CHAPTER 4685
DEPARTMENT OF HEALTH
HEALTH MAINTENANCE ORGANIZATIONS

4685 0100 DEFINITIONS
4685 0805 UNCOVERED EXPENDITURES
4685 0815 INCURRED BUT NOT REPORTED LIABILITIES
4685 0900 SUBROGATION AND COORDINATION OF BENEFITS
COORDINATION OF BENEFITS
4685 0905 PURPOSE AND APPLICABILITY
4685 0910 DEFINITIONS
4685 0915 COORDINATION OF BENEFITS, PROCEDURES
4685 0925 PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN
4685 0930 MISCELLANEOUS PROVISIONS
4685 0935 EFFECTIVE DATE, EXISTING CONTRACTS
4685 0940 MODEL COORDINATION OF BENEFITS CONTRACT PROVISION
4685 0950 TEXT OF MODEL COORDINATION OF BENEFITS PROVISIONS FOR GROUP CONTRACTS
QUALITY ASSURANCE
4685 1100 QUALITY EVALUATION
4685 1105 DEFINITIONS
4685 1110 PROGRAM
4685 1115 ACTIVITIES
4685 1120 QUALITY EVALUATION STEPS
4685 1125 FOCUSED STUDY STEPS
4685 1130 FILED WRITTEN PLAN AND WORK PLAN
4685 1700 REQUIREMENTS FOR COMPLAINT SYSTEM
4685 1900 RECORDS OF COMPLAINTS
4685 1910 UNIFORM REPORTING
4685 1940 NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #2 STATEMENT OF REVENUE AND EXPENSES
4685 1950 NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #4 ENROLLMENT AND UTILIZATION TABLE
4685 1980 QUARTERLY REPORTS
4685 2100 ANNUAL REPORTS
4685 2250 USE OF FILED MATERIAL
4685 2800 FEES
4685 3300 PERIODIC FILINGS

4685.0100 DEFINITIONS.

[For text of subps 1 to 3, see M.R.]

Subp. 4. **Complaint.** "Complaint" means any written grievance by a complainant, as defined in subpart 4a, against a health maintenance organization which has been submitted by a complainant under part 4685.1700 and which is not under litigation. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the time the individual was an enrollee.

Examples of complaints are the scope of coverage for health care services; denials of service; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered.

Subp. 4a. **Complainant.** "Complainant" means an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant, or former enrollee who submits a complaint, as defined in subpart 4.

[For text of subps 5 to 8, see M.R.]

Subp. 8a. **Immediately and urgently needed service.** "Immediately and urgently needed service" means a service that, if not provided promptly, could reasonably be expected to result in serious jeopardy to mental or physical health, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

[For text of subp. 9, see M.R.]

Subp. 9a. **NAIC Blank.** "NAIC Blank" means the most recent version of the National Association of Insurance Commissioners' Blank for Health Maintenance Organizations published by the Brandon Insurance Service Company, Nashville, Tennessee. The NAIC Blank is incorporated by reference and is available for inspection at Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155. The NAIC Blank is subject to annual changes by the publisher, but health maintenance organizations must use the 1988 version.

[For text of subps 9b to 15, see M.R.]

Statutory Authority: *MS s 62D.03; 62D.04; 62D.08; 62D.11; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 903*

4685.0805 UNCOVERED EXPENDITURES.

Subpart 1. **Defined.** Uncovered expenditures as referred to in Minnesota Statutes, section 62D.041, are expenditures by a health maintenance organization or a contracting provider for health care services by a provider who is not a participating entity and who is not under agreement with the health maintenance organization. Examples of providers not under such an agreement may include those providing out-of-area services, in-area emergency services, and certain referral services.

Subp. 2. **Documentation required.** If a health maintenance organization claims certain expenditures that meet the criteria of subpart 1 are covered because they are guaranteed, insured, or assumed, the health maintenance organization must give to the commissioner, with its annual report, documentation of the arrangements. If the arrangements are unchanged from the previous year, the health maintenance organization may reference previously filed documents. Documentation means applicable contracts between the health maintenance organization and the entity guaranteeing, and an explanation thereof.

Subp. 3. **When insured.** An uncovered expenditure may be considered insured within the applicable coverage limitation and covered if the health maintenance organization can demonstrate to the commissioner that:

A. the health maintenance organization has reinsurance under Minnesota Statutes, section 62D.04, subdivision 1, for nonelective emergency services and services provided outside the service area if those services were provided by nonparticipating providers and any other services provided by nonparticipating providers; or

B. the health maintenance organization has insolvency insurance that expressly covers enrollee obligations incurred before and after the date of insolvency, including obligations to nonparticipating providers.

