CHAPTER 4685
DEPARTMENT OF HEALTH
CERTIFICATION AND REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

NOTE: Under Minnesota Statutes, section 144.011, the State Board of Health was abolished and all of its duties transferred to the commissioner of health.

4685.0100 DEFINITIONS.

Subpart 1. **Scope.** All terms used herein which are defined in Minnesota Statutes, chapter 62D shall have the meanings attributed to them therein. For the purposes of parts 4685.0100 to 4685.5600 the terms defined herein shall have the meanings given to them.

Subp. 2. **Accepted actuarial principles.** "Accepted actuarial principles" means those prevailing statistical rules relating to the calculation of risks and premiums or prepayment charges of health maintenance organizations, prepaid group practice plans or commercial health insurance carriers.

Subp. 3. **Act.** "Act" means the Health Maintenance Act of 1973, Laws of Minnesota 1973, chapter 670, Minnesota Statutes, chapter 62D.

Subp. 4. **Complaint.** "Complaint" means any written enrollee grievance against a health maintenance organization or provider arising out of the

provision of health care services, and which has been filed by an enrollee or his representative in accordance with parts 4685.1400 to 4685.2000 and is not or is not yet the cause or subject of an enrollee election to litigate.

Subp. 5. **Comprehensive health maintenance service.** "Comprehensive health maintenance service" means a group of services which includes at least all of the types of services defined below:

A. "Emergency care" means professional health services immediately necessary to preserve life or stablize health.

B. "In-patient hospital care" means necessary hospital services affording residential treatment to patients. Such services shall include room and board, drugs and medicine, dressings, nursing care, Xrays, and laboratory examination, and other usual and customary hospital services.

C. "In-patient physician care" means those health services performed, prescribed or supervised by physicians within a hospital, for registered bed patients therein, which services shall include diagnostic and therapeutic care.

D. "Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service, treatment of alcohol and other chemical dependency, treatment of mental and emotional conditions, provision of prescription drugs, and other supportive treatment.

E. "Preventive health services" means health education, health supervision including evaluation and follow-up, immunization and early disease detection.

Subp. 6. **Enrollee copayment provisions.** "Enrollee copayment provisions" means those contract clauses requiring charges to enrollees, in addition to fixed, prepaid sums, to supplement the cost of providing covered comprehensive health maintenance services; "enrollee copayment provisions" also means the difference between an indemnity benefit and the charge of a provider for health services rendered.

Subp. 7. **Formal procedural requirements.** "Formal procedural requirements" means those rules governing the conduct of administrative hearings applicable to and affecting the rights, duties and privileges of each party of a "contested case," as such term is defined and as such rules are set forth in Minnesota Statutes, chapter 14.

Subp. 8. **Governing body.** "Governing body" means the board of directors, or if otherwise designated in the basic organizational document and/or bylaws, those persons vested with the ultimate responsibility for the management of the corporate entity that has been issued a certificate of authority as a health maintenance organization.

Subp. 9. **In-area services.** "In-area services" are those services provided within the geographical areas served by the health maintenance organization as described in its application for a certificate of authority and any subsequent changes therein filed with the commissioner of health.

Subp. 10. **Open enrollment.** "Open enrollment" means the acceptance for coverage by health plans of group enrollees without regard to underwriting restrictions, and coverage of individual or nongroup enrollees with regard only to those underwriting restrictions permissible under Minnesota Statutes, section 62D.10, subdivision 2, and subdivision 4.

Subp. 11. **Out-of-area health care services.** "Out-of-area health care services" are those services provided outside of the health maintenance organization's geographic service area, as such area is described in the health maintenance organization's application for a certificate of authority, and any subsequent changes therein filed with the commissioner of health.

Subp. 12. **Period of confinement.** "Period of confinement" means a period of time specified in a health maintenance contract relating to the amount of days of inpatient hospital care and defining a period during which an enrollee may not receive any inpatient hospital care in order to become entitled to a renewed period of hospital coverage. This term means the same as "spell of illness" and similar terms as they may be used in provisions to limit hospital care.

Subp. 13. **Provide.** "Provide" as that word is used in Minnesota Statutes, section 62D.09, means to send by United States postal service, by alternative carrier, or by other method to the place of residence or employment of each enrollee or, if such enrollee is a member of a specified group covered by a health maintenance contract, to the office of the authorized representative of any such group.

Subp. 14. **Summary of current evidence of coverage.** "Summary of current evidence of coverage" means written notice to be provided to enrollees by every health maintenance organization as prescribed in the act. Such notice shall describe changes in health maintenance contract coverage but need not necessarily be specific as to changes respecting the coverage of any individual enrollee.

Subp. 15. **Underwriting restrictions.** "Underwriting restrictions" means those internal predetermined standards within a health maintenance organization which specify and exclude from coverage certain health conditions or persons with certain health conditions which, if such persons or conditions were enrolled or covered, would obligate the health maintenance organization to provide a greater amount, kind or intensity of service than that required by the general population or that contemplated in the process of setting the prepayment amount.

Statutory Authority: *MS s 62D.20*

4685.0200 AUTHORITY, SCOPE AND PURPOSE.

Parts 4685.0100 to 4685.5600 are promulgated pursuant to Minnesota Statutes, sections 62D.03, subdivision 4, clause (m); 62D.04, subdivision 1, clause (c); 62D.04, subdivision 1, clause (d); 62D.04, subdivision 1, clause (g); 62D.06, subdivision 2; 62D.08, subdivision 1; 62D.08, subdivision 3; 62D.08, subdivision 3, clause (e); 62D.12, subdivision 2, clause (g); and 62D.20 relating to health maintenance organizations in particular, and Minnesota Statutes, sections 14.02, 14.04 to 14.36, and 14.38 relating generally to the promulgation of administrative rules. Parts 4685.0100 to 4685.5600 and all future changes herein apply to all health maintenance organizations operating in the state of Minnesota at the time of their adoption and to all health maintenance organizations hereafter certified, and are promulgated to carry out the Health Maintenance Act of 1973 and to facilitate the full and uniform implementation and enforcement of that law.

Statutory Authority: *MS s 62D.20*

4685.0300 APPLICATION.

Subpart 1. **Forms.** Application for certificates of authority shall be submitted on forms provided by the commissioner of health which shall include, but not be limited to the matters covered in this part.

Subp. 2. **Disclosure in applications.** Each application for a certificate of authority shall include disclosure of the following:

A. Any contractual or financial arrangements between members of the board of directors/principal officers and the health maintenance organization including: a description of any obligations, specified by contract or otherwise, to be met by each party in accordance with any such arrangement; and a listing of the dollar amounts of any consideration to be paid each party in accordance with any such arrangements.

B. Any financial arrangements between members of the board of directors/principal officers and any provider or other person, which provider or other person also has a financial relationship with the health maintenance organization. This disclosure shall include:

(1) a description of the obligations to be met by each party in accordance with any such arrangements;

(2) a listing of the dollar amounts of the consideration to be paid each party in accordance with any such arrangements; and

(3) a listing and description of any circumstances under which a director/principal officer is employed by or engages in a substantial commercial or professional relationship with any provider/other person.

Subp. 3. **Insurance.** Each application for a certificate of authority shall attach pertinent documents, including copies of insurance contracts, in verification of compliance with Minnesota Statutes, sections 62D.04, subdivision 1, clause (f), 62D.05, 62D.12, subdivisions 4 and 9, and 62D.13 with respect to assumption of risks and insurance against risks.

Subp. 4. **Financial responsibility.** Each application shall state which option for demonstrating financial responsibility has been elected pursuant to Minnesota Statutes, section 62D.04, subdivision 1, clause (e) and any pertinent documents which demonstrate financial responsibility shall be attached to the application.

