Sec. 5. **LOCAL APPROVAL.**

This act takes effect the day after the governing body of the city of Minneapolis complies with Minnesota Statutes, section 645.021, subdivision 3. Section 3 is effective for calendar year 1987 and every year thereafter.

Approved March 30, 1988

CHAPTER 434—S.F.No. 1861

An act relating to health maintenance organizations; insurance; requiring replacement coverage in the event an HMO cancels coverage; increasing state comprehensive health plan liabilities in the event a member terminates coverage; allowing for mediation of disputes about health maintenance organization agreements; allowing interest on unpaid charges; increasing health maintenance organization notice requirements and annual reporting requirements; amending Minnesota Statutes 1986, sections 62D.07; 62D.08, subdivision 5; 62D.09; 62D.101; 62D.11; 62D.12, subdivision 2, and by adding a subdivision; 62D.17, subdivision 1; 62D.20; 62E.11, by adding subdivisions; 62E.14, subdivisions 1, 3, and by adding a subdivision; 62E.16; Minnesota Statutes 1987 Supplement, sections 62A.17, subdivision 6; and 62D.08, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 62D; repealing Laws 1984, chapter 464, sections 29 and 40.

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

Section 1. **FINDINGS.**

The legislature finds that access to continuous and uninterrupted health care coverage is necessary for citizens of Minnesota enrolled in health care plans. While Minnesota law requires conversion policies for members of group health plan contracts, no similar right is extended to holders of individual contracts.

The legislature finds it necessary for individual health care coverage policyholders to immediately be afforded the same protections as group contract holders. The legislature further finds that a legal requirement is necessary to protect the access to health care coverage for the citizens of Minnesota who hold individual health care contracts. In view of continuing uncertainty in the marketplace, the legislature finds it necessary to impose this legal requirement on all existing individual contracts the day after enactment, so that no other consumers face a threat to their health care coverage.

Sec. 2. Minnesota Statutes 1987 Supplement, section 62A.17, subdivision 6, is amended to read:

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

or dependent at the expiration of the posttermination or layoff 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, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. A health maintenance contract issued by a health maintenance organization that provides posttermination 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 posttermination 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. 3. Minnesota Statutes 1986, section 62D.07, is amended to read:

62D.07 **EVIDENCE OF COVERAGE.**

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

Subd. 2. No evidence of coverage or contract, or amendment thereto shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or contract or amendment thereto has been filed with the commissioner of health pursuant to section 62D.03 or 62D.08.

Subd. 3. ~~An evidence~~ Contracts and evidences 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 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, and requirements for referrals, prior authorizations, and second opinions;

(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 and contract, a clear and complete statement of enrollees' rights as consumers~~, including but not limited to a description of each of the following:~~. The statement must be in bold print and captioned "Important Consumer Information and Enrollee Bill of Rights" and must include but not be limited to the following provisions in the following language or in substantially similar language approved in advance by the commissioner:

CONSUMER INFORMATION

(1) COVERED SERVICES: Services provided by (name of health maintenance organization) will be covered only if services are provided by participating (name of health maintenance organization) providers or authorized by (name of health maintenance organization). Your contract fully defines what services are covered and describes procedures you must follow to obtain coverage.

(2) PROVIDERS: Enrolling in (name of health maintenance organization) does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of (name of health maintenance organization), you must choose among remaining (name of health maintenance organization) providers.

(3) REFERRALS: Certain covered benefits are covered only upon referral. See section (section number) of your contract for referral requirements. All referrals to non-(name of health maintenance organization) providers and certain types of health care providers must be authorized by (name of health maintenance organization).

(4) EMERGENCY SERVICES: Emergency services from providers who are not affiliated with (name of health maintenance organization) will be covered only if proper procedures are followed. Your contract explains the procedures and benefits associated with emergency care from (name of health maintenance organization) and non-(name of health maintenance organization) providers.

