective the day following final enactment and shall apply to the adjustment made pursuant to Minnesota Statutes, section 124.155 in fiscal year 1984 and thereafter.

Approved April 24, 1984

CHAPTER 464 — H.F.No. 1561

An act relating to health; health maintenance organizations; providing continued coverage upon replacement of an insurance carrier; including health maintenance organization contracts in certain statutorily mandated coverages; providing for the disclosure and reporting by the organization of detailed financial, administrative and ownership information; providing for reporting of changes in provider agreements; granting the commissioner authority to adopt rules regarding the content of provider and other agreements; requiring certain deposits against insolvency; authorizing organizations to enter into certain health services contracts; requiring certain consumer rights information in evidences of coverage and

annual information statements; providing for reimbursement of, and direct payments to, enrollees; providing for examination by the commissioner of health; specifying the examination powers of the commissioner; classifying certain data used for review purposes; prescribing penalties; amending Minnesota Statutes 1982, sections 60A.082; 62A.041; 62A.042; 62A.044; 62A.14; 62A.147; 62D.02, subdivision 8, and by adding subdivisions; 62D.04; 62D.05, subdivision 3; 62D.07, subdivisions 1, 3, and by adding subdivisions; 62D.08, subdivisions 1, 3, and by adding subdivisions; 62D.09; 62D.10, subdivision 3, and by adding a subdivision; 62D.101, subdivisions 2 and 2a; 62D.12, subdivisions 1, 2, 4, 9, 10, and by adding subdivisions; 62D.14; 62D.15, subdivision 1; 62D.17, subdivisions 1 and 4; 62D.19; 62D.22, subdivision 5, and by adding a subdivision; amending Minnesota Statutes 1983 Supplement, sections 62A.17, subdivision 6; 62D.03, subdivision 4; proposing new law coded in Minnesota Statutes, chapter 62D; repealing Minnesota Statutes 1982, sections 62D.10, subdivision 2; 62D.12, subdivision 7; 62D.22, subdivision 9; and 62D.27.

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

Section 1. Minnesota Statutes 1982, section 60A.082, is amended to read:

60A.082 **GROUP INSURANCE; BENEFITS CONTINUED IF INSURER CHANGED.**

A person covered under group life, group accidental death and dismemberment, group disability income or group medical expense insurance, shall not be denied benefits to which he is otherwise entitled solely because of a change in the insurance company writing the coverage or in the group contract applicable to the person. In the case of one or more carriers replacing or remaining in place after one or more plans have been discontinued, each carrier shall accept any person who was covered under the discontinued plan or plans without denial of benefits to which other persons in the group covered by that carrier are entitled. "Insurance Company" shall include a service plan corporation under chapter 62C or 62D.

The commissioner shall promulgate rules to carry out this section. Nothing in this section shall preclude an employer, union or association from reducing the level of benefits under any group insurance policy or plan.

Sec. 2. Minnesota Statutes 1982, section 62A.041, is amended to read:

62A.041 **MATERNITY BENEFITS; UNMARRIED WOMEN.**

Each group policy of accident and health insurance issued or renewed after June 4, 1971, and each group health maintenance contract issued or renewed after the effective date of this section shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each group policy issued or renewed after July 1, 1976, and each group contract issued or renewed after the effective date of this section shall

provide the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Each individual policy of accident and health insurance and each individual health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each individual policy issued or renewed after July 1, 1976, and each individual contract issued or renewed after the effective date of this section shall also provide the same coverage for that child as that provided for the child of a married insured or a married enrollee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

Sec. 3. Minnesota Statutes 1982, section 62A.042, is amended to read:

62A.042 **FAMILY COVERAGE; COVERAGE OF NEWBORN INFANTS.**

Subdivision 1. **INDIVIDUAL FAMILY POLICIES; RENEWALS.** No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), and no individual health maintenance contract which provides for coverage for more than one person under chapter 62D, shall be renewed to insure or cover any person in this state or be delivered or issued for delivery to any person in this state unless such policy or contract includes as insured or covered members of the family any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation or premature birth.

Subd. 2. **GROUP POLICIES; RENEWALS.** No group accident and sickness insurance policy and no group health maintenance contract which ~~provides~~ provide for coverage of family members or other dependents of an employee or other member of the covered group shall be renewed to cover members of a group located in this state or delivered or issued for delivery in this state unless such policy or contract includes as insured or covered family members or dependents any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation or premature birth.

Sec. 4. Minnesota Statutes 1982, section 62A.044, is amended to read:

62A.044 **PAYMENTS TO GOVERNMENTAL INSTITUTIONS.**

No group or individual policy of accident and sickness insurance issued or renewed after May 22, 1973 pursuant to this chapter, ~~and~~ no group or individual service plan or subscriber contract issued or renewed after May 22, 1973 pursuant to chapter 62C, and no group or individual health maintenance contract issued or renewed after the effective date of this section pursuant to chapter 62D, shall contain any provision denying or prohibiting payments for covered and authorized services rendered by a hospital or medical institution owned or operated by the federal, state, or local government or practitioners therein in any instance wherein charges for such services are imposed against the policy holder ~~or~~, subscriber, or enrollee. The unit of government operating the institution may maintain an action for recovery of such charges.

Sec. 5. Minnesota Statutes 1982, section 62A.14, is amended to read:

62A.14 **HANDICAPPED CHILDREN.**

Subdivision 1. **INDIVIDUAL FAMILY POLICIES.** An individual hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or an individual health maintenance contract delivered or issued for delivery in this state after the effective date of this section, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or health maintenance organization by the policyholder or enrollee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two year period following the child's attainment of the limiting age.

Subd. 2. **GROUP POLICIES.** A group hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or a group health maintenance contract delivered or issued for delivery in this state after the effective date of this section, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or

organization by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two year period following the child's attainment of the limiting age.

Sec. 6. Minnesota Statutes 1982, section 62A.147, is amended to read:

62A.147 **DISABLED EMPLOYEES' BENEFITS; DEFINITIONS.**

Subdivision 1. For the purposes of this section and section 62A.148, the terms defined in this section shall have the meanings here given them.