Subp. 5. **Statistics.** The application shall detail procedures established to develop, compile, evaluate, and report statistics which shall include the collection and maintenance of at least the following data:

A. operational statistics sufficient to meet the requirements of Minnesota Statutes, section 62D.08, subdivision 3, clause (a) relating to annual financial reports;

B. gross utilization aggregates, including hospital discharges, surgical hospital discharges, hospital bed days, outpatient visits, laboratory tests and Xrays;

C. demographic characteristics, including the age and sex of enrollees;

D. disease-specific and age-specific mortality rates; and

E. enrollment statistics compiled in accordance with Minnesota Statutes, section 62D.08, subdivision 3, clause (b).

Subp. 6. **Provider agreements.** The application shall include copies of all types of agreements with providers by virtue of which enrollees will receive health care from the providers, and a description of any other relationships with providers who might attend enrollees together with a statement describing the manner in which these other relationships assure availability and accessibility of health care.

Subp. 7. **Other requirements.** Each application must also include documentation and/or evidence of compliance with all of the requirements of the act and parts 4685.0100 to 4685.5600, and the commissioner of health may require such other information in applications for certificates of authority as the commissioner feels is necessary to make a determination on the application.

Statutory Authority: *MS s 62D.20*

4685.0400 OPERATING REQUIREMENTS AND REQUIREMENTS FOR ISSUANCE OF A CERTIFICATE OF AUTHORITY.

Each health maintenance organization must submit the information required in Minnesota Statutes, chapter 62D and part 4685.0300 and the commissioner must find that each health maintenance organization meets the statutory requirements and the standards of parts 4685.0100 to 4685.5600 before the commissioner may issue a certificate of authority. The failure of an operating

health maintenance organization to comply with the requirements is proper basis for disciplinary action under Minnesota Statutes, sections 62D.15 to 62D.17.

Statutory Authority: *MS s 62D.20*

4685.0500 INSURANCE.

A health maintenance organization may provide for the payment for the cost of emergency services, out-of-area services or other services which go beyond the minimum services required herein through a policy of insurance.

Statutory Authority: *MS s 62D.20*

4685.0600 FINANCIAL RESPONSIBILITY.

In making its determination of financial responsibility, the commissioner will apply the following guidelines as appropriate:

A. a reasonable period of time for the continued availability of health care services is 60 days;

B. financial soundness can be demonstrated by showing the capacity of the applicant to produce a cash flow sufficient to cover normal operating expenses for 60 days, plus all initial organizational and promotional expenses;

C. adequate working capital can be shown by the availability of an amount of money sufficient to cover normal operating expenses for 60 days, plus any and all initial organizational and promotional expenses;

D. the comparability to the charges for similar services used by other health maintenance organizations and other health delivery systems will be used in considering the proposed schedule of charges; and

E. a determination of financial responsibility shall include consideration of a health maintenance organization's insurance coverage of its own risks and the risks it may bear in agreeing to provide services to enrollees relative to the organization's own financial reserves and surplus.

These considerations must give full force and effect to Minnesota Statutes, sections 62D.04, subdivision 1, clause (f); 62D.05, subdivision 3; 62D.12, subdivisions 4 and 9; 62D.13, and parts 4685.0300, subpart 3, and 4685.0500.

Statutory Authority: *MS s 62D.20*

4685.0700 COMPREHENSIVE HEALTH MAINTENANCE SERVICES.

Subpart 1. **Providing health maintenance services.** All health maintenance organizations shall provide comprehensive health maintenance services to enrollees.

Subp. 2. **Minimum services.** Such comprehensive health maintenance services shall include but need not be limited to:

A. provisions for emergency in area health care services which shall be available 24 hours a day, seven days a week; be provided either directly through health maintenance organization facilities or through arrangements with other providers; be provided by a physician and other licensed and ancillary health personnel, as appropriate, readily available at all times; and be covered for enrollees requiring such services but who, for reasons of medical necessity and not convenience, are unable to obtain them directly from the health maintenance organization in which they are enrolled or from providers or other persons with whom the health maintenance organization in which they are enrolled has arrangements for the provision of services;

B. provisions covering out-of-area services which must include out-of-area emergency care;

C. all inpatient hospital care except as exclusions or limitations are hereafter permitted;

D. all inpatient physician care except as exclusions or limitations are hereafter permitted;

E. all outpatient health services except as exclusions or limitations are hereafter permitted; and

F. procedures for providing preventive health services.

Subp. 3. **Permissible limitations and/or exclusions.** Permissible limitations upon and/or exclusions from those comprehensive health maintenance services required in subpart 2 may include:

A. limitations upon and/or exclusions of the provision of corrective appliances and artificial aids;

B. limitations upon and/or exclusions of cosmetic surgery;

C. limitations upon and/or exclusion of dental services;

D. limitations upon and/or exclusions of routine refractions and the fitting and provision of contact lenses and eyeglasses;

E. limitations upon and/or exclusions of ambulance transportation;

F. limitations upon and/or exclusions of hemodialysis or other procedures for treatment of chronic renal failure, of organ transplants, and/or experimental procedures, to the extent that such procedures, treatments or services are not covered by a policy of insurance, a nonprofit health service plan contract, or other program of coverage;

G. limitations upon and/or exclusions of custodial and/or domiciliary care;

H. limitations upon and/or exclusions of care for injuries incurred while on military duty, to the extent that such care is, in fact, covered or available in another program of coverage;

I. limitations upon and/or exclusions of home health care services;

J. limitations upon and/or exclusion of services and other items not prescribed, recommended or approved by a physician that is providing services through the enrollee's health maintenance organization or a provider to whom such physician has referred the enrollee, except in a situation where for reason of medical necessity and not convenience the enrollee is unable to obtain needed health care from the health maintenance organization, such as in emergency or out-of-area situations;

K. limitation upon/or exclusion of those maternity services which relate to a conception occurring prior to the effective date of coverage of the enrollee;

L. limitations upon outpatient treatment of mental and emotional conditions and alcohol and other chemical dependency, except there may be no limitation applied to diagnosis and referral to sources of care;

M. limitations upon the provision of prescription drugs, except during hospitalization;

N. such limitations or exclusions on inpatient hospital care as defined in part 4685.0100, subpart 5, item A, and required in subpart 2, item C, as are specifically authorized below. Each health maintenance organization may have:

(1) Limitations upon the number of days of inpatient hospital care, depending on the nature of the coverage, which at least correspond with the following minimum provisions:

(a) For health maintenance contracts issued to a specified group or groups, the coverage may be limited to 365 days of care in a given period of confinement for a condition arising from a single illness or injury, provided that if this coverage is exhausted the benefit must be renewed, or a new period of confinement commenced, upon the occurrence of a separate illness or injury or upon the passage of no more than 90 days without utilization of inpatient hospital care; and provided further, that if an enrollee group rejects in writing such limits of coverage in favor of lesser limits, the coverage may be limited to no less than 180 days, with no more than 90 days between periods of confinement.

(b) For individual health maintenance contracts, the coverage may be limited to 90 days of care in a given period of confinement for a condition arising from a single illness or injury, provided that if this coverage is exhausted the benefit must be renewed or a new period of confinement commenced, upon the occurrence of a separate illness or injury or upon the passage of no more than 90 days without utilization of inpatient hospital care.

(c) For inpatient hospital care out of the service area of the health maintenance organization as defined in part 4685.1100, item B, and part 4685.0100, subpart 11, and as required in subpart 2, item B, the coverage may be limited to 60 days of care in each contract year.

These provisions relate to the aggregate number of days of both acute care and convalescent care, both of which must be rendered to enrollees by the health maintenance organization, but which may be limited, as indicated. These provisions do not relate to custodial or domiciliary care which may be limited or excluded completely pursuant to item G, nor do these provisions allow limitations or exclusions relative to the spectrum of service during a covered day, which is provided for below.