(5) EXCLUSIONS: Certain services or medical supplies are not covered. You should read the contract for a detailed explanation of all exclusions.

(6) CONTINUATION: You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your contract.

(7) CANCELLATION: Your coverage may be canceled by you or (name of health maintenance organization) only under certain conditions. Your contract describes all reasons for cancellation of coverage.

ENROLLEE BILL OF RIGHTS

(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)~~ Enrollees have 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~~ including emergency services ~~available,~~ as defined in your contract, 24 hours a day and seven days a week;

~~(3)~~ (2) Enrollees have the ~~consumer's~~ right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;

~~(4)~~ (3) Enrollees have the right to refuse treatment~~;~~, and

~~(5)~~ the right to privacy of medical and financial records maintained by the

New language is indicated by underline, deletions by ~~strikeout~~.

health maintenance organization and its health care providers, in accordance with existing law;

~~(6)~~ (4) Enrollees have the right to file a grievance with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers; and

~~(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 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)~~ (5) Enrollees have 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.

Subd. 4. ~~Any subsequent approved change in an evidence of coverage shall be issued to each enrollee.~~

~~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. Individual health maintenance organization contracts shall clearly state the existence of the grace period.

Subd. ~~6~~ 5. Individual health maintenance contracts shall state that any person ~~entering into an individual health maintenance contract~~ may cancel the contract within ten days of its receipt and ~~to~~ have the 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.

New language is indicated by underline, deletions by ~~strikeout~~.

Subd. 6. The contract and evidence of coverage shall clearly explain the conditions upon which a health maintenance organization may terminate coverage.

Subd. 7. The contract and evidence of coverage shall clearly explain continuation and conversion rights afforded to enrollees.

Subd. 8. Individual and group contract holders shall be given 30 days' advance, written notice of any change in subscriber fees or benefits.

Subd. 9. Individual health maintenance organization contracts shall be delivered to enrollees no later than the date coverage is effective. For enrollees with group contracts, an evidence of coverage shall be delivered or issued for delivery not more than 15 days from the date the health maintenance organization is notified of the enrollment or the effective date of coverage, whichever is later.

Subd. 10. An individual health maintenance organization contract and an evidence of coverage must contain a department of health telephone number that the enrollee can call to register a complaint about a health maintenance organization.

Sec. 4. Minnesota Statutes 1987 Supplement, 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, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) The number of new enrollees enrolled during the year, the number of group enrollees and the number of individual 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 addresses of all persons set forth in section 62D.03, subdivision 4, clause (c) who were associated with the health mainte-

nance 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 (d); ~~and~~

(e) A separate report addressing health maintenance contracts sold to individuals covered by Medicare, Title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; and

(f) 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 the duties under sections 62D.01 to 62D.29.

Sec. 5. Minnesota Statutes 1986, section 62D.08, subdivision 5, is amended 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~~ 120 days before the effective date. When the health maintenance organization terminates a provider for cause, death, disability, or loss of license, the health maintenance organization must notify the commissioner within three working days of the date the health maintenance organization sends out or receives the notice of cancellation ~~or~~, discontinuance, or termination. 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. The levy of a fine does not preclude the commissioner from using other penalties described in sections 62D.15 to 62D.17.

Sec. 6. Minnesota Statutes 1986, 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 include a detailed description of benefits provided by the health maintenance organization shall include a statement of consumer information and rights as described in section 62D.07, subdivision 3, paragraph (c).

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

Subd. 3. Every health maintenance organization or its representative shall annually, before 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~~;~~; (3) the current evidence of coverage or contract; and (4) a statement of consumer information and rights as described in section 62D.07, subdivision 3, paragraph (c).