Subd. 2. "Covered employee" means any person who, at the time he suffered an injury resulting in total disability or became totally disabled by reason of illness, was employed by and receiving a salary, commission, hourly wage, or other remuneration for his services by any employer providing, offering or contributing to group insurance coverage or group coverage through a health maintenance contract, for that employee who was so enrolled for the coverage.

Subd. 3. "Total disability" means (a) the inability of an injured or ill employee to engage in or perform the duties of his regular occupation or employment within the first two years of such disability and (b) after the first two years of such disability, the inability of the employee to engage in any paid employment or work for which he may, by his education and training, including rehabilitative training, be or reasonably become qualified.

Subd. 4. "Group insurance" means any policy or contract of accident and health protection, including health maintenance contracts, regardless of by whom underwritten, which provides benefits, including cash payments for reimbursement of expenses or the provision of usual needed health care and medical services as the result of any injury, sickness, disability or disease suffered by a group of employees, or any one of them, and which protection is paid for or otherwise provided in full or in part by an employer.

Subd. 5. "Employer" means any natural person, company, corporation, partnership, association, firm, or franchise which employs any employee.

Subd. 6. "Insurer" means any person, company, corporation including a nonprofit corporation and a health maintenance organization, partnership, association, firm or franchise which underwrites or is by contract or other agreement obligated to provide accident and health protection benefits to any group of employees of any employer.

Sec. 7. Minnesota Statutes 1983 Supplement, section 62A.17, subdivision 6, is amended to read:

Subd. 6. **CONVERSION TO INDIVIDUAL POLICY.** A group insurance policy that provides post termination or lay off coverage as required by this section shall also include a provision allowing a covered employee, surviving

spouse, or dependent at the expiration of the post termination or lay off coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3. A health maintenance contract issued by a health maintenance organization that provides post-termination or layoff coverage as required by this section shall also include a provision allowing a former employee, surviving spouse, or dependent at the expiration of the post-termination or layoff coverage provided in subdivision 2 to obtain from the health maintenance organization, at the former employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual health maintenance contract. Effective January 1, 1985, enrollees who have become nonresidents of the health maintenance organization's service area shall be given the option, to be arranged by the health maintenance organization, of a number three qualified plan, a number two qualified plan, or a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3 if an arrangement with an insurer can reasonably be made by the health maintenance organization. This option shall be made available at the enrollee's expense, without further evidence of insurability and without interruption of coverage.

A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse, or a dependent in lieu of the optional coverage otherwise required by this subdivision.

The individual policy or contract shall be renewable at the option of the individual as long as the individual is not covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under title XVIII of the Social Security Act, as amended. Any revisions in the table of rate for the individual policy shall apply to the covered person's original age at entry and shall apply equally to all similar policies issued by the insurer.

Sec. 8. Minnesota Statutes 1982, section 62D.02, subdivision 8, is amended to read:

Subd. 8. "Health maintenance contract" means any contract whereby a health maintenance organization agrees to provide comprehensive health maintenance services to enrollees, provided that the contract may contain reasonable enrollee copayment provisions. Copayment provisions in group contracts shall not discriminate on the basis of age, sex, race, length of enrollment in the plan, or economic status; and during every open enrollment period in which all offered health benefit plans, including those subject to the jurisdiction of the commission-

ers of commerce or health, fully participate without any underwriting restrictions, copayment provisions shall not discriminate on the basis of preexisting health status. In no event shall the annual copayment exceed the maximum out-of-pocket expenses allowable for a number three qualified insurance policy under section 62E.06. Where sections 62D.01 to 62D.30 permit a health maintenance organization to contain reasonable copayment provisions for preexisting health status, these provisions may vary with respect to length of enrollment in the plan. Any contract may provide for health care services in addition to those set forth in subdivision 7.

Sec. 9. Minnesota Statutes 1982, section 62D.02, is amended by adding a subdivision to read:

Subd. 12. "Participating entity" means any of the following persons, providers, companies, or other organizations with which the health maintenance organization has contracts or other agreements:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.11, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner of health;

(2) a health care professional licensed under health-related licensing boards, as defined in section 214.01, subdivision 2, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner of health;

(3) a group, professional corporation, or other organization which provides the services of individuals or entities identified in (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) any person or organization providing administrative, financial, or management services to the health maintenance organization if the total payment for all services exceeds three percent of the gross revenues of the health maintenance organization.

"Participating entity" does not include (a) another health maintenance organization with which a health maintenance organization has made contractual arrangements or (b) any entity with which a health maintenance organization has contracted primarily in order to purchase or lease equipment or space or (c) employees of the health maintenance organization or (d) employees of any participating entity identified in clause (3) of this subdivision.

Sec. 10. Minnesota Statutes 1982, section 62D.02, is amended by adding a subdivision to read:

Subd. 13. "Major participating entity" shall include the following:

(1) a participating entity that receives from the health maintenance organization as compensation for services a sum greater than 30 percent of the health maintenance organization's gross annual revenues;

(2) a participating entity providing administrative, financial, or management services to the health maintenance organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health maintenance organization;

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors of the health maintenance organization.

Sec. 11. Minnesota Statutes 1982, section 62D.02, is amended by adding a subdivision to read:

Subd. 14. "Separate health services contracts" means prepaid dental services contracts and other similar types of prepaid health services agreements in which services are provided by participating entities or employees of the health maintenance organization, but does not include contracts subject to chapter 62A or 62C.