(2) Limitations upon and/or exclusions of television, telephone and similar convenience or amenity items available in connection with inpatient hospital care but which are not medically necessary as a part of the care of the enrollee; and limitations upon and/or exclusions of inpatient hospital care, for those conditions or under those circumstances where inpatient physician care is also limited or excluded, provided that inpatient physician care and hospital care may not be so limited or excluded beyond a limitation or exclusion otherwise explicitly authorized in subpart 3.

(3) Limitations upon and/or exclusion of private room accommodations.

(4) Limitations upon inpatient treatment for alcohol and other chemical dependency and inpatient treatment for mental and emotional conditions, provided that a health maintenance organization must provide for treatment for alcohol and other chemical dependency in a licensed residential primary treatment program or hospital for up to the greater of 28 days or a number of days equivalent to 20 percent of the other inpatient hospital care coverage; and provided further, that a health maintenance organization must provide for inpatient treatment for mental and emotional conditions of at least 30 days in each contract year.

O. those conditions that are subject to underwriting restrictions when the imposition of such restrictions is otherwise proper, provided that underwriting restrictions may only relate to pre-existing chronic health conditions, and those acute conditions for which an applicant is being treated at the time of the proposed enrollment.

Statutory Authority: *MS s 62D.20*

4685.0800 COPAYMENTS, LIMITATIONS, EXCLUSIONS AND RESTRICTIONS ON SERVICE.

Subpart 1. **Imposition of copayments, limitations, exclusions, and restrictions on service.** In addition to the limitations and exclusions allowed in part 4685.0700, subpart 3, a health maintenance organization may impose copayments for services or goods provided and may impose certain restrictions on services. Any such provisions must clearly be stated in the evidence of coverage in compliance with Minnesota Statutes, section 62D.07, subdivision 3 (b) and comply with the following standards.

Subp. 2. **Limitations and exclusions.** There may be no limitations or exclusions other than those allowed by the statutes or in rules promulgated pursuant to Minnesota Statutes, section 62D.20. Where exclusions are allowed, it is the express policy of the commissioner of health to favor limitations rather

than exclusions and the commissioner may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single prepaid sum.

Subp. 3. **Restrictions.** Reasonable restrictions other than limitations, exclusions and copayments are permissible. These include, but are not limited to restrictions on the frequency or length of time a health maintenance service is provided (example: repeated, frequent physical exams), or the denial of a service that is not reasonably required to maintain the enrollees in good health (example: physical exams requested only for the protection or convenience of third parties). The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

Subp. 4. **Copayments.** Reasonable copayments, as defined in part 4685.0100, subpart 6, are allowed. Any amount or form of copayment shall be deemed reasonable when imposed on services which, pursuant to parts 4685.0400 to 4685.1300, may be excluded completely, provided that the copayment is not greater than the cost or charge of that particular service. Furthermore, copayments, either on specific services or in the aggregate, may be imposed on out-of-area services and emergency care by providers who do not have arrangements with the health maintenance organization in the form of a reasonable deductible, plus a 25 percent coinsurance feature, plus all charges which exceed a specified annual aggregate amount not less than $25,000.

The standard of reasonableness, in all circumstances, shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

No copayment may be imposed on preventive health care services as defined in part 4685.0100, subpart 5, item E, including administration of immunization, well-baby care, periodic screening and prenatal care, provided that this prohibition shall not be construed to prevent a copayment on maternity services in general, which may include prenatal care.

Copayments may not exceed 25 percent of the costs or charges for a particular service, except those copayments imposed upon services which may be excluded completely, out-of-area and emergency care described previously in this section, preventive health care services, and prescription drug benefits.

Copayments imposed upon prescription drug benefits shall be reasonable under the general provisions described in this part.

Statutory Authority: *MS s 62D.20*

4685.0900 SUBROGATION AND COORDINATION OF BENEFITS.

The health maintenance organization may require an enrollee to reimburse it for the reasonable value of health maintenance services provided to an enrollee who is injured through the act or omission of a third person or in the course of employment to the extent the enrollee collects damages or workers' compensation benefits for the diagnosis, care and treatment of his injury. The health maintenance organization may be subrogated to the enrollee's rights against the third person or the enrollee's employer to the extent of the reasonable value of the health maintenance services provided including the right to bring suit in the enrollee's name. The health maintenance organization may also provide in its evidences of coverage for coordination of benefits, whereby the health maintenance organization is entitled to determine whether and to what extent an enrollee has indemnity or other coverage for the services or goods provided to

the enrollee or benefits paid on behalf of the enrollee by the health maintenance organization, to establish standard for priorities among those obligated to provide services or indemnification, to refer to other, prior sources of care, and to enforce the health maintenance organization's right to recover under those standards. Provided, however, no health maintenance organization may recover the value of services rendered from an enrollee beyond any amount actually received by the enrollee in indemnification for the value of services rendered by the health maintenance organization.

Statutory Authority: *MS s 62D.20*

4685.1000 AVAILABILITY AND ACCESSIBILITY.

Applicants shall be in compliance with Minnesota Statutes, section 62D.04, subdivision 1, clause (a) when, upon review of an application for a certificate of authority, the commissioner of health is satisfied that:

A. comprehensive health care services will be provided directly by the applicant, through arrangements with other providers, or in compliance with part 4685.0500;

B. provider staff patterns and ratios of physicians, paramedical and ancillary health personnel to potential enrollees will be in accordance with acceptable professional practices and will reasonably meet anticipated enrollee needs;

C. the applicant will comply with the requirements set forth in part 4685.0700, subpart 2, items A and B, regarding the provision of emergency and out-of-area services; and

D. the applicant's geographic location and hours of operation will facilitate the reasonable delivery of health care services to potential enrollees. In assessing this standard of reasonable delivery of services, the commissioner of health may consider the utilization patterns of the existing health care delivery system in the proposed geographic area.

Statutory Authority: *MS s 62D.20*

4685.1100 QUALITY EVALUATION.

Arrangements for an ongoing evaluation of the quality of health care shall include, but not necessarily be limited to, provisions for:

A. meeting the standards of quality review set forth in the Social Security Amendments of 1972, United States Code, title 42, section 1320(c); and

B. an ongoing internal peer review system; and

C. a defined set of standards and procedures in selecting providers to serve enrollees, and as to the selection of individual providers, the retention of records relative to the number of persons scrutinized in this system and the number of providers screened who were rejected under the described procedures; and

D. the commissioner of health or each health maintenance organization may also conduct enrollee surveys of the enrollees of each health maintenance organization to ascertain enrollee satisfaction as a part of the overall quality evaluation program.

Statutory Authority: *MS s 62D.20*

4685.1200 STATISTICS.

Each health maintenance organization shall establish and maintain procedures to develop, compile, evaluate, and report statistics which shall include the collection and maintenance of at least the following data:

A. operational statistics sufficient to meet the requirements of Minnesota Statutes, section 62D.08, subdivision 3, clause (a) relating to annual financial reports;

B. gross utilization aggregates, including hospital discharges, surgical hospital discharges, hospital bed days, outpatient visits, laboratory tests and Xrays;

C. demographic characteristics, including the age and sex of enrollees;

D. disease-specific and age-specific mortality rates; and

E. enrollment statistics compiled in accordance with Minnesota Statutes, section 62D.08, subdivision 3, clause (b).

Statutory Authority: *MS s 62D.20*

4685.1300 EFFECTIVE DATE OF OPERATING REQUIREMENTS.

When changes are required in existing evidences of coverage or health maintenance contracts in order to implement the provisions of parts 4685.0100 to 4685.5600, such changes shall be implemented upon the renewal date of such documents commencing with the first renewal after 180 days after the effective date of parts 4685.0100 to 4685.5600. New contracts or evidences of coverage to be implemented after 180 days after the effective date of parts 4685.0100 to 4685.5600 must be in compliance with parts 4685.0100 to 4685.5600 upon implementation.