Subd. 4. Health maintenance organizations which issue contracts to persons who are covered by Title XVIII of the Social Security Act (Medicare) must give the applicant, at the time of application, an outline containing at least the following information:

(1) a description of the principal benefits and coverage provided in the contract, including a clear description of nursing home and home care benefits covered by the health maintenance organization;

(2) a statement of the exceptions, reductions, and limitations contained in the contract;

(3) the following language: "This contract does not cover all skilled nursing home care or home care services and does not cover custodial or residential nursing care. Read your contract carefully to determine which nursing home facilities and home care services are covered by your contract, and what procedures you must follow to receive these benefits.";

(4) a statement of the renewal provisions including any reservation by the health maintenance organization of the right to change fees;

(5) a statement that the outline of coverage is a summary of the contract issued or applied for and that the contract should be read to determine governing contractual provisions; and

(6) a statement explaining that the enrollee's Medicare coverage is altered by enrollment with the health maintenance organization, if applicable.

Subd. 5. Health maintenance organizations shall provide enrollees with a list of the names and locations of participating providers to whom enrollees have direct access without referral no later than the effective date of enrollment or date the evidence of coverage is issued and upon request. Health maintenance organizations need not provide the names of their employed providers.

Subd. 6. Any list of providers issued by the health maintenance organization shall include the date the list was published and contain a bold type notice in a prominent location on the list of providers with the following language, or substantially similar language approved in advance by the commissioner:

"Enrolling in (name of health maintenance organization) does not guarantee services by a particular provider on this list. If you wish to be certain of receiving care from a specific provider listed, you should contact that provider to ask whether or not he or she is still a (name of health maintenance organization) provider and whether or not he or she is accepting additional patients."

Sec. 7. Minnesota Statutes 1986, section 62D.101, is amended to read:

62D.101 **CONTINUATION AND CONVERSION PRIVILEGES FOR FORMER SPOUSES AND CHILDREN.**

Subdivision 1. **TERMINATION OF COVERAGE.** No health maintenance contract which, in addition to covering an enrollee, also covers the enrollee's spouse shall contain a provision for termination of coverage for a spouse covered under the health maintenance contract solely as a result of a break in the marital relationship ~~except by reason of an entry of a valid decree of dissolution of marriage between the parties~~.

Subd. 2. **CONVERSION PRIVILEGE.** Every health maintenance contract, 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~~ sections 62A.146 and 9, ~~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.

Subd. 2a. **CONTINUATION PRIVILEGE.** Every health maintenance contract 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~~ shall be continued until the earlier of the following dates:

(a) The date ~~of remarriage of either the enrollee or the enrollee's former spouse~~ the enrollee's former spouse becomes covered under another group plan or Medicare; or

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

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the enrollee on a monthly basis to the group contract holder to be paid to the health maintenance organization. In no event shall the fee charged exceed 102 percent of the cost to the plan for the period of coverage for other similarly situated spouses and dependent children when the marital relationship has not dissolved, regardless of whether the cost is paid by the employer or employee.

Subd. 3. **APPLICATION.** Subdivision 1 applies to every health maintenance contract which is delivered, issued for delivery, renewed or amended on or after July 19, 1977.

Subdivisions 2 and 2a apply to every health maintenance contract which is delivered, issued for delivery, renewed, or amended on or after March 1, 1983.

Sec. 8. **[62D.104] REQUIRED OUT-OF-AREA CONVERSION.**

Enrollees who have individual health maintenance organization contracts and who have become nonresidents of the health maintenance organization's service area but remain residents of the state of Minnesota shall be given the option, to be arranged by the health maintenance organization if an agreement with an insurer can reasonably be made, 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, or, if such enrollees are covered by Title XVIII of the Social Security Act (Medicare), they shall be given the option of a Medicare supplement plan as provided by sections 62A.31 to 62A.35.

This option shall be made available at the enrollee's expense, without further evidence of insurability and without interruption of coverage.

If a health maintenance organization cannot make arrangements for conversion coverage, the health maintenance organization shall notify enrollees of health plans available in other service areas.