Sec. 12. Minnesota Statutes 1983 Supplement, section 62D.03, subdivision 4, is amended to read:

Subd. 4. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, and shall be in a form prescribed by the commissioner of health. Each application shall include the following:

(a) a copy of the basic organizational document, if any, of the applicant and of each major participating entity; such as the articles of incorporation, or other applicable documents, and all amendments thereto;

(b) a copy of the bylaws, rules and regulations, or similar document, if any, and all amendments thereto which regulate the conduct of the affairs of the applicant and of each major participating entity;

(c) a list of the names, addresses, and official positions of the following ~~persons~~:

~~All members of the board of directors or governing body of the local governmental unit, and the principal officers of the organization; which shall contain a full disclosure in the application of the extent and nature of any contract or financial arrangements between them and the health maintenance organization, including a full disclosure of any financial arrangements between them and any provider or other person concerning any financial relationship with the health maintenance organization;~~

(1) all members of the board of directors, or governing body of the local government unit, and the principal officers and shareholders of the applicant organization; and

(2) all members of the board of directors, or governing body of the local government unit, and the principal officers of the major participating entity and each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

The commissioner may by rule identify persons included in the term "principal officers";

(d) a full disclosure of the extent and nature of any contract or financial arrangements between the following:

(1) the health maintenance organization and the persons listed in clause (c)(1);

(2) the health maintenance organization and the persons listed in clause (c)(2);

(3) each major participating entity and the persons listed in clause (c)(1) concerning any financial relationship with the health maintenance organization; and

(4) each major participating entity and the persons listed in clause (c)(2) concerning any financial relationship with the health maintenance organization;

(e) the name and address of each participating entity and the agreed upon duration of each contract or agreement;

(f) a copy of the form of each contract binding the participating entities and the health maintenance organization. Contractual provisions shall be consistent with the purposes of sections 62D.01 to 62D.29 in regard to the services to be performed under the contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health maintenance organization, the nature and extent of risk sharing permissible, and contractual termination provisions;

(g) a copy of each contract binding major participating entities and the health maintenance organization. Upon the request of the health maintenance organization, contract information filed with the commissioner may be nonpublic and subject to the provisions of section 13.37, subdivision 1(b).

Upon initial filing of each contract, the health maintenance organization shall file a separate document detailing the projected annual expenses to the major participating entity in performing the contract and the projected annual revenues received by the entity from the health maintenance organization for such performance. The commissioner shall disapprove any contract with a major participating entity if the contract will result in an unreasonable expense under

section 62D.19. The commissioner shall notify a major participating entity within 30 days if a contract may be disapproved.

Within 120 days of the anniversary of the implementation of each contract, the health maintenance organization shall file a document detailing the actual expenses incurred by the major participating entity in performing the contract in the preceding year and the actual revenues received from the health maintenance organization by the entity in payment for the performance.

Contracts implemented prior to the effective date of this subdivision shall be filed within 90 days of such effective date. Commencing with the next anniversary of the implementation of each of these contracts immediately following filing, the health maintenance organization shall, as otherwise required by this subdivision, file annual actual expenses and revenues. These contracts are subject to the provisions of section 62D.19, but are not subject to the prospective review prescribed by this clause, unless or until the terms of the contract are modified.

~~(d)~~ (h) a statement generally describing the health maintenance organization, its health ~~care plan or plans~~ maintenance contracts and separate health service contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide enrollees with comprehensive health maintenance services and separate health services;

~~(e)~~ (i) a copy of the form of each evidence of coverage to be issued to the enrollees;

~~(f)~~ (j) a copy of the form of each individual or group health maintenance contract and each separate health service contract which is to be issued to enrollees or their representatives;

~~(g)~~ (k) financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement may be deemed to satisfy this requirement;

~~(h)~~ ~~(1)~~ (l) a description of the proposed method of marketing the plan, ~~(2)~~ a schedule of proposed charges, and ~~(3)~~ a financial plan which includes a three year projection of the expenses and income and other sources of future capital;

~~(i)~~ (m) a statement reasonably describing the geographic area or areas to be served and the type or types of enrollees to be served;

~~(j)~~ (n) a description of the complaint procedures to be utilized as required under section 62D.11;

~~(k)~~ (o) a description of the procedures and programs to be implemented to meet the requirements of section 62D.04, subdivision 1, clauses (b) and (c) and to monitor the quality of health care provided to enrollees;

~~(l)~~ (p) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 62D.06;

(q) a copy of any agreement between the health maintenance organization and an insurer or nonprofit health service corporation regarding reinsurance, stop-loss coverage, or any other type of coverage for potential costs of health services, as authorized in section 62D.04, subdivision 1(f) and section 62D.13; and

~~(m)~~ (r) other information as the commissioner of health may reasonably require to be provided.

Sec. 13. Minnesota Statutes 1982, section 62D.04, is amended to read:

62D.04 **ISSUANCE OF CERTIFICATE AUTHORITY.**

Subdivision 1. Upon receipt of an application for a certificate of authority, the commissioner of health shall determine whether the applicant for a certificate of authority has:

(a) Demonstrated the willingness and potential ability to assure that health care services will be provided in such a manner as to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(b) Arrangements for an ongoing evaluation of the quality of health care;

(c) A procedure to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the quality, availability and accessibility of its services, and such other matters as may be reasonably required by regulation of the commissioner of health;

(d) Reasonable provisions for emergency and out of area health care services;

(e) Demonstrated that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner of health may consider ~~either the standards of clauses (1) and (2), or the standards of clauses (3) and (4), whichever the applicant shall elect~~:

(1) the financial soundness of its arrangements for health care services and the proposed schedule of charges used in connection therewith;

(2) the adequacy of its working capital;

(3) arrangements which will guarantee for a reasonable period of time the continued availability or payment of the cost of health care services in the event of discontinuance of the health maintenance organization; ~~and~~

(4) agreements with providers for the provision of health care services; and

(5) any deposit of cash or securities submitted in accordance with section 19.

(f) Demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care; provided, however, that the requirement in this paragraph shall not prohibit a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds $5,000 in any year, (ii) for the cost of providing comprehensive health care services to its members on a non-elective emergency basis, or while they are outside the area served by the organization, or (iii) for not more than 95 percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed 105 percent of its income for such fiscal years; and

(g) Otherwise met the requirements of sections 62D.01 to 62D.29.