Statutory Authority: *MS s 62D.20*

GOVERNING BODY; CONSUMER MEMBERS; ENROLLEE PARTICIPATION; COMPLAINT SYSTEM

4685.1400 SELECTION OF GOVERNING BODY.

Subpart 1. **Selection of non-consumer members.** Non-consumer members of the governing body shall be selected in accordance with procedures set forth in each health maintenance organization's basic organizational document and/or bylaws.

Subp. 2. **Selection of enrollee directors.** The basic organizational document and/or bylaws shall also provide a reasonable procedure by which the enrollee directors are to be elected. Such procedure must include notification:

A. to those entitled to vote for enrollee directors of the time, place, and method by which such nomination and election is to be conducted at least two weeks prior to the nomination and election;

B. to those entitled to vote for enrollee directors of the names of consumer nominees, a general description of their backgrounds and a description of the method by which a ballot may be cast; and

C. to all enrollees of the results of such election including a general description of the backgrounds of the enrollee directors, to be given not later than at the time of issuance of the next annual summary of information to enrollees.

Subp. 3. **Consumer representatives.** Consumer representatives on the governing body must be enrollees at the time of their election and during their term of office. Should a consumer representative be removed for failure to meet this qualification or for any other reason set forth in the bylaws, he may be replaced only until the next election by another consumer elected by the remaining consumer representatives on the governing body.

Subp. 4. **Definitions for determination of whether enrollee is a consumer.** The terms below which appear in Minnesota Statutes, section 62D.02, subdivision 10 will be defined as follows in determining whether or not an enrollee is a consumer:

A. A "licensed health professional" is any person licensed under Minnesota Statutes to provide or administer health services.

B. A "health care facility" is any hospital, nursing home, or boarding care home required to be licensed as such under Minnesota Statutes, sections 144.50 to 144.56 or 144.583.

C. A "substantial financial interest in the provision of health care services" is a person's receipt or right to receive not less than 25 percent of his gross annual income directly from the rendering of health service.

D. A "substantial managerial interest in the provision of health care services" is a person's supervisory or administrative responsibilities as an employee of a health care facility.

Statutory Authority: *MS s 62D.20*

4685.1500 ENROLLEE OPINION.

The commissioner of health will review the proposed mechanism for affording enrollees an opportunity to express their opinions on matters of policy and operation to see if it reasonably provides such an opportunity. Permissible alternatives to those mechanisms described in Minnesota Statutes, section 62D.06, subdivision 2 may include but are not limited to one or more of the following:

A. permitting enrollees to attend, after prior reasonable notice, and express their opinions at certain regular meetings of the governing body or special meetings called for the express purpose of affording enrollees an opportunity to express their opinions;

B. creating a special committee of the governing body which will hold meetings on at least a quarterly basis and which will be open to all enrollees to express their opinions;

C. designating a special administrative office within the health maintenance organization, responsible directly to the governing body, which will be open to enrollees to express their opinions on a regular basis;

D. creating enrollee councils, representing enrolled groups and groups of individual enrollees which will be afforded a reasonable opportunity to meet with the governing body or its designee to express enrollee opinion; and

E. such other mechanisms as the commissioner may authorize or approve.

Statutory Authority: *MS s 62D.20*

4685.1600 ENROLLEES WHO ARE CONTRACT HOLDERS.

All enrollees who are contract holders, without regard to any membership or other status in the health maintenance organization corporation, must be afforded the opportunity to participate in the nomination and election of the consumer board members pursuant to Minnesota Statutes, section 62D.06, subdivision 1. All enrollees must be afforded the benefits of the enrollee opinion mechanisms and the complaint system. For the purpose of this part, a "contract holder" is the member of the covered group through which coverage is acquired, such as the employed person in an employment group, or in the case of an individual contract, is the person named in the contract as the covered person, as distinguished from others who may be covered as dependents of the covered person.

Statutory Authority: *MS s 62D.20*

4685.1700 REQUIREMENTS FOR COMPLAINT SYSTEM.

Health maintenance organization complaint system procedures for the resolution of written, enrollee complaints concerning the provision of health care services shall be considered reasonable and acceptable to the commissioner of health if they:

A. establish mechanisms through which written enrollee complaints may be filed by and presented by the enrollee or his authorized representative, and considered and retained by the health maintenance organization;

B. provide for informal discussions, consultations, or conferences between the enrollee complainant and a person with the authority to resolve or recommend the resolution of the complaint within 30 days after it is filed;

C. provide for hearings:

(1) at which any complaint not otherwise resolved shall be considered within 90 days after it is filed;

(2) at which a person or persons with authority to resolve or recommend the resolution of the complaint shall preside;

(3) which shall include the receipt of testimony, explanations or other information from enrollees, staff persons, administrators, providers or other persons, as is deemed necessary by the presiding person or persons for a fair appraisal of the complaint; and

(4) from which concise, written notice of all findings shall be given the complainant within 30 days of the conclusion of any such hearing.

D. provide for impartial arbitration of any complaint which is unresolved by the mechanisms set forth in item B pursuant to a procedure approved by the commissioner subject to Minnesota Statutes, chapter 572. The impartial arbitration procedure shall specify the method by which the neutral arbitrator(s) shall be mutually selected by the parties to the arbitration, the costs of the procedure and how they shall be borne. The arbitrator(s) shall be required to render an award within 30 days from the date of closing the hearings unless otherwise mutually agreed by the parties, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof in accordance with Minnesota Statutes, sections 572.16 and 572.21;

E. provide for giving notice to all enrollees of the existence and operation of said complaint system; and

F. provide for any other procedures approved by the commissioner of health.

Statutory Authority: *MS s 62D.20*

4685.1800 OTHER PROCESSING OF COMPLAINTS.

A health maintenance organization need not utilize those procedures described in part 4685.1700 as to any written and filed enrollee complaint which is processed by the health maintenance organization's legal counsel or liability insurer, provided that such other processing:

A. fairly considers the rights of all parties to the complaint;

B. is accompanied by a concise written record of all findings and recommendations arising therefrom, a copy of which record shall be given the enrollee complainant within 30 days of the conclusion of any such processing; and

C. results in the resolution of the complaint or an enrollee election to litigate within 90 days of its filing.

Statutory Authority: *MS s 62D.20*

4685.1900 RECORDS OF COMPLAINTS.

Every health maintenance organization shall maintain a record of each complaint filed with it during the prior three years. The record shall, where applicable, include:

A. the complaint or a copy thereof and the date of its filing;

B. a brief written summary of the outcome of all informal discussions, consultations, or conferences held relative to each complaint and the date or dates on which each such informal discussion, consultation, or conference occurred. Such summary shall include an acknowledgment by those participating in the form of their signatures;

C. the date or dates of any hearing and a copy of the hearing findings given the enrollee complainant;

D. the dates of commencement and conclusion of another processing conducted in accordance with part 4685.1800, and a copy of the concise written record of all findings and recommendations arising therefrom, which record shall include an acknowledgment by those participating in the form of their signatures;

E. the date of submission of any complaint to arbitration; a copy of the arbitrator's decision; and the date of the decision; and

F. a brief written summary, including the filing date, of each complaint which becomes a subject of litigation; a brief written summary, with dates, of the findings or outcome of any prior processing held relative to the complaint; and a brief written statement describing the outcome of the complaint or claim as determined in litigation.