Sec. 9. **[62D.105] COVERAGE OF CURRENT SPOUSE AND CHILDREN.**

Subdivision 1. **REQUIREMENT.** Every health maintenance contract, which in addition to covering the enrollee also provides coverage to the spouse and dependent children of the enrollee shall: (1) permit the spouse and dependent children to elect to continue coverage when the enrollee becomes enrolled for benefits under Title XVIII of the Social Security Act (Medicare); and (2) permit the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan.

Subd. 2. **CONTINUATION PRIVILEGE.** The coverage described in subdivision 1 may be continued until the earlier of the following dates:

(1) the date coverage would otherwise terminate under the contract;

(2) 36 months after continuation by the spouse or dependent was elected; or

(3) the date the spouse or dependent children become covered under another group health plan or Medicare.

If coverage is provided under a group policy, any required fees for the coverage shall be paid by the enrollee on a monthly basis to the group contract holder for remittance to the health maintenance organization. In no event shall the fee charged exceed 102 percent of the cost to the plan for such coverage for other similarly situated spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

Sec. 10. Minnesota Statutes 1986, section 62D.11, is amended to read:

62D.11 **COMPLAINT SYSTEM.**

Subdivision 1. Every health maintenance organization shall establish and maintain a complaint system including an impartial arbitration provision, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services. "Provision of health services" includes, but is not limited to, questions of the scope of coverage, quality of care, and administrative operations. Arbitration shall be subject to chapter 572, except (a) in the event that an enrollee elects to litigate a complaint prior to submission to arbitration, and (b) no medical malpractice damage claim shall be subject to arbitration unless agreed to by both parties subsequent to the event giving rise to the claim.

Subd. 1a. Where a complaint involves a dispute about a health maintenance organization's coverage of an immediately and urgently needed service, the commissioner may either (a) review the complaint and any information and testimony necessary in order to make a determination and order the appropriate remedy pursuant to sections 62D.15 to 62D.17, or (b) order the health maintenance organization to use an expedited system to process the complaint.

Subd. 2. The health maintenance organization shall maintain a record of each written complaint filed with it for ~~three~~ five years and the commissioner of health shall have access to the records.

Sec. 11. Minnesota Statutes 1986, 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, and section 8; (e) enrollee moving out of an eligible group, subject to section 62A.17, subdivisions 1 and 6, and section 8; (f) failure to make copayments required by the health care plan; or (g) other reasons established in rules promulgated by the commissioner of health.

~~An enrollee~~ Subd. 2a. Enrollees shall be given 30 days notice of any cancellation or nonrenewal, except that enrollees who are eligible to receive replacement coverage under section 13, subdivision 1, shall receive 90 days notice as provided under section 13, subdivision 5.

Sec. 12. Minnesota Statutes 1986, section 62D.12, is amended by adding a subdivision to read:

Subd. 14. Each health maintenance organization shall establish a telephone number, which need not be toll free, that providers may call with questions about coverage, prior authorization, and approval of medical services. The telephone number must be staffed by an employee of the health maintenance organization during normal working hours during the normal work week. After normal working hours, the telephone number must be equipped with an answering machine and recorded message to allow the caller an opportunity to leave a message. The health maintenance organization must respond to questions within 24 hours after they are received, excluding weekends and holidays. At the request of a provider, the health maintenance organization shall provide a copy of the health maintenance contract for enrollees in the provider's service area.

Sec. 13. **[62D.121] REQUIRED REPLACEMENT COVERAGE.**

Subdivision 1. When membership of an enrollee who has individual health coverage is terminated by the health maintenance organization for a reason other than (a) failure to pay the charge for health care coverage; (b) failure to make copayments required by the health care plan; (c) enrollee moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership, the health maintenance organization must offer or arrange to offer replacement coverage, without evidence of insurability, without preexisting condition exclusions, and without interruption of coverage.