Subd. 2. Within 90 days after the receipt of the application for a certificate of authority, the commissioner of health shall determine whether or not the applicant meets the requirements of this section. If the commissioner of health determines that the applicant meets the requirements of sections 62D.01 to 62D.29, he shall issue a certificate of authority to the applicant. If the commissioner of health determines that the applicant is not qualified, he shall so notify the applicant and shall specify the reason or reasons for such disqualification.

Subd. 3. Except as provided in section 62D.03, subdivision 2, no person who has not been issued a certificate of authority shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts or literature. Provided, however, that persons who are operating under a contract with, operating in association with, enrolling enrollees for, or otherwise authorized by a health maintenance organization licensed under sections 62D.01 to 62D.29 to act on its behalf may use the terms "health maintenance organization" or "HMO" for the limited purpose of denoting or explaining their association or relationship with the authorized health maintenance organization. No health maintenance organization which has a minority of consumers as members of its board of directors shall use the words "consumer controlled" in its name or in any way represent to the public that it is controlled by consumers.

Subd. 4. Upon being granted a certificate of authority to operate as a health maintenance organization, the organization must continue to operate in compliance with the standards set forth in subdivision 1. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority, in accordance with sections 62D.15 to 62D.17.

Sec. 14. **[62D.041] PROTECTION AGAINST INSOLVENCY.**

Subdivision 1. **DEFINITION.** For the purposes of this section, the term "uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency, including out-of-area services, referral services, and any other expenditures for health care services for which the health maintenance organization is at risk.

Subd. 2. **REQUIRED DEPOSIT.** Unless otherwise provided in this section, each health maintenance organization shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, freely alienable securities, or any combination of these or other measures that is acceptable to the commissioner in the amount set forth in this section. If a health maintenance organization does not have the required reserves or its reserves are not properly computed, operations shall be adjusted to correct the condition, according to a written plan proposed by the health maintenance organization and approved by the commissioner. If a health maintenance organization does not propose measures to correct its reserves or surplus within a reasonable time, if a corporation violates the plan which has been approved, or if there is evidence that an improper reserve or surplus status cannot be corrected within a reasonable time, the commissioner of commerce may take action against the corporation under chapter 60B.

Subd. 3. **AMOUNT FOR BEGINNING ORGANIZATIONS.** The amount for an organization that is beginning operation shall be the greater of: (a) five percent of its estimated expenditures for health care services for its first year of operation; (b) twice its estimated average monthly uncovered expenditures for its first year of operation; or (c) $100,000.

At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the organization or trustee, cash, freely alienable securities, or any combination of these or other measures acceptable to the commissioner in an amount equal to four percent of its estimated annual uncovered expenditures for that year.

Subd. 4. **AMOUNT FOR EXISTING ORGANIZATIONS.** Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to the larger of:

(a) one percent of the preceding 12 months' uncovered expenditures; or

(b) $100,000 on the first day of the fiscal year beginning six months or more after the effective date of this section.

In the second fiscal year, if applicable, the amount of the additional deposit shall be equal to two percent of its estimated annual uncovered expenditures. In the third year, if applicable, the additional deposit shall be equal to

three percent of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit shall be equal to four percent of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.

Subd. 5. **WAIVER.** The commissioner may waive any of the deposit requirements set forth in subdivisions 2 and 3 whenever satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, hospital, or medical service corporations, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

Subd. 6. **FINANCIAL EXEMPTIONS.** When an organization has achieved a net worth not including land, buildings, and equipment of at least $1,000,000 or has achieved a net worth including organization-related land, buildings, and equipment of at least $5,000,000, the annual deposit requirement does not apply.

The annual deposit requirement does not apply to an organization if the total amount of the accumulated deposit is equal to 25 percent of its estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation for admittance of an accident and health insurer in this state, whichever is less.

If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including land, buildings, and equipment of at least $1,000,000 or which has been in operation for at least ten years and has a net worth including organization-related land, buildings, and equipment of at least $5,000,000, the annual deposit requirement does not apply. If the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by $400,000 not including organization-related land, buildings, and equipment, for each additional organization, for guaranteeing organizations that have been in operation for at least five years, and by $2,000,000 including organization-related land, buildings, and equipment, for each additional organization, for guaranteeing organizations that have been in operation for at least ten years. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer does not apply during any time that the guaranteeing organization maintains for each organization it sponsors a net worth at least equal to the capital and surplus requirements for an accident and health insurer.

Subd. 7. **CONTROL OF OVER DEPOSITS.** All income from deposits shall belong to the depositing organizations and shall be paid to it as it becomes

available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, freely alienable securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

Subd. 8. **REDUCTION BY COMMISSIONER.** In any year in which an annual deposit is not required of an organization's request the commissioner shall reduce the required, previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section.

Sec. 15. Minnesota Statutes 1982, section 62D.05, subdivision 3, is amended to read:

Subd. 3. A health maintenance organization may contract with providers of health care services to render the services the health maintenance organization has promised to provide under the terms of its health maintenance contracts, may, subject to section 62D.12, subdivision 11, enter into separate prepaid dental contracts, or other separate health service contracts, may, subject to the limitations of section 62D.04, subdivision 1, clause (f), contract with insurance companies and nonprofit health service plan corporations for insurance, indemnity or reimbursement of its cost of providing health care services for enrollees or against the risks incurred by the health maintenance organization, and may contract with insurance companies and nonprofit health service plan corporations to insure or cover the enrollees' costs and expenses in the health maintenance organization, including the customary prepayment amount and any co-payment obligations.

Sec. 16. Minnesota Statutes 1982, section 62D.07, subdivision 1, is amended to read:

Subdivision 1. Every enrollee residing in this state is entitled to evidence of coverage under a health ~~care plan~~ maintenance contract. The health maintenance organization or its designated representative shall issue the evidence of coverage.