Statutory Authority: *MS s 62D.20*

4685.2000 COMPLAINT REPORTS.

Every health maintenance organization shall submit to the commissioner of health, along with its annual report, a report on the experience of its respective complaint system during the immediately preceding calendar year. Such reports shall include at least the following information:

A. the name and location of the reporting health maintenance organization;

B. the reporting period in question;

C. the name of the individual(s) responsible for the operation of the complaint system;

D. the total number of written complaints received by the health maintenance organization;

E. the total number of written complaints received, classified as to whether they were principally medical care, psychosocial, or coverage-related in nature, or classified according to a classification most suited to the characteristics of the particular health maintenance organization, unless unduly burdensome;

F. the number of enrollees by whom or for whom more than one written complaint was made and the total number of such complaints; and

G. the total number of written complaints resolved to the enrollee's apparent satisfaction.

Statutory Authority: *MS s 62D.20*

4685.2100 ANNUAL REPORTS.

In addition to all other information specified in the act, every health maintenance organization shall include in its annual report to the commissioner of health the following:

A. the results of any and all elections conducted during the preceding calendar year relative to consumer representation on the health maintenance organization's governing body;

B. a copy of the health maintenance organization's most recent information summary provided to its enrollees in accordance with Minnesota Statutes, section 62D.09;

C. a description of the method and results of the system to evaluate the quality of health services. Such evaluation shall include, but not necessarily be limited to, study of the quality of care for at least one disease condition or age group; and

D. a schedule of prepayment charges made to enrollees during the preceding year and any changes which have been implemented or approved up to the reporting date.

Statutory Authority: *MS s 62D.20*

4685.2200 TERMINATION OF COVERAGE.

Subpart 1. **Justification.** In addition to those reasons specified in Minnesota Statutes, section 62D.12, subdivision 2, a health maintenance organization may, upon 30 days notice, cancel or fail to renew the coverage of an enrollee if such enrollee:

A. knowingly gives false, material information at the time of enrollment relative to his health status, provided such cancellation or nonrenewal is made six months of the date of enrollment; or

B. moves out of the geographic service area filed with the commissioner, provided such cancellation or nonrenewal is made within one year following the date the health maintenance organization was provided written notification of the address change.

Subp. 2. **Notice.** In any situation where 30 days notice of cancellation or nonrenewal of the coverage of a specified group plan or of the coverage of any individual therein is required, notice given by a health maintenance organization to an authorized representative of any such group shall be deemed to be notice to all affected enrollees in any such group and satisfy the notice requirement of the act.

The notice requirement of Minnesota Statutes, section 62D.12, subdivision 2 shall be deemed to be satisfied in the event of voluntary enrollee or voluntary group cancellation or nonrenewal of coverage, including such voluntary cancellation manifested by the enrollee's failure to pay the prescribed prepayment amount.

The notice requirement of Minnesota Statutes, section 62D.12, subdivision 2, shall not compel a health maintenance organization to provide health care services beyond a date for which payment therefore may not reasonably be expected to be received.

Subp. 3. **Termination of dependents at limiting age.** A health maintenance organization may terminate enrollees who are covered dependents in a family health maintenance contract upon the attainment by the dependent enrollee of a limiting age as specified in the contract. Provided, however, that no health maintenance contract may specify a limiting age of less than 18 years of age. Provided further that if any health maintenance contract provides for the termination of coverage based on the attainment of a specified age it shall also provide in substance that attainment of that age shall not terminate coverage while the child is incapable of self-sustaining employment by reason of mental disability or physical handicap, and chiefly dependent upon the enrollee for support and maintenance, provided proof of incapacity and dependency is furnished by the enrollee within 31 days of attainment of the age, and subsequently as required by the health maintenance organization, but not more frequently than annually after a two-year period following attainment of the age.

Statutory Authority: *MS s 62D.20*

4685.2300 INSURANCE TERMINOLOGY.

Except as it relates to the name of any health maintenance organization, Minnesota Statutes, section 62D.12, subdivision 3 shall not be construed to prohibit the use of the words cited or described therein if such usage is incidental to the text of any health maintenance organization contract or literature, enhances the accuracy or understanding thereof, and is not deceptive or misleading.

Statutory Authority: *MS s 62D.20*

4685.2400 MAXIMUM ENROLLMENT.

The maximum number of enrollees permitted a health maintenance organization shall pertain to current enrollment at any single point in time.

Statutory Authority: *MS s 62D.20*

4685.2500 ENROLLMENT DISCRIMINATION.

A health maintenance organization which refuses to enroll recipients of medical assistance or Medicare because of its good faith inability to qualify for such payments because of state or federal requirements shall not be deemed to be discriminating against any such recipients.

Statutory Authority: *MS s 62D.20*

4685.2600 CERTIFICATE OF NEED.

For the purpose of complying with Minnesota Statutes, section 63D.22, subdivision 6, any health maintenance organization intending to modify the construction of or construct a health care facility as defined in part 4685.1400, subpart 4, item B, shall be deemed to be an "applicant," as such term is defined in section 201(b), Minnesota State Planning Agency Certificate of Need Act Rules and Regulations, 1971.

Statutory Authority: *MS s 62D.20*

4685.2700 USE OF FUNDS.

All income of a health maintenance organization, however derived, including refunds, dividends or rebates on its insurance policies or nonprofit health service plan contracts, shall be considered part of its net earnings and subject to the provisions of Minnesota Statutes, section 62D.12, subdivision 9.

Statutory Authority: *MS s 62D.20*

4685.2800 FEES.

Every filing submitted to the commissioner by a health maintenance organization subject to Minnesota Statutes, sections 62D.01 to 62D.29 (the Health Maintenance Act of 1973) shall be accompanied by the following fees:

A. for filing an application for a certificate of authority, $250;
B. for filing each annual report, $50;
C. for filing an amendment to a certificate of authority, $25;
D. for each examination, $125 per eight hour day; and
E. for all other filings, $25.

Statutory Authority: *MS s 62D.20*

OPEN ENROLLMENT

4685.2900 EFFECTIVE DATE OF OPEN ENROLLMENT.

Open enrollment requirements shall be implemented by an existing health plan within a one-year period commencing July 1, 1975. Health plans formed after the effective date of the act, shall implement such requirements within a one-year period to commence 24 months after beginning operation as a health plan.

Statutory Authority: *MS s 62D.10*

4685.3000 SCOPE.

The requirements of Minnesota Statutes, section 62D.10, subdivision 2, shall apply to those health plans which offer nongroup contracts.

The requirements of Minnesota Statutes, section 62D.10, subdivision 3, shall apply to those health plans which offer group contracts.

Health plans offering nongroup and group contracts shall be subjected to Minnesota Statutes, section 62D.10, subdivision 2, with respect to their nongroup and to Minnesota Statutes, section 62D.10, subdivision 3, with respect to their

group contracts.

Statutory Authority: *MS s 62D.10*

4685.3100 NOTICE.

All health plans offering group plans shall provide for reasonable and timely notice of open enrollment provisions to prospective group enrollees or their representatives, including the dates of annual open enrollment and the manner in which to enroll. Such notice shall be given at least 15 days and not more than 45 days prior to the commencement of each annual open enrollment period. All health plans offering individual enrollments shall advertise the dates of their open enrollment and the manner in which to enroll in at least one newspaper of general distribution in the geographical area served by the plan. The advertisement shall run on at least two occasions at least 15 days and at most 45 days before the beginning of the open enrollment period. The advertisement shall be of sufficient size to reasonably apprise readers of the availability of the open enrollment period.

Statutory Authority: *MS s 62D.10*

4685.3200 WAIVER.

Subpart 1. **Application to the commissioner.** The requirements of Minnesota Statutes, section 62D.10 may be waived or the imposition of necessary underwriting restrictions may be authorized upon a written application to the commissioner stating the grounds for the request.