Subp. 4. **When guaranteed.** An uncovered expenditure may be considered guaranteed and covered if the health maintenance organization demonstrates to the commissioner that the guarantor has agreed to guarantee obligations of the health maintenance organization to nonparticipating providers and if:

A. the guarantor has demonstrated to the commissioner that it has set aside an amount of money in a restricted reserve or other method acceptable to the commissioner equal to the amount of deposit that it is guaranteeing; the guarantor has issued a letter of credit; or the guarantor has demonstrated to the commissioner that it is a governmental entity with the power to tax;

B. according to its terms, the guarantee cannot expire without written notice from the guarantor to the commissioner and the notice must occur at least 60 days before the expiration date;

C. the guarantee is irrevocable, unconditional, and may be drawn upon after the insolvency of the health maintenance organization; and

D. the guarantee may be drawn upon by the commissioner.

Subp. 5. **When assumed.** An uncovered expenditure may be considered assumed and covered if the health maintenance organization can demonstrate to the commissioner any other arrangement for uncovered expenditures to be paid by an entity other than the health maintenance organization even in the event of the insolvency of the health maintenance organization. The commissioner shall require financial information relating to the capability of the entity to assume the risk of uncovered expenditures.

Subp. 6. **Calculating uncovered expenditures.** The health maintenance organi-

zation must make an annual calculation of uncovered expenditures according to items A to E.

A. The health maintenance orgamzation shall determine the amount of annual uncovered expenditures in the relevant year before adjustments for guarantees, insurance, or assumptions.

B. The health maintenance organization shall adjust the amount of uncovered expenditures in item A by subtracting:

(1) reinsurance receipts that are described in subpart 3, item A, that are accrued to the relevant year, and that reduced those expenditures; and

(2) any relevant assumptions of risk.

C. The health maintenance organization shall multiply the adjusted amount in item B by 33 percent.

D. The health maintenance organization may subtract from the amount in item C the amounts of any guarantees and insolvency insurance that would reduce uncovered expenditures in the event of insolvency or nonpayment.

E. The health maintenance organization shall use forms supplied by the commissioner in annual reports to report uncovered expenditures.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.0815 INCURRED BUT NOT REPORTED LIABILITIES.

Subpart 1. **Written records of claims.** A health maintenance organization shall keep written records of claims, according to items A to C.

A. A health maintenance organization shall establish and maintain files and records that accurately document its process for calculating claim liabilities, including incurred but not reported claims, that are submitted in annual and quarterly reports to the commissioner.

B. Written records pertaining to claims incurred but not reported shall be maintained separately from other records pertaining to claims payable.

C. The health maintenance organization must have complete and accurate claim data available for the commissioner to audit as required under Minnesota Statutes, section 62D.14.

Subp. 2. **Calculation of incurred but not reported claims.** The liability for incurred but not reported claims shall be calculated in conformity with generally accepted accounting principals and actuarial standards. The health maintenance organization shall calculate its incurred but not reported claims by taking past actual claims experience and then adjusting this base figure for changing trends. Factors that shall be considered reasonable adjustments to the base figure include the following:

A. changes in enrollment mix, provider mix, and product mix;

B. changes in claims or billing procedures;

C. changes in utilization;

D. organizational changes;

E. medical advancements and new procedures; and

F. any other factors the health maintenance organization can demonstrate have an effect on incurred but not reported claims experience.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

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 an 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 shall provide covered health services first, and coordinate benefits according to parts 4685.0905 to 4685.0950.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

COORDINATION OF BENEFITS

4685.0905 PURPOSE AND APPLICABILITY.

The purpose of parts 4685.0905 to 4685.0950 is to:

A. permit, but not require, plans to include a coordination of benefits provision;

B. establish the order in which plans pay claims;

C. provide the authority for the orderly transfer of information needed to pay claims promptly;

D. reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan does not have to pay its benefits first;

E. reduce delays in payment of claims; and

F. make all contracts that contain a coordination of benefits provision consistent with this regulation.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.0910 DEFINITIONS.

Subpart 1. **Scope.** The following words and terms, when used in parts 4685.0905 to 4685.0950, have the following meanings unless the context clearly indicates otherwise.

Subp. 2. **Allowable expense.**

A. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

B. Notwithstanding this definition, items of expense under coverages such as dental care, vision care, or prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan that provides benefits only for such items of expense may limit its definition of allowable expenses to those items of expense.

C. When a plan provides benefits in the form of service, the reasonable cash value of each service is both an allowable expense and a benefit paid.

D. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

E. When coordination of benefits is restricted to specific coverage in a contract, for example, major medical or dental, the definition of allowable expense must include the corresponding expenses or services to which coordination of benefits applies.

F. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction

will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(1) Only benefit reductions based upon provisions similar in purpose to those described above and which are contained in the primary plan may be excluded from allowable expenses.

(2) This provision shall not be used by a secondary plan to refuse to pay benefits because a health mamtenance organization enrollee has elected to have health care services provided by a nonhealth maintenance organization provider and the health maintenance organization, pursuant to its contract is not obligated to pay for providing those services.

Subp. 3. **Claim.** "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

A. services, including supplies;

B. payment for all or a portion of the expenses incurred;

C. a combination of items A and B; or

D. an indemnification.

Subp. 4. **Claim determination period.**

A. "Claim determination period" means the period of time over which allowable expenses are compared with total benefits payable in the absence of coordination of benefits, to determine whether overinsurance exists and how much each plan will pay or provide. The claim determination period must not be less than 12 consecutive months.

B. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

C. As each claim is submitted, each plan must determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. The determination may be adjusted as allowable expenses are incurred later in the same claim determination period.

Subp. 5. **Coordination of benefits.** "Coordination of benefits" means a provision establishing the order in which plans pay their claims.

Subp. 6. **Hospital indemnity benefits.** "Hospital indemnity benefits" are not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Subp. 7. **Plan.** "Plan" means a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage that will be considered in applying the coordination of benefits provision of that contract. The right to include a type of coverage is limited by the rest of this definition.

A. The definition shown in the Model Coordination of Benefits Provisions in part 4685.0950 is an example of what may be used. Any definition that satisfies this subpart may be used.

B. Instead of "plan," a group contract may use "program" or some other term.

C. Plan includes:

(1) Group insurance and group subscriber contracts.

(2) Uninsured arrangements of group or group-type coverage.

(3) Group or group-type coverage through health maintenance organizations and other prepayment, group practice, and individual practice plans.

(4) Group-type contracts. Group-type contracts are contracts that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts may be included in the definition of plan, at the option of the insurer or the service provider and the contract client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated, for example, franchise or blanket. Individually underwritten and issued guaranteed renewable policies are not group-type even though purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(5) The amount by which group or group-type hospital indemnity benefits exceed $100 a day.

(6) The medical benefits coverage in group, group-type, and individual automobile no-fault and traditional automobile fault-type contracts.

(7) Medicare or other governmental benefits, except as provided in item D, subitem (7). That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

D. Plan does not include:

(1) individual or family insurance contracts;

(2) individual or family subscriber contracts;

(3) individual or family coverage through health maintenance organizations;

(4) individual or family coverage under other prepayment, group practice, and individual practice plans;

(5) group or group-type hospital indemnity benefits of $100 a day or less;

(6) school accident-type coverages that cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a to and from school basis; and

(7) a state plan under Medicaid, or a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Subp. 8. **Primary plan.** "Primary plan" means a plan that requires benefits for a person's health care coverage to be determined without taking into consideration the existence of any other plan. A plan is a primary plan if either of the following is true:

A. The plan either has no order of benefit determination rules or it has provisions that differ from those permitted by parts 4685.0905 to 4685.0950. There may be more than one primary plan.

B. All plans that cover the person use the order of benefit determination rules required by parts 4685.0905 to 4685.0950 and, under those rules, the plan determines its benefits first.

Subp. 9. **Secondary plan.** "Secondary plan" means a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules in parts 4685.0905 to 4685.0950 determine the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan which under these rules has its benefits determined before those of that secondary plan.

Subp. 10. **This plan.** In a coordination of benefits provision, "this plan" refers to the part of the group contract providing the health care benefits to which the coordination of benefits provision applies and that may be reduced because of the benefits of other plans. Any other part of the group contract providing

health care benefits is separate from this plan. A group contract may apply one coordination of benefits provision to certain of its benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate coordination of benefits provisions to coordinate other benefits.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

4685.0915 COORDINATION OF BENEFITS; PROCEDURES.

Subpart 1. **General.** The general order of benefits is as follows:

A. The primary plan must pay or provide its benefits as if the secondary plan or plans do not exist. A plan that does not include a coordination provision may not take into account the benefits of another plan as defined in part 4685.0910 when it determines its benefits. The one exception is that a contract holder's coverage designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

B. A secondary plan may take the benefits of another plan into account only when, under this part, it is secondary to that other plan.

C. The benefits of the plan that covers the person as an employee, member, or subscriber, that is, other than as a dependent, are determined before those of the plan that covers the person as a dependent.