Sec. 17. Minnesota Statutes 1982, section 62D.07, subdivision 3, is amended to read:

Subd. 3. An evidence of coverage shall contain:

(a) No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which are untrue, misleading or deceptive as defined in section 62D.12, subdivision 1; and

(b) A clear, concise and complete statement of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health ~~care~~ ~~plan~~ maintenance contract;

(2) Any exclusions or limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(3) Where and in what manner information is available as to how services, including emergency and out of area services, may be obtained;

(4) The total amount of payment and copayment, if any, for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates; and

(5) A description of the health maintenance organization's method for resolving enrollee complaints and a statement identifying the commissioner as an external source with whom grievances may be registered.

(c) On the cover page of the evidence of coverage, a clear and complete statement of enrollees' rights as consumers, including but not limited to a description of each of the following:

(1) based upon the delivery system of each health maintenance organization, a statement which describes any type of health care professional as defined in section 145.61, whose services may be available only by referral of the health maintenance organization's participating staff;

(2) the right to available and accessible services which can be secured as promptly as appropriate for the symptoms presented, in a manner which assures continuity and, when medically necessary, the right to emergency services available 24 hours a day and 7 days a week;

(3) the consumer's right to be informed of his or her health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;

(4) the right to refuse treatment;

(5) the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law;

(6) the right to file a grievance with the health maintenance organization and the commissioner when experiencing a problem with the health maintenance organization or its health care providers;

(7) the right to initiate a legal proceeding when dissatisfied with the health maintenance organization's final determination regarding a grievance;

(8) the right of the enrollee and his or her dependents to continue group coverage in the event the enrollee is terminated or laid off from employment, provided that the cost of such coverage is paid by the enrollee and furthermore, the right of the enrollee to convert to an individual contract at the end of the continuation period;

(9) the right for notification of enrollees regarding the cancellation or termination of contracts with participating primary care professionals, and the right to choose from among remaining participating primary care professionals;

(10) the right to cancel an individual health maintenance contract within ten days of its receipt and to have premiums paid refunded if, after examination of the contract, the individual is not satisfied with it for any reason. The individual is responsible for repaying the health maintenance organization for any services rendered or claims paid by the health maintenance organization during the ten days; and

(11) the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force.

Sec. 18. Minnesota Statutes 1982, section 62D.07, is amended by adding a subdivision to read:

Subd. 5. A grace period of 31 days shall be granted for payment of each premium for an individual health maintenance contract falling due after the first premium, during which period the contract shall continue in force.

Sec. 19. Minnesota Statutes 1982, section 62D.07, is amended by adding a subdivision to read:

Subd. 6. Any person entering into an individual health maintenance contract may cancel the contract within ten days of its receipt and to have premium paid refunded if, after examination of the contract, the individual is not satisfied with it for any reason. The individual is responsible for repaying the health maintenance organization for any services rendered or claims paid by the health maintenance organization during the ten days.

Sec. 20. Minnesota Statutes 1982, section 62D.08, subdivision 1, is amended to read:

Subdivision 1. A health maintenance organization shall, unless otherwise provided for by regulations adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted under clauses (a), (b), (e), (f), (g), (i), (j), ~~(k),~~ (l), ~~and~~ (m), (n), (o), (p), (q) and (r) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within 30 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Sec. 21. Minnesota Statutes 1982, section 62D.08, subdivision 3, is amended to read:

Subd. 3. Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, and (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment;

(b) The number of new enrollees enrolled during the year, the number of enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) A summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c) in such form as may be required by the commissioner of health;

(d) A report of the names and ~~residence~~ addresses of all persons set forth in section 62D.03, subdivision 4, clause (c) who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause ~~(e)~~ (d); and

(e) Such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out his duties under sections 62D.01 to 62D.29.

Sec. 22. Minnesota Statutes 1982, section 62D.08, is amended by adding a subdivision to read:

Subd. 4. Any health maintenance organization which fails to file a verified report with the commissioner on or before April 1 of the year due shall be subject to the levy of a fine up to $500 for each day the report is past due. This failure will serve as a basis for other disciplinary action against the organization, including suspension or revocation, in accordance with sections 62D.15 to 62D.17. The commissioner may grant an extension of the reporting deadline upon good cause shown by the health maintenance organization. Any

fine levied or disciplinary action taken against the organization under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 to 14.69.

Sec. 23. Minnesota Statutes 1982, section 62D.08, is amended by adding a subdivision to read:

Subd. 5. Every health maintenance organization shall inform the commissioner of any change in the information described in section 62D.03, subdivision 4, clause (e), including any change in address, any modification of the duration of any contract or agreement, and any addition to the list of participating entities, within ten working days of the notification of the change. Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner within seven working days of the date the health maintenance organization sends out or receives the notice of cancellation or discontinuance. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to $100 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14.

Sec. 24. Minnesota Statutes 1982, section 62D.09, is amended to read:

62D.09 **INFORMATION TO ENROLLEES.**

Subdivision 1. Any written marketing materials which may be directed toward potential enrollees and which includes a detailed description of benefits provided by the health maintenance organization shall include a statement of consumer rights as described in section 62D.07, subdivision 3(c).

Subd. 2. The application for coverage by the health maintenance organization shall be accompanied by the statement of consumer rights as described in section 62D.07, subdivision 3(c).

Subd. 3. Every health maintenance organization or its representative shall annually, before ~~April~~ June 1, provide to its enrollees the following: (1) a summary of ~~:~~ its most recent annual financial statement including a balance sheet and statement of receipts and disbursements; (2) a description of the health maintenance organization, its health care plan or plans, its facilities and personnel, any material changes therein since the last report, ~~and~~ (3) the current evidence of coverage; and (4) a statement of consumer rights as described in section 62D.07, subdivision 3, paragraph (c).