Subd. 2. If the health maintenance organization has terminated individuals from coverage in a service area, the replacement coverage shall be health maintenance organization coverage issued by the health maintenance organization terminating coverage unless the health maintenance organization can demonstrate to the commissioner that offering health maintenance organization replacement coverage would not be feasible. In making the determination, the commissioner shall consider (1) loss ratios and forecasts, (2) lack of agreements between health care providers and the health maintenance organization to offer that product, (3) evidence of anticipated premium needs compared with established rates, (4) the financial impact of the replacement coverage on the overall financial solvency of the plan, and (5) the cost to the enrollee of health maintenance organization replacement coverage as compared to cost to the enrollee of the replacement coverage required under subdivision 3 of this section.

Subd. 3. If replacement coverage is not provided by the health maintenance organization, as explained under subdivision 2, the replacement coverage shall provide, for enrollees covered by Title XVIII of the Social Security Act, coverage at least equivalent to a Medicare supplement two plan as defined in section 62A.34, except that the replacement coverage shall also cover the liability for any Medicare Part A and Part B deductible as defined under Title XVIII of the Social Security Act. After satisfaction of the Medicare Part B deductible, the replacement coverage shall be based on 120 percent of the Medicare Part B eligible expenses less the Medicare Part B payment amount. The fee or premium of the replacement coverage shall not exceed the premium charged by the state comprehensive health plan as established under section 62E.08, for a qualified Medicare supplement plan. All enrollees not covered by Medicare shall be given the option of a number three qualified plan or a number two qualified plan as defined in section 62E.06, subdivisions 1 and 2, for replacement coverage. The fee or premium for a number three qualified plan shall not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number three qualified plan of insurance in force in Minnesota. The fee or premium for a number two qualified plan shall not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two qualified plan of insurance in force in Minnesota.

If the replacement coverage is health maintenance organization coverage, the fee shall not exceed 125 percent of the cost of the average fee charged by health maintenance organizations for a similar health plan. The commissioner of health will determine the average cost of the plan on the basis of information provided annually by the health maintenance organizations concerning the rates charged by the health maintenance organizations for the plans offered. Fees or premiums charged under this section must be actuarially justified.

Subd. 4. The commissioner will approve or disapprove the replacement coverage within 30 days. A health maintenance organization shall not give enrollees a notice of cancellation of coverage until a replacement policy has been filed with the commissioner and approved or disapproved.

Subd. 5. The health maintenance organization must provide the terminated enrollees with a notice of cancellation 90 days before the date the cancellation takes effect. If the replacement coverage is approved by the commissioner under subdivision 4, the notice shall clearly and completely describe the replacement coverage that the enrollees are eligible to receive and explain the procedure for enrolling. If the replacement coverage is not approved by the commissioner, the health maintenance organization shall provide a cancellation notice with information that the enrollee is entitled to enroll in the state comprehensive health insurance plan with a waiver of the waiting period for preexisting conditions under section 62E.14, subdivisions 1, paragraph (d), and 6.

Subd. 6. The commissioner may waive the notice required in this section if the commissioner determines that the health maintenance organization has not received information regarding Medicare reimbursement rates from the Health Care Financing Administration before September 1 for contracts renewing on

January 1 of the next year. In no event shall enrollees covered by Title XVIII of the Social Security Act receive less than 60 days' notice of contract termination.

Subd. 7. **GEOGRAPHIC ACCESSIBILITY.** If the commissioner determines that there are not enough providers to assure that enrollees have accessible health services available in a geographic service area, the commissioner shall institute a plan of corrective action that shall be followed by the health maintenance organization. Such a plan may include but not be limited to requiring the health maintenance organization to make payments to nonparticipating providers for health services for enrollees, requiring the health maintenance organization to discontinue accepting new enrollees in that service area, and requiring the health maintenance organization to reduce its geographic service area. If a nonparticipating provider has been a participating provider with the health maintenance organization within the last year, any payments made under this section must not exceed the payment level of the previous contract unless the commissioner determines that without adjusting payments the health maintenance organization will be unable to meet the health care needs of enrollees in the area.