Subp. 2. **Compliance.** The commissioner shall determine whether or not compliance with the requirement for open enrollment would:

A. contravene the maximum enrollment limitation of 500,000 enrollees imposed by the act;

B. prevent a health plan from competing effectively with other health plans or with commercial health insurers for the enrollment of new members or for the retention of current members;

C. result in a health plan incurring unreasonably high expenses in relation to the value of the benefits or services it provides;

D. jeopardize the availability or adequacy of a health plan's working capital and any required surpluses or reserves; or

E. endanger the ability of a health plan to meet its current and future obligations to enrollees.

Subp. 3. **Considerations.** In making this determination the commissioner of health shall:

A. consider information supplied by a health plan in its application for the waiver or underwriting restrictions;

B. be permitted access to all health plan records pertinent to such application;

C. consider prevailing practices and standards relating to the financing and delivery of health care service in the community; and

D. consider any comments submitted by the commissioner of insurance or any interested party.

Statutory Authority: *MS s 62D.10*

4685.3300 PERIODIC FILINGS.

Subpart 1. **Filing requirements.** Required filings will be acted upon at the next official meeting of the commissioner of health following the filing date, provided the filing date is at least 15 days before said meeting. Exceptions to the requirement for filing 15 days in advance of a meeting will be made upon the filing of a statement of urgency and the circumstances involved.

Subp. 2. **Provider agreements.** The provisions of Minnesota Statutes, section 62D.08, subdivision 1 shall apply to any substantive modification in any agreement with providers as described and required for filing in part 4685.0300, subpart 6.

Subp. 3. **Filing of contract.** The filing of any contracts or evidences of coverage pursuant to Minnesota Statutes, section 62D.07 or 62D.08, subdivision 1 shall be accompanied by sufficient evidence on cost of services on which copayments are being imposed so as to allow the commissioner of health to determine the impact and reasonableness of the copayment provisions.

Subp. 4. **Service area.** The filing of amendments to an HMO's geographic service area pursuant to Minnesota Statutes, sections 62D.08, subdivision 1, and 62D.03, subdivision 4, clause (i) must contain sufficient supporting documentation of service area, facility and personnel availability and accessibility to allow a determination of compliance with part 4685.1000.

Subp. 5. **Additional data.** Upon receipt of any filing under Minnesota Statutes, sections 62D.07, and 62D.08, subdivision 1 or part 4685.3300, the commissioner of health may request such additional data as is reasonably necessary to determine legal propriety of the filed material. Failure of a health maintenance organization to provide such data as required by part 4685.3300 or requested by the commissioner pursuant to this part shall result in disapproval of the filing.

Statutory Authority: *MS s 62D.20*

4685.3400 IMPROPER PRACTICES.

It shall be an improper practice for a health maintenance organization to advertise or market its operation by making qualitative judgment or statements concerning any health professional who provides services for a health maintenance organization.

A health maintenance organization shall not enroll a person who resides outside the health maintenance organization's defined service area, unless the health maintenance organization provides the enrollee with written notice of the consequences of his special enrollment.

Statutory Authority: *MS s 62D.12*

PLANNING GRANTS

4685.3500 SUBMISSION OF AN APPLICATION.

Subpart 1. **Forms.** Applications shall be submitted on forms prescribed by the commissioner of health which shall address but need not be limited to:

A. Name and address of the applicant corporation and a copy of the corporation's articles of incorporation.

B. Names, addresses, occupations and place of employment of the members of the governing body of the applicant corporation.

C. Description of the proposed geographic area and population groups.

D. Objectives, work plans, methods and budget which would be used in the proposed project. The description of these items shall include but not be limited to the following four health maintenance organization planning elements:

(1) proposed enrollee groups and system of market analysis;

(2) potential ability of the applicant to develop a viable and financially sound health maintenance organization;

(3) potential availability and cooperation of providers; and

(4) proposed organizational structure of the health maintenance organization.

E. Applicant's description of the need for the project in the proposed geographic area of population groups.

F. Any other information which would be necessary to enable the commissioner of health to evaluate the application consistent with the provisions of parts 4685.3500 to 4685.3900 and any applicable legislation. Failure to submit all information requested may result in rejection of the application.

Subp. 2. **Submission deadline.** Applications shall be submitted on or before deadlines prescribed by the commissioner of health. Such deadlines shall be announced by the commissioner at least 30 days prior to the date the application is due.

Subp. 3. **Announcement of deadlines.** Announcement of the application process and deadlines shall be made to individuals and groups including but not limited to Minnesota areawide comprehensive health planning agencies as defined in Minnesota Statutes, section 145.72, subdivision 5, as amended, or any successor agency, Minnesota health maintenance organizations and other individuals and groups which have requested an application in writing within the last 12 months.

Statutory Authority: *MS s 62D.20*

4685.3600 REVIEW OF APPLICATION.

Subpart 1. **Review and comment by comprehensive health planning agency.** Applications shall be submitted by the commissioner of health for review and comment to any areawide comprehensive health planning agency or successor agency having jurisdiction over all or part of the proposed service area of the applicant. The review and comment report shall be considered by the commissioner as long as such report is made to the commissioner within 60 days from when the grant application was submitted to such agency. The agency report shall address at least the items covered in subparts 2 and 3, and Minnesota Statutes, section 62D.28.

Subp. 2. **Factors in determining planning grants.** The commissioner of health shall consider the following factors in determining the organizations which shall receive planning grants, the amount of money to be awarded and the terms and conditions for issuance of such planning grants. The order of the factors has no priority significance.

A. Extent to which the applicant exhibits knowledge of activities necessary to develop a health maintenance organization.

B. Prospects for support from proposed enrollees.

C. Prospects for cooperation from area providers.

D. Qualifications of the persons responsible for the organization to conduct planning.

E. Unmet health needs of the proposed service area.

F. Consistency with other health planning goals in the community.

G. Ability of the organization to obtain additional or continued planning, development and operating funds.

H. Lack of other health maintenance organizations or of health maintenance organizations of this proposed organizational model in the geographic area.

I. Ability to comply with Minnesota Statutes, section 62D.28 (1974).

Subp. 3. **Consideration of the ability of applicant to complete objectives.** With respect to applications for continuation grants, in addition to the factors in subpart 2, the commissioner of health shall consider the ability of the applicant to satisfactorily complete its stated objectives and the likelihood that continued state funding could contribute to development of a health maintenance organization.

Statutory Authority: *MS s 62D.20*

4685.3700 AWARDING OF GRANTS.

Within 90 days of the deadline for submission of the application, the commissioner of health shall inform the applicant in writing of its decision and the reasons therefor. The award of grant moneys shall be conditioned upon the applicant's compliance with part 4685.3800.

Statutory Authority: *MS s 62D.20*

4685.3800 OPERATION OF GRANT PROJECTS.

Subpart 1. **Compliance.** No grant moneys shall be distributed by the commissioner of health until the grantee complies with this part. If the applicant does not comply with this part within 30 days of receipt of the commissioner's decision to award the grant, the commissioner may revoke such award. Each grantee shall enter into a grant agreement with the commissioner which shall include but not be limited to the following assurances by the grantee:

A. The grantee shall maintain adequate fiscal control and fund accounting procedures including records pertaining to grant awards, obligations, unobligated balances and expenditures. Accounting records shall be supported by source documentation.

B. The Minnesota Department of Health and Minnesota legislative auditor shall be permitted access to records maintained in accordance with the grant project at any time either of these state agencies deems necessary.

C. The grantee shall agree to accept supervision, consultation and follow-up provided by the Minnesota Department of Health to accomplish the goals and objectives of the grant.

D. The grantee shall submit quarterly progress reports and financial reports according to a schedule and forms established by the commissioner of health.