Sec. 25. Minnesota Statutes 1982, section 62D.10, subdivision 3, is amended to read:

Subd. 3. A health plan providing health maintenance services or reimbursement for health care costs to a specified group or groups may limit the open enrollment in each group plan to members of such group or groups, but after it has been in operation 24 months shall have an annual open enrollment period of at least ~~one month~~ 14 days during which it ~~accepts enrollees from the members of each group up to a minimum of five percent of its current enrollment in each group plan~~ shall accept all otherwise eligible individuals in the order in which they apply for enrollment in a manner which does not discriminate on the basis of age, sex, race, health, or economic status. The health maintenance organization shall notify potential enrollees of any limitations on the number of new enrollees to be accepted. "Specified groups" may include, but shall not be limited to:

(a) Employees of one or more specified employers;

(b) Members of one or more specified labor unions;

(c) Members of one or more specified associations;

(d) Patients of physicians providing services through a health care plan who had previously provided services outside the health care plan; and

(e) Members of an existing group insurance policy.

Sec. 26. Minnesota Statutes 1982, section 62D.10, is amended by adding a subdivision to read:

Subd. 5. Any fee charged by a health maintenance organization for the process of determining an applicant's eligibility, and any other application fee charged, shall be refunded with interest to the applicant if the applicant is not accepted for enrollment in the health maintenance organization, or credited with interest to the applicant's premiums due if the applicant is accepted for enrollment in the organization.

Sec. 27. Minnesota Statutes 1982, section 62D.101, subdivision 2, is amended to read:

Subd. 2. **CONVERSION PRIVILEGE.** Every health maintenance contract, ~~other than a contract whose continuance is contingent upon continued employment or membership, which contains a provision for termination of coverage of the spouse upon dissolution of marriage~~ as described in subdivision 1 shall contain a provision allowing a former spouse and dependent children of an enrollee, without providing evidence of insurability, to obtain from the health maintenance organization at the expiration of any continuation of coverage required under subdivision 2a or section 62A.146, or upon termination of coverage by reason of an entry of a valid decree of dissolution which does not require the health maintenance organization to provide continued coverage for the former spouse, an individual health maintenance contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the

option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the health maintenance organization within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate fee. A contract providing reduced benefits at a reduced fee may be accepted by the former spouse and dependent children in lieu of the optional coverage otherwise required by this subdivision. The individual health maintenance contract shall be renewable at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under Title XVIII of the Social Security Act, as amended. Any revisions in the table of rate for the individual contract shall apply to the former spouse's original age at entry, and shall apply equally to all similar contracts issued by the health maintenance organization.

Sec. 28. Minnesota Statutes 1982, section 62D.101, subdivision 2a, is amended to read:

Subd. 2a. **CONTINUATION PRIVILEGE.** Every health maintenance contract~~, other than a contract whose continuance is contingent upon continued employment or membership,~~ as described in subdivision 1 shall contain a provision which permits continuation of coverage under the contract for the enrollee's former spouse and children upon entry of a valid decree of dissolution of marriage, if the decree requires the enrollee to provide continued coverage for those persons. The coverage may be continued until the earlier of the following dates:

(a) The date of remarriage of either the enrollee or the enrollee's former spouse; or

(b) The date coverage would otherwise terminate under the health maintenance contract.

Sec. 29. **[62D.103] SECOND OPINION RELATED TO CHEMICAL DEPENDENCY AND MENTAL HEALTH.**

A health maintenance organization shall promptly evaluate the treatment needs of any enrollee who is seeking treatment for a problem related to chemical dependency or mental health conditions. In the event that the health maintenance organization or a participating provider determines that no type of treatment, either inpatient or outpatient, is necessary, the enrollee shall immediately be entitled to a second opinion by a health care professional qualified in diagnosis and treatment of the problem. An enrollee who seeks a second opinion from a health care professional not affiliated with the health maintenance organization must do so at his or her own expense. The health maintenance organization or participating provider shall consider the second opinion but is not obligated to accept the conclusion of the second opinion. The health mainte-

nance organization or participating provider shall document its consideration of the second opinion.

Sec. 30. Minnesota Statutes 1982, section 62D.12, subdivision 1, is amended to read:

Subdivision 1. No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Any written advertising is misleading if it fails to disclose that there are limitations on the services of some health care professionals. This general disclosure is not required on billboards. Each health maintenance organization shall be subject to sections 72A.17 to 72A.321, relating to the regulation of trade practices, except (a) to the extent that the nature of a health maintenance organization renders such sections clearly inappropriate and (b) that enforcement shall be by the commissioner of health and not by the commissioner of insurance. Every health maintenance organization shall be subject to sections ~~325.79~~ 325F.69 and ~~325.907~~ 8.31.

Sec. 31. Minnesota Statutes 1982, section 62D.12, subdivision 2, is amended to read:

Subd. 2. No health maintenance organization may cancel or fail to renew the coverage of an enrollee except for (a) failure to pay the charge for health care coverage; (b) termination of the health care plan; (c) termination of the group plan; (d) enrollee moving out of the area served, subject to section 62A.17, subdivisions 1 and 6; (e) enrollee moving out of an eligible group, subject to section 62A.17, subdivisions 1 and 6; (f) failure to make copayments required by the health care plan; or (g) other reasons established in regulations promulgated by the commissioner of health. An enrollee shall be given 30 days notice of any cancellation or nonrenewal.

Sec. 32. Minnesota Statutes 1982, section 62D.12, subdivision 4, is amended to read:

Subd. 4. No health maintenance contract or evidence of coverage shall provide for the reimbursement of an enrollee other than through a policy of insurance, except ~~to refund payments made by or on behalf of an enrollee; or, with the prior approval of the commissioner of health, payments to enrollees for obligations incurred for non-elective emergency or out-of-area services received; or with prior approval, direct payments to providers for out-of-area, non-elective emergency or referral medical, hospital, or other health services rendered to enrollees~~ as stated in this subdivision:

(a) the health maintenance organization may refund payments made by or on behalf of an enrollee;

Changes or additions are indicated by underline, deletions by ~~strikeout~~.

(b) the health maintenance organization may make direct payments to enrollees or providers for obligations incurred for nonelective emergency or out-of-area services received.