Sec. 14. **[62D.122] MEDIATION.**

When current parties to a health maintenance organization contract between providers of health care services and the health maintenance organization believe they will be unable to reach agreement on the terms of renewal or maintenance of the agreement, either party may request the commissioner of health to order that the dispute be submitted to mediation. The parties to the dispute shall enter mediation upon the order of the commissioner of health. Whether or not a request for mediation from one of the parties has been received, the commissioner shall order mediation if failure to reach agreement would significantly impair access to health care services on the part of current enrollees of that health maintenance organization. In determining whether access to health care services for current enrollees will be significantly impaired, the commissioner shall consider:

(1) the number of enrollees affected,

(2) the ability of the plan to make alternate arrangements with other participating providers for the provision of health care services to the affected enrollees,

(3) the availability of nonparticipating providers who may become participating providers for those with whom the health maintenance organization is in dispute,

(4) the time remaining until termination of the provider contract, and

(5) whether failure to resolve the dispute may establish a precedent for similar disputes in other parts of the state or might impede competition among health plans.

During the period in which the dispute is in mediation, no action to terminate provider or enrollee contracts may be taken by either party. Participation in mediation shall be required of all parties for a period of not more than 30 days. Notice of termination of provider agreements, as required under section 5, shall take effect no earlier than 31 days after the first day of mediation under this section.

When mediation is ordered by the commissioner, arrangements for mediation shall be made through either the office of dispute resolution in the state planning agency, or the office of administrative hearings.

Costs of the mediation shall be borne equally by the health maintenance organization and the health care providers unless otherwise agreed to by the parties. The office of administrative hearings shall establish rates for mediation services comparable to those charged by mediators listed with the office of dispute resolution.

The mediator shall not have authority to impose a settlement or otherwise bind a participant to a nonvoluntary resolution of the dispute; however, any agreement reached as a result of the mediation shall be enforceable.

Except as otherwise provided under chapter 13 and sections 62D.03 and 62D.14, the commissioner shall make public the results of any mediation agreement.

Sec. 15. Minnesota Statutes 1986, 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 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 may have ~~a reasonable time~~ 15 days within which to ~~remedy the defect in its operations which gave rise to the penalty citation, or have~~ file a written request for 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. 16. Minnesota Statutes 1986, section 62D.20, is amended to read:

62D.20 **RULES.**

Subdivision 1. The commissioner of health may, pursuant to chapter 14, promulgate such reasonable rules as are necessary or proper to carry out the

provisions of sections 62D.01 to 62D.29. Included among such rules shall be those which provide minimum requirements for the provision of comprehensive health maintenance services, as defined in section 62D.02, subdivision 7, and reasonable exclusions therefrom. Nothing in such rules shall force or require a health maintenance organization to provide elective, induced abortions, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility, or the office of a physician; the rules shall provide every health maintenance organization the option of excluding or including elective, induced abortions, except as medically necessary to prevent the death of the mother, as part of its comprehensive health maintenance services.

Subd. 2. The commissioner shall adopt rules that address the issue of appropriate prior authorization requirements, considering consumer needs, administrative concerns, and the nature of the benefit.

Sec. 17. Minnesota Statutes 1986, section 62E.11, is amended by adding a subdivision to read:

Subd. 9. Each contributing member that terminates individual health coverage regulated under chapter 62A, 62C, 62D, or 64B for reasons other than (a) nonpayment of premium; (b) failure to make copayments; (c) enrollee moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and does not provide or arrange for replacement coverage that meets the requirements of section 13; shall pay a special assessment to the state plan based upon the number of terminated individuals who join the comprehensive health insurance plan as authorized under section 62E.14, subdivision 1, paragraph (d), and section 21. Such a contributing member shall pay the association an amount equal to the average cost of an enrollee in the state plan in the year in which the member terminated enrollees, multiplied by the total number of terminated enrollees who enroll in the state plan.