E. The grantee shall maintain a policy and shall implement a procedure of equal employment opportunity in accordance with the state of Minnesota Affirmative Action Policy and Titles VI and VII of the Civil Rights Act of 1974. The grantee shall furnish information relative to the affirmative action policy and programs to the state upon request.

F. The grantee shall comply with all additional terms and conditions established by the commissioner of health which are consistent with the provisions of the act and parts 4685.0100 to 4685.5600.

Subp. 2. **Approval for revisions.** Prior approval from the Minnesota Department of Health shall be obtained for revision of objectives or the budget whenever:

A. The revision results in substantial change in the objectives of the grant-supported project.

B. The cumulative amount of transfers among/between expense categories exceeds or is expected to exceed ten percent of the grant budget.

Statutory Authority: *MS s 62D.20*

4685.3900 TERMINATION OF A GRANT.

The commissioner of health may terminate any grant project if there is evidence of any one of the following:

A. failure to comply with part 4685.3800;

B. substantial inability to complete objectives and work plan described in the grantee's application; or

C. use of the state health maintenance organization planning funds for activities not described in the application or revisions approved by the department.

If a grant is to be terminated prior to the date originally specified in the grant award, the commissioner of health shall inform the grantee in writing of its

intent to terminate the grant, giving the reasons therefor and the date on which termination will be effective.

Statutory Authority: *MS s 62D.20*

4685.4000 DEFINITIONS.

Subpart 1. **Applicability.** In addition to the definitions in Minnesota Statutes, sections 62D.02 and 62E.02 and part 4685.0100, the terms and phrases defined in this section have the meaning given them.

Subp. 2. **Applicable employer.** "Applicable employer" applies to any person, partnership, association, trust, estate, corporation or political subdivision which:

A. during the calendar quarter preceding the date of request pursuant to part 4685.4200 or 4685.4500, employed in Minnesota an average number of not less than 100 employees, other than employees engaged in seasonal employment as defined in Minnesota Statutes, section 268.07, subdivision 5;

B. offers, or on whose behalf there is offered, in the calendar quarter preceding the date of request pursuant to part 4685.4200 or 4685.4500, a health benefits plan to its eligible employees, whether purchased from an insurer or a health maintenance organization or provided directly by the applicable employer on a self-insured basis;

C. has received a written request for inclusion in the health benefits plan from a health maintenance organization in the manner prescribed by part 4685.4200. Such a written request is not required before applicability to employers who do not offer an accident and health insurance option but are otherwise included under this definition.

One ceases being an applicable employer for a particular calendar quarter in which either one fails to employ 100 persons as in item A; or, one ceases to offer a health benefits plan to employees during a calendar quarter as in item B.

Subp. 3. **Collective bargaining agreement.** "Collective bargaining agreement" means an agreement entered into between an employer, who is required by any state or federal law to negotiate health benefits with employees in a bargaining unit and to produce a written agreement evidencing the result of such bargaining, and the bargaining representative of its employees.

Subp. 4. **Designee.** "Designee" means any person or entity authorized to act on behalf of an applicable employer or group of applicable employers to offer an accident and health insurance policy, health maintenance contract, or self-insured health benefits plan, to the applicable employer's eligible employees.

Subp. 5. **Eligible employee.** "Eligible employee" means an employee who meets the terms and conditions established by an applicable employer, or its designee to participate in an existing health benefits plan.

Subp. 6. **Existing health benefits plan.** "Existing health benefits plan" means either any contract or agreement between an applicable employer, or its designee, and a health maintenance organization or an insurer which provides for payment for, or provision of, medical, surgical or hospital care; or any self-insured program made available by the applicable employer which provides for payment for, or provision of, medical, surgical or hospital care.

A plan shall be deemed an "existing health benefits plan" when it is subject to the terms of a collective bargaining agreement which specifically mandates health benefits or identifies the health maintenance organization or insurer which is to be contracted with for health benefits.

Subp. 7. **To offer a health benefits plan.** "To offer a health benefits plan," as the phrase is used in Minnesota Statutes, section 62E.17, subdivision 1, means to make participation in an existing health benefits plan available to eligible employees, or to such employees and their eligible dependents, where a financial

contribution is made by the employer on behalf of such employees.

Statutory Authority: *MS s 62E.17*

4685.4100 APPLICABILITY TO EMPLOYERS.

An employer who, prior to the effective date of parts 4685.0100 to 4685.5600, offered a dual option of either an accident and health insurance policy or health maintenance organization contract and continues to make a dual option available, shall not be considered to be an "applicable employer" for purposes of parts 4685.0100 to 4685.5600.

If an employer has executed a written agreement with an insurer and health maintenance organization to offer a dual option at the next renewal of the health benefits contract, the employer shall not be considered to be an "applicable employer" for the purposes of parts 4685.0100 to 4685.5600.

An employer who offers an accident and health insurance option and is not requested in writing by a health maintenance organization shall not be deemed to be an "applicable employer" subject to offering the health maintenance organization option and shall not be deemed in violation of this law.

Nothing in parts 4685.0100 to 4685.5600 shall prevent an employer from seeking out a health maintenance organization or insurer in order to offer the dual option without being subject to parts 4685.0100 to 4685.5600.

An employer which is preempted from complying with Minnesota Statutes, section 62E.17, subdivision 1, as a result of the Employee Retirement Income Security Act, United States Code, title 29, sections 1144 (a) and 1144 (b)(2)(B) is not an "applicable employer" for the purposes of parts 4685.0100 to 4685.5600.

Statutory Authority: *MS s 62E.17*

4685.4200 REQUEST TO EMPLOYER FOR DUAL OPTION INCLUSION BY A HEALTH MAINTENANCE ORGANIZATION.

A request for dual option inclusion in an employer's health benefits plan by a health maintenance organization shall be received by the employer or the employer's designee not less than 120 days in advance of the renewal date of the existing health benefits plan, unless the employer or its designee waives this time requirement. The request shall:

A. Be in writing, dated and directed to the specific employer, or the employer's designee.

B. Provide evidence that the health maintenance organization has a certificate to operate a health maintenance organization in Minnesota.

C. Describe the service area of that health maintenance organization filed with the commissioner of health according to Minnesota Statutes, section 62D.03, subdivision 4, clause (i).

D. Describe the location of facilities where health services are provided or will be provided, and give the days and hours of operation of those facilities. The provision for listing of days and hours of operation shall be waived for health maintenance organizations which provide health services through more than 20 ambulatory health care locations.

E. Include sample contracts to be entered into between the health maintenance organization and the employer, or its designee. The health maintenance organization shall specify the final contract at least 30 days prior to the group open enrollment.

F. State the proposed schedule of charges to be required for various categories of enrollment. After the request is submitted to the employer but at least 30 days prior to the group open enrollment, the schedule of charges may be adjusted by the health maintenance organization in consideration of demographic and other information provided by the employer.

G. Provide a copy of the most recent annual financial statement of health maintenance organization.

H. Include sample copies of marketing brochures and membership literature.

Statutory Authority: *MS s 62E.17*

4685.4300 SUBSTITUTION OF ANOTHER HEALTH MAINTENANCE ORGANIZATION.

If the applicable employer or its designee, subject to part 4685.4200, selects one or more other health maintenance organization which may not have made a request under 4685.4200, but is willing to be included in the health benefits plan, the applicable employer is not required to include the option of enrollment in the specific health maintenance organization which initiated the request for inclusion.

Statutory Authority: *MS s 62E.17*

4685.4400 MULTIPLE HEALTH MAINTENANCE ORGANIZATION OPTIONS.

An applicable employer, or its designee, may include in the health benefits plan offered to its employees, the option of enrollment in other health maintenance organizations which the applicable employer or its designee may decide to offer.