Sec. 33. Minnesota Statutes 1982, section 62D.12, subdivision 9, is amended to read:

Subd. 9. All net earnings of the health maintenance organization shall be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. No health maintenance organization shall provide for the payment, whether directly or indirectly, of any part of its net earnings, to any person as a dividend or rebate; provided, however, that ~~authorized expenses of a health maintenance organization shall include:~~

~~(a) cash rebates to enrollees, or to persons who have made payments on behalf of enrollees; or, when approved by the commissioner of health as provided in subdivision 4, direct payments to enrollees for obligations incurred for non-elective emergency or out-of-area services received; or, with prior approval, direct payments to providers for out-of-area, non-elective emergency or referral medical, hospital, or other health services rendered to enrollees;~~

~~(b) free or reduced cost health service to enrollees; or~~

~~(c) payments to providers or other persons based upon the efficient provision of services or as incentives to provide quality care. All net earnings shall be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care.~~ health maintenance organizations may make payments to providers or other persons based upon the efficient provision of services or as incentives to provide quality care. The commissioner of health shall, pursuant to sections 62D.01 to 62D.29, revoke the certificate of authority of any health maintenance organization in violation of this subdivision.

Sec. 34. Minnesota Statutes 1982, section 62D.12, is amended by adding a subdivision to read:

Subd. 9a. Authorized expenses of a health maintenance organization shall include:

(1) cash rebates to enrollees, or to persons who have made payments on behalf of enrollees;

(2) direct payments to enrollees or providers as provided in subdivision 4, clause (b);

(3) free or reduced cost health service to enrollees;

(4) payments to any organization or organizations selected by the health maintenance organization which are operated for charitable, educational, or religious or scientific purposes.

Changes or additions are indicated by underline, deletions by ~~strikeout~~.

Sec. 35. Minnesota Statutes 1982, section 62D.12, subdivision 10, is amended to read:

Subd. 10. No health maintenance contract or evidence of coverage entered into, issued, amended, renewed or delivered on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit to an enrollee or other beneficiary by the amount of, or in any proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, as amended subsequent to the date of commencement of such benefit, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, workers' compensation, or any similar federal or state law, as amended subsequent to the date of commencement of that benefit.

Sec. 36. Minnesota Statutes 1982, section 62D.12, is amended by adding a subdivision to read:

Subd. 13. No health maintenance organization offering an individual or group health maintenance contract shall refuse to provide or renew the coverage because the applicant or enrollee has an option to elect workers' compensation coverage pursuant to section 176.012.

Sec. 37. Minnesota Statutes 1982, section 62D.14, is amended to read:

62D.14 **EXAMINATIONS.**

Subdivision 1. The commissioner of health may make an examination of the ~~financial~~ affairs of any health maintenance organization and its contracts, agreements, or other arrangements with ~~providers~~ any participating entity as often as the commissioner of health deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years, provided that examinations of participating entities pursuant to this subdivision shall be limited to their dealings with the health maintenance organization and its enrollees.

Subd. 2. The commissioner ~~of health may make an examination concerning the quality of health care services provided to enrollees by any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health care plan as often as the commissioner of health deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years. Provided, that examinations of providers pursuant to this subdivision shall be limited to their dealings with the health maintenance organization and its enrollees~~ will notify the organization and any involved participating entity in writing when an examination has been initiated. The commissioner will include in this notice a full statement of the pertinent facts and of the matters being examined, and may include a statement that the organization or participating entity must submit to the commissioner within 30 days from the date of the notice a complete written report concerning those matters.

Changes or additions are indicated by underline, deletions by ~~strikeout~~.

Subd. 3. In order to accomplish his duties under this section with respect to the dealings of the participating entities with the health maintenance organization, the commissioner of health shall have the right to:

(a) inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed ~~under such contract~~; ~~and~~

(b) audit and inspect any books and records of a health maintenance organization and a participating entity which pertain to services performed and determinations of amounts payable under such contract;

(c) require persons or organizations under examination to be deposed and to answer interrogatories, regardless of whether an administrative hearing or other civil proceeding has been or will be initiated; and

(d) employ site visits, public hearings, or any other procedures considered appropriate to obtain the information necessary to determine the issues.

Subd. 4. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee, or any application obtained from any person, shall be ~~confidential~~ private as defined in chapter 13 and shall not be disclosed to any person except (a) to the extent ~~that it may be~~ necessary to carry out the purposes of sections 62D.01 to 62D.29, the commissioner and his or her designee shall have access to the above data or information but the data removed from the health maintenance organization or participating entity shall not identify any particular patient or client by name or contain any other unique personal identifier; (b) upon the express consent of the enrollee or applicant; (c) pursuant to statute or court order for the production of evidence or the discovery thereof; or (d) in the event of claim or litigation between such person and the provider or health maintenance organization wherein such data or information is pertinent. In any case involving a suspected violation of a law applicable to health maintenance organizations in which access to health data maintained by the health maintenance organization or participating entity is necessary, the commissioner and his or her agents, while maintaining the privacy rights of individuals and families, shall be permitted to obtain data that identifies any particular patient or client by name. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

Subd. 5. The commissioner of health shall have the power to administer oaths to and examine witnesses, and to issue subpoenas.

Subd. 6. Reasonable expenses of examinations under this section shall be assessed by the commissioner of health against the organization being examined, and shall be remitted to the commissioner of health for deposit in the general fund of the state treasury.

Subd. 7. Failure to provide relevant information necessary for conducting examinations pursuant to this section shall be subject to the levy of a fine up to $200 for each day the information is not provided. A fine levied under this subdivision shall be subject to the contested case and judicial review provisions of chapter 14. In the event a timely request for review is made, accrual of a fine levied shall be stayed pending completion of the contested case and judicial review proceeding.