Subp. 2. **Dependent child: parents not separated or divorced.** Benefits for a dependent child when the parents are not separated or divorced must be coordinated according to the procedures in items A to E.

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.

B. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

C. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

D. A group contract that includes coordination of benefits and is issued or renewed or that has an anniversary date on or after 60 days after October 9, 1989, must include the substance of the provisions in items A to C. Until October 9, 1989, the group contract may contain wording such as: "Except as stated in subpart 3, the benefits of a plan that covers a person as a dependent of a male are determined before those of a plan that covers the person as a dependent of a female."

E. If one parent's plan contains the coordination plan described in items A to C, and the other parent's plan contains the coordination plan based on the gender of the parent, and if, as a result, the parents' plans do not agree on the coordination of benefits, the coordination plan based on the gender of the parent determines the order of benefits.

Subp. 3. **Dependent child: separated or divorced parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are coordinated according to this subpart. If a court orders one of the parents to pay the health care expenses of the child, and the entity that pays or provides the parent's plan knows of the order, the benefits of that parent's plan are determined first. The plan of the other parent is the secondary plan. This paragraph does not apply to any claim determination period or plan year during which benefits are actually paid or provided before the entity knows of the order. If a court order does not require one of the parents to pay the child's health care expenses, benefits are coordinated according to items A to C.

A. The benefits of the plan of the parent with custody of the child are determined first.

B. The benefits of the plan of the spouse of the parent with the custody of the child are determined second.

C. The benefits of the plan of the parent without custody of the child are determined last.

D. In the case of joint custody, the primary plan will be determined according to subpart 2.

Subp. 4. **Active/inactive employee.** The benefits of a plan that covers a person as an employee, who is neither laid off nor retired, or as a dependent of that employee are determined before benefits of a plan that covers that person as a laid-off or retired employee or as a dependent of that employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

Subp. 5. **Longer/shorter length of coverage.** If none of these rules determines the order of benefits, the benefits of the plan that covered an employee, member, or subscriber longer are determined before those of the plan that covered that person for the shorter term.

A. To determine the length of time a person has been covered under a plan, two plans are treated as one if the claimant was eligible under the second plan within 24 hours after the first ended.

B. The start of a new plan does not include:

(1) a change in the amount of scope of a plan's benefits;

(2) a change in the entity that pays, provides, or administers the plan's benefits; or

(3) a change from one type of plan to another, such as from a single employer plan to that of a multiple employer plan.

C. The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group is the date used to determine the length of time the claimant's coverage under the present plan has been in force.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.0925 PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.

Subpart 1. **Total allowable expenses.** When a plan is a secondary plan under part 4685.0915, its benefits may be reduced so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowable expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay allowable expenses, not otherwise paid, that were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims that were submitted up to that time during the claim determination period.

Subp. 2. **Reducing benefits of a secondary plan.** The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of coordination of benefits provisions in parts 4685.0905 to 4685.0950 and the benefits that would be payable for the allowable expenses under the other plans, in the absence of coordination of benefits provisions in parts 4685.0905 to 4685.0950, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

A. When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

B. Item A may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

4685.0930 MISCELLANEOUS PROVISIONS.

Subpart 1. **Reasonable cash values of services.** A secondary plan that provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, if benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this subpart shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

Subp. 2. **Coordination of benefits with a noncomplying plan.** Some plans contain a coordination provision that violates parts 4685.0905 to 4685.0950 by declaring that the plan's coverage is excess to all others, or is always secondary. This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet been conformed with this regulation under part 4685.0905. A plan may coordinate its benefits with a plan that does not comply with parts 4685.0905 to 4685.0950 according to items A to D.

A. If the complying plan is the primary plan, it must pay or provide its benefits on a primary basis.

B. If the complying plan is the secondary plan, it must pay or provide its benefits first, but the benefits payable are determined as if the complying plan is the secondary plan, and are limited to the complying plan's liability.

C. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall pay benefits as if the benefits of the noncomplying plan are identical to its own. However, the complying plan must adjust its payments when it receives information on the actual benefits of the noncomplying plan.

D. If the noncomplying plan reduces its benefits so that the member receives less in benefits than the member would have received had the complying plan paid benefits as the secondary plan and the noncomplying plan paid benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall pay to or on behalf of the member an amount equal to the difference.

The complying plan shall not pay more than the complying plan would have paid had it been the primary plan less any amount it previously paid. The complying plan is subrogated to all rights of the member against the noncomplying plan. A payment by the complying plan under this item does not prejudice any claim against the noncomplying plan in the absence of subrogation.