Statutory Authority: *MS s 62E.17*

4685.4500 OBLIGATION TO OFFER THE ACCIDENT AND HEALTH INSURANCE OPTION.

An applicable employer shall offer an accident and health insurance policy to eligible employees and their dependents at the next renewal of the existing health benefits contract. The applicable employer may choose any insurer which operates pursuant to Minnesota Statutes, chapter 62A or 62C.

Statutory Authority: *MS s 62E.17*

OFFER OF THE DUAL OPTION TO EMPLOYEES

4685.4600 COLLECTIVE BARGAINING.

For those employees whose existing health benefits plan is offered through collective bargaining agreement, the dual option shall be subject to the collective bargaining process, when a new collective bargaining agreement is negotiated or if such agreement is automatically renewable, on its anniversary date. If the collective bargaining representative rejects all the new dual option alternatives, the employer shall not be considered to be an applicable employer for the purposes of parts 4685.0100 to 4685.5600 until the next renewal date of the existing health benefits plan. If more than one dual option request is forwarded to the collective bargaining representative, the employer may specify that no more than one of the dual option alternatives be selected. The applicable employer shall be required to make dual option available to employees not subject to collective bargaining at the next renewal date of the contract covering those employees.

Statutory Authority: *MS s 62E.17*

4685.4700 RENEWAL DATE.

The employer's obligation to offer a dual option to employees shall be applicable on the first renewal of the existing health benefits plan. In the case of an existing health benefits plan that has no fixed term, the contract shall be treated as renewable on the anniversary date of the contract or the renewal of the collective bargaining agreement, at the discretion of the employer. If the applicable employer is self-insured, the fiscal year shall be considered the term of the existing health benefits plan.

Statutory Authority: *MS s 62E.17*

4685.4800 GROUP ENROLLMENT PERIOD.

An applicable employer who offers the option of enrollment with an insurer or health maintenance organization pursuant to part 4685.4200 or 4685.4500 shall provide for a group open enrollment period in which dual option is offered. During the first time dual option is made available, the health benefits plan alternatives shall be presented to each eligible employee with the requirement that an affirmative written selection be made by each employee among the alternatives included in the health benefits plan.

Statutory Authority: *MS s 62E.17*

4685.4900 SELECTION BY NEW EMPLOYEES OR TRANSFEREES.

The opportunity to select among the options within a health benefits plan shall be made available to new employees and employees who have been transferred to a new geographic location at the time the employees are eligible to participate in the health benefits plan, regardless of whether this coincides with the open enrollment period. At the time such employees are eligible to participate in the health benefits plan, such opportunity shall be presented to such employees with the requirement that they make an affirmative written selection among the alternatives included in the health benefits plan.

Statutory Authority: *MS s 62E.17*

4685.5000 ACCESS TO EMPLOYEES.

The applicable employer shall provide each health maintenance organization or insurer which is included in its health benefits plan under part 4685.4200 or 4685.4500 with fair and reasonable access, at least 30 days prior to and during the group enrollment period, for the purpose of presenting and explaining its program. This accessibility shall include, at a minimum, the opportunity for distribution of educational literature, brochures, announcements of meetings and other relevant printed materials to each eligible employee. This information shall be free of untrue or misleading statements, as prohibited by Minnesota Statutes, sections 62D.12, subdivision 1, and 72A.17 to 72A.321. In no event shall the access to eligible employees provided to a new option under part 4685.4200 or 4685.4500 be more restrictive than that provided offerers of alternatives in the health benefits plan, whether or not the representatives of the other alternatives elect to avail themselves of such accessibility.

Statutory Authority: *MS s 62E.17*

4685.5100 CANCELLATION OF OPTION.

If, following completion of the first annual enrollment period and before the actual effective date, less than 25 employees select an option offered in accordance with part 4685.4200 or 4685.4500, then the applicable employer, health maintenance organization under part 4685.4200, or insurer under part 4685.4500 may choose not to provide such new option. If the new option is canceled due to this clause, the applicable employer shall reopen the enrollment process and shall permit each eligible employee to select among the remaining options in the health benefits plan, without penalty to the employees.

Statutory Authority: *MS s 62E.17*

EMPLOYER CONTRIBUTION FOR DUAL OPTION ALTERNATIVE

4685.5200 EMPLOYER MONETARY CONTRIBUTION.

The monetary contribution by an applicable employer for dual option added pursuant to part 4685.4200 or 4685.4500 shall be based on terms no less favorable than the terms on which contributions to the existing health benefits plans are based. In no event shall the employer's contribution be less in absolute dollar amount per employee for the new dual option alternative than the employer's current contribution for the existing health benefits plan, unless

the same absolute dollar amount of the current contribution would exceed the schedule of charges of the new dual option alternative. The applicable employer shall use payroll deduction to collect the eligible employee's contribution toward health benefit coverage if such a payroll deduction system is used under the existing health benefits plan.

Statutory Authority: *MS s 62E.17*

4685.5300 EMPLOYER'S CONTRIBUTION DETERMINED.

The amount of the applicable employer's contribution shall be determined in a manner consistent with the following factors.

A. The amount of the applicable employer's contribution shall not be reduced on the basis of administrative expenses of the applicable employer or its designee associated with offering the dual option.

B. The amount of the applicable employer's contribution may exclude such portions of the contribution allocated to benefits other than medical, surgical, and hospital care (e.g., life or disability insurance) for which eligible employees and their eligible dependents will continue to be covered, regardless of selection of the dual option alternative.

Statutory Authority: *MS s 62E.17*

4685.5400 FIXED AMOUNT BY COLLECTIVE BARGAINING AGREEMENT.

If the amount of the applicable employer's contribution for health benefits is fixed by a collective bargaining agreement or by a contract with eligible employees, the amount so determined shall constitute the applicable employer's obligation for contribution toward the health maintenance organization prepayment charge or accident and health insurance premium on behalf of an eligible employee and his or her eligible dependents. Where the applicable employer's contribution for health benefits is determined by a collective bargaining agreement, but the amount so fixed includes contribution for benefits in addition to health benefits, the applicable employer or its designee shall determine the portion of such employer's contribution applicable to health benefits in accordance with parts 4685.5200 to 4685.5500.

Statutory Authority: *MS s 62E.17*

4685.5500 ABSENCE OF COLLECTIVE BARGAINING AGREEMENT OR CONTRACT.

In the absence of a collective bargaining agreement or employer-employee contract specifying contribution for health benefits, the applicable employer's contribution on the behalf of eligible employees and their eligible dependents, unless otherwise agreed to by the health maintenance organization or insurer and the applicable employer or its designee, shall be based upon the total costs of such health services offered to Minnesota employees for the most recent period for which experience is available, reduced by such amounts identified in accordance with part 4685.5300, item B. Such cost determination shall be consistent with part 4685.5200.

Statutory Authority: *MS s 62E.17*

4685.5600 DUAL OPTION ON A SELF-INSURED BASIS.

The requirement for offering an accident and health insurance policy in parts 4685.0100 to 4685.5600 shall be satisfied if the employer pays claims under a health benefits plan which includes all the mandated benefits required by Minnesota Statutes, chapter 62A or 62C. For the purposes of parts 4685.0100 to 4685.5600, the self-insured plan need not be otherwise approved by the commissioner of insurance.

The requirements for offering a health maintenance organization contract in parts 4685.0100 to 4685.5600 shall be satisfied if the employer provides health

services which include all the comprehensive health maintenance services required by Minnesota Statutes, chapter 62D. For the purposes of parts 4685.0100 to 4685.5600, the employer-operated health maintenance organization need not be otherwise authorized by the commissioner of health to perform health maintenance organization functions.

Statutory Authority: *MS s 62E.17*