Sec. 38. Minnesota Statutes 1982, section 62D.15, subdivision 1, is amended to read:

Subdivision 1. The commissioner of health may suspend or revoke any certificate of authority issued to a health maintenance organization under sections 62D.01 to 62D.29 if he finds that:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health ~~care~~ ~~plan~~ maintenance contract, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62D.03, unless amendments to such submissions have been filed with and approved by the commissioner of health;

(b) The health maintenance organization issues evidences of coverage which do not comply with the requirements of section 62D.07;

(c) The health maintenance organization is unable to fulfill its obligations to furnish comprehensive health maintenance services as required under its health ~~care~~ ~~plan~~ maintenance contract;

(d) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(e) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section 62D.06;

(f) The health maintenance organization has failed to implement the complaint system required by section 62D.11 in a manner designed to reasonably resolve valid complaints;

(g) The health maintenance organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(h) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(i) The health maintenance organization has otherwise failed to substantially comply with sections 62D.01 to 62D.29 or with any other statute or

administrative rule applicable to health maintenance organizations, or has submitted false information in any report required hereunder.

Sec. 39. Minnesota Statutes 1982, section 62D.17, subdivision 1, is amended to read:

Subdivision 1. The commissioner of health may, for any violation of statute or rule applicable to a health maintenance organization, or in lieu of suspension or revocation of a certificate of authority under section 62D.15, levy an administrative penalty in an amount ~~not less than $100 nor more than~~ up to $10,000 for each violation. In the case of contracts or agreements made pursuant to section 62D.05, subdivisions 2 to 4, each contract or agreement entered into or implemented in a manner which violates sections 62D.01 to 62D.29 shall be considered a separate violation. Reasonable notice in writing to the health maintenance organization shall be given of the intent to levy the penalty and the reasons therefor, and the health maintenance organization ~~shall~~ may have a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation, or have an administrative hearing and review of the commissioner of health's determination. Such administrative hearing shall be subject to judicial review pursuant to chapter 14.

Sec. 40. Minnesota Statutes 1982, section 62D.17, subdivision 4, is amended to read:

Subd. 4. (a) The commissioner of health may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of sections 62D.01 to 62D.29.

(b) Within 20 days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of sections 62D.01 to 62D.29 have occurred. Such hearings shall be subject to judicial review as provided by chapter 14.

If the acts or practices alleged involve violation of the reporting requirements under section 62D.08, or if the commissioner of commerce has ordered the rehabilitation, liquidation, or conservation of the health maintenance organization in accordance with section 62D.18, there shall be no automatic stay of the cease and desist order. If a timely request for a hearing is made, the respondent may show cause why the order should be stayed pending completion of the administrative contested case process. Written arguments on this issue shall be filed with the commissioner no later than 15 days from the date the hearing is requested. The commissioner has 15 days from the date the written arguments are filed to render a decision regarding the requested stay.

To the extent the acts or practices alleged do not involve violations of section 62D.08, if a timely request for a hearing is made, the cease and desist order shall be stayed for a period of 30 days from the date the hearing is

requested. During this stay, the respondent may show cause why the order should not become effective upon the expiration of the stay. Arguments on this issue shall be made through briefs filed with the commissioner no later than ten days prior to the expiration of the stay.

Sec. 41. Minnesota Statutes 1982, section 62D.19, is amended to read:

62D.19 **UNREASONABLE EXPENSES.**

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner of insurance shall, pursuant to the administrative procedures act, promulgate rules to implement and enforce this section.

In an effort to achieve the stated purposes of 62D.01 to 62D.29; in order to safeguard the underlying nonprofit status of health maintenance organizations; and to ensure that the payment of health maintenance organization moneys to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense.

Sec. 42. Minnesota Statutes 1982, section 62D.22, subdivision 5, is amended to read:

Subd. 5. Except as otherwise provided in sections 62A.01 to 62A.42 and 62D.01 to 62D.29, and except as they eliminate elective, induced abortions, wherever performed, from health or maternity benefits, provisions of the insurance laws and provisions of nonprofit health service plan corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under sections 62D.01 to 62D.29.

Sec. 43. Minnesota Statutes 1982, section 62D.22, is amended by adding a subdivision to read:

Subd. 10. Any person or committee conducting a review of a health maintenance organization or a participating entity, pursuant to sections 62D.01 to 62D.29, shall have access to any data or information necessary to conduct the review. All data or information is subject to admission into evidence in any civil action initiated by the commissioner of health against the health maintenance organization. The data and information are subject to chapter 13.

Sec. 44. **INTERAGENCY AGREEMENT.**

In order to implement the provisions of 62D.01 to 62D.30, the commissioner of health and commissioner of commerce shall enter into an agreement for coordinated enforcement of laws pertaining to health maintenance organizations. The agreement shall contain procedures whereby each commissioner, to the extent resources are available, shall provide technical assistance to the other in those policy matters which each commissioner has unique, specialized expertise.

Sec. 45. **STUDY OF COPAYMENT RESTRICTION.**

The commissioner shall solicit information from consumers, health maintenance organizations, insurers, employers, and other interested parties concerning the impact of restrictions on copayment discrimination based upon preexisting health status. The commissioner shall report a summary of the information along with an analysis and recommendation concerning the need to continue the restrictions on copayment discrimination upon preexisting health status by March 1, 1986.

Sec. 46. **REPEALER.**

Minnesota Statutes 1982, sections 62D.10, subdivision 2; 62D.12, subdivision 7; 62D.22, subdivision 9; and 62D.27, are repealed.

Sec. 47. **EFFECTIVE DATE.**

Section 12 is effective the day following final enactment. Sections 17 and 24 are effective January 1, 1985. The prohibition against discrimination on the basis of preexisting health status contained in section 8, is effective for contracts effective on or after January 1, 1985.

Approved April 24, 1984

CHAPTER 465 — S.F.No. 887

An act relating to transportation; providing for the inclusion of former municipal state-aid streets in the county state-aid highway system; amending Minnesota Statutes 1982, section 162.02, subdivision 1, and by adding a subdivision.

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

Section 1. Minnesota Statutes, 1982, section 162.02, subdivision 1, is amended to read:

Subdivision 1. **CREATION.** There is created a county state-aid highway system which ~~shall~~ must be established, located, constructed, reconstructed, improved, and maintained as public highways by the ~~several~~ counties under rules and regulations not inconsistent with this section made and promulgated by the