The average cost of an enrollee in the state comprehensive health insurance plan shall be determined by dividing the state plan's total annual losses by the total number of enrollees from that year. This cost will be assessed to the contributing member who has terminated health coverage before the association makes the annual determination of each contributing member's liability as required under this section.

In the event that the contributing member is terminating health coverage because of a loss of health care providers, the commissioner may review whether or not the special assessment established under this subdivision will have an adverse impact on the contributing member or its enrollees or insureds, including but not limited to causing the contributing member to fall below statutory net worth requirements. If the commissioner determines that the special assessment would have an adverse impact on the contributing member or its enrollees or insureds, the commissioner may adjust the amount of the special assessment, or establish alternative payment arrangements to the state plan. For health maintenance organizations regulated under chapter 62D, the commissioner of health shall make the determination regarding any adjustment in the special

assessment and shall transmit that determination to the commissioner of commerce.

Sec. 18. Minnesota Statutes 1986, section 62E.11, is amended by adding a subdivision to read:

Subd. 10. Any contributing members who have terminated individual health plans and do not provide or arrange for replacement coverage that meets the requirements of section 13, and whose former insureds or enrollees enroll in the state comprehensive health insurance plan with a waiver of the preexisting conditions pursuant to section 62E.14, subdivision 1, paragraph (d), and section 21, will be liable for the costs of any preexisting conditions of their former enrollees or insureds treated during the first six months of coverage under the state plan. The liability for preexisting conditions will be assessed before the association makes the annual determination of each contributing member's liability as required under this section.

Sec. 19. Minnesota Statutes 1986, section 62E.14, subdivision 1, is amended to read:

Subdivision 1. **CERTIFICATE, CONTENTS.** The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person shall enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

(a) Name, address, age, and length of time at residence of the applicant;

(b) Name, address, and age of spouse and children if any, if they are to be insured;

(c) Evidence of rejection, a requirement of restrictive riders, a rate up, or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least one association members within six months of the date of the certificate, or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk;

(d) ~~Evidence that the applicant meets the eligibility requirements of section 62E.081, subdivision 1; and~~ If the applicant has been terminated from individual health coverage which does not provide replacement coverage, evidence that no replacement coverage that meets the requirements of section 13 was offered, and evidence of termination of individual health coverage by an insurer, nonprofit health service plan corporation, or health maintenance organization provided that the contract or policy has been terminated for reasons other than (1) failure to pay the charge for health care coverage; (2) failure to make copayments required by the health care plan; (3) enrollee moving out of the area served; or (4) a materially false statement or misrepresentation by the enrollee in the application for membership; and

(e) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan. Upon ceasing to be a resident of Minnesota a person is no longer eligible to purchase or renew coverage under the state plan.

Sec. 20. Minnesota Statutes 1986, section 62E.14, subdivision 3, is amended to read:

Subd. 3. **PREEXISTING CONDITIONS.** No person who obtains coverage pursuant to this section shall be covered for any preexisting condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of an application except as provided under subdivisions 4 and 5, and section 21.

Sec. 21. Minnesota Statutes 1986, section 62E.14, is amended by adding a subdivision to read:

Subd. 6. A Minnesota resident who holds an individual health maintenance contract, individual nonprofit health service corporation contract, or an individual insurance policy previously approved by the commissioners of health or commerce, may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition as described in subdivision 3, without interruption in coverage, provided (1) no replacement coverage that meets the requirements of section 13 was offered by the contributing member, and (2) the policy or contract has been terminated for reasons other than (a) nonpayment of premium; (b) failure to make copayments required by the health care plan; (c) moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and, provided further, that the option to enroll in the plan is exercised within 30 days of termination of the existing policy or contract.

Coverage allowed under this section is effective on the date of termination, when the contract or policy is terminated and the enrollee has completed the proper application and paid the required premium or fee.

Expenses incurred from the preexisting conditions of individuals enrolled in the state plan under this subdivision must be paid by the contributing member canceling coverage as set forth in section 18.

The application must include evidence of termination of the existing policy or certificate as required in subdivision 1.

Sec. 22. Minnesota Statutes 1986, section 62E.16, is amended to read:

62E.16 **CONVERSION PRIVILEGES.**

Every program of self-insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state, shall include, in addition to the provisions required by

section 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions if the individual insured leaves the group regardless of the reason for leaving the group, or upon cancellation or termination of the coverage for the group except where uninterrupted and continuous group coverage is otherwise provided to the group. If the health maintenance organization has canceled coverage for the group because of a loss of providers in a service area, the health maintenance organization shall arrange for other health maintenance or indemnity conversion options that shall be offered to enrollees without the addition of underwriting restrictions. The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. The person may exercise this right to conversion within 30 days of leaving the group or within 30 days following receipt of due notice of cancellation or termination of coverage of the group and upon payment of premiums from the date of termination or cancellation. Due notice of cancellation or termination of coverage for a group shall be provided to each employee having coverage in the group by the insurer, self-insurer or health maintenance organization canceling or terminating the coverage except where reasonable evidence indicates that uninterrupted and continuous group coverage is otherwise provided to the group. Every employer having a policy of group accident and health insurance, group subscriber or contract of coverage by a health maintenance organization shall, upon request, provide the insurer or health maintenance organization a list of the names and addresses of covered employees. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue coverage under the same or a different contract without the addition of underwriting restrictions until the individual would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived. An individual conversion contract issued by a health maintenance organization shall not be deemed to be an individual enrollment contract for the purposes of section 62D.10.

Sec. 23. **REQUIRED STUDIES.**

Subdivision 1. The commission on health plan regulatory reform created in Laws 1987, chapter 370, article 1, section 11, shall make recommendations for expedited review mechanisms for complaints concerning health maintenance organization coverage of an immediately and urgently needed service.

Subd. 2. The board of the Minnesota comprehensive health association shall conduct a study examining the plan options currently offered by the association, in order to determine whether provision of additional plan options would better meet the needs of current and future enrollees. The board shall report its findings to the legislature and the commissioner of health and the commissioner of commerce by February 15, 1989.

Sec. 24. **REPEALER.**

Laws 1984, chapter 464, sections 29 and 40, are repealed. Section 14 is repealed June 30, 1990.

Sec. 25. **EFFECTIVE DATE.**

Sections 11, 13, 14, 17, 18, 19, 20, 21, and 22 are effective the day following final enactment. Section 3, subdivision 3, paragraph (c), is effective January 1, 1989.

Approved March 30, 1988

CHAPTER 435—S.F.No. 1970

An act relating to human services; exempting Indian health service facilities from rate establishment; requiring rate establishment for out-of-state hospitals; amending Minnesota Statutes 1987 Supplement, section 256.969, subdivision 3.

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

Section 1. Minnesota Statutes 1987 Supplement, section 256.969, subdivision 3, is amended to read:

Subd. 3. **SPECIAL CONSIDERATIONS.** (a) In determining the rate the commissioner of human services will take into consideration whether the following circumstances exist:

(1) minimal medical assistance and general assistance medical care utilization;

(2) unusual length of stay experience; and

(3) disproportionate numbers of low-income patients served.

(b) To the extent of available appropriations, the commissioner shall provide supplemental grants directly to a hospital described in section 256B.031, subdivision 10, paragraph (a), that receives medical assistance payments through a county-managed health plan that serves only residents of the county. The payments must be designed to compensate for actuarially demonstrated higher health care costs within the county, for the population served by the plan, that are not reflected in the plan's rates under section 256B.031, subdivision 4.

(c) The computation of each hospital's payment rate and the relative values of the diagnostic categories are not subject to the routine service cost limitation imposed under the Medicare program.

(d) Indian health service facilities are exempt from the rate establishment methods required by this section and section 256D.03, subdivision 4, and shall be reimbursed at the facility's usual and customary charges to the general public.