Subp. 3. **Allowable expense.** A term such as "usual and customary," "usual and prevailing," or "reasonable and customary" may be substituted for the term "necessary," "reasonable," or "customary." A term such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the coordination provisions apply.

Subp. 4. **Subrogation.** Provisions for coordination or subrogation may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

4685.0935 EFFECTIVE DATE; EXISTING CONTRACTS.

Subpart 1. **Applicability of coordination rules.** Coordination requirements in parts 4685.0905 to 4685.0950 apply to every group contract that provides health care benefits issued on or after October 9, 1989.

Subp. 2. **Deadline for compliance.** A group contract that provides health care benefits and that was issued before October 9, 1989, shall be brought into compliance with this regulation by the later of:

A. the next anniversary date or renewal date of the group contract; or

B. the expiration of any applicable collectively bargained contract under which it was written.

Statutory Authority: *MS s 62D 08; 62D.182; 62D.20*

History: *14 SR 901*

4685.0940 MODEL COORDINATION OF BENEFITS CONTRACT PROVISION.

Subpart 1. **General.** Use of the model coordination of benefits provision for group contracts in part 4685.0950 is subject to subparts 2 and 3 and part 4685.0915.

Subp. 2. **Flexibility.** A group contract's coordination provision does not have to use the words and format shown in part 4685.0950. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans that provide services, that pay benefits for expenses incurred, and that indemnify. No other substantive changes are allowed.

Subp. 3. **Prohibited coordination and benefit design.**

A. A group contract may not reduce benefits on the basis that:

(1) another plan exists;

(2) a person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(3) a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

B. No contract may contain a provision that its benefits are excess or always secondary to any plan, except as allowed in parts 4685.0905 to 4685.0950.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

4685.0950 TEXT OF MODEL COORDINATION OF BENEFITS PROVISIONS FOR GROUP CONTRACTS.

Group contracts must contain language on coordination of benefits that is substantially similar to the following model provisions.

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY.

(A) This coordination of benefits (COB) provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. "Plan" and "this plan" are defined below.

(B) If this coordination of benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

(1) shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

(2) may be reduced when, under the order of benefits determination rules,

another plan determines its benefits first. The above reduction is described in section IV.

II. DEFINITIONS.

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

* When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care: when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES.

A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Nondependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph (B)(3) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents:"

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the order of benefit determination rules outlined in Paragraph B(2).

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (4) is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN.

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. [health maintenance organization] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. [health maintenance organization] need not tell, or get the consent of, any person to do this. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under This Plan must give [health maintenance organization] any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT.

A payment made under another plan may include an amount which should have been paid under this plan. If it does, [health maintenance organization] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. [health maintenance organization] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY.

If the amount of the payments made by [health maintenance organization] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

QUALITY ASSURANCE

4685.1100 QUALITY EVALUATION.

The commissioner of health or each health maintenance organization may 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.03; 62D 04; 62D 11; 62D.20*

History: *14 SR 903*

4685.1105 DEFINITIONS.

Subpart 1. **Scope.** The following definitions apply to parts 4685.1100 to 4685.1130, unless the context clearly requires another meaning.

Subp. 2. **Criteria.** "Criteria" means standards that can be used to determine attainment of quality health care. Criteria may be explicit or implicit. Explicit criteria are a set of norms or indicators that are developed by health care professionals and are predetermined. Implicit criteria are the judgments of health care professionals regarding information related to quality of care.

Subp. 3. **Data.** "Data" refers to the following and similar types of information: patient charts, reports, records, enrollee surveys, staff surveys, staff concerns, performance appraisals, research, financial information, observation, professional organization credentialing reviews, and complaints registered.

Subp. 4. **Focused study.** "Focused study" means a study that begins with a hypothesis and includes systematic data collection, to provide information to identify or resolve problems or potential problems with quality of care. Focused studies include a written methodology and corrective action strategies when appropriate.

Subp. 5. **Monitoring.** "Monitoring" means collection of information relating to quality of care. Monitoring may be in the form of prospective, concurrent, or retrospective audits; reports; surveys; observation; interviews; complaints; peer review; or focused studies.

Subp. 6. **Outcome.** "Outcome" means the end result of care, or a change in patient health status. Examples of outcomes of care include a hospital admission or readmission, an advanced stage of a disease, recovery, alleviation of symptoms, or death.

Subp. 7. **Process.** "Process" means the nature of events and activities in the delivery of health care.

Subp. 8. **Structure.** "Structure" means the institutional or organizational aspects of care. Structure includes the organizing framework that brings the provider and patient together, organizational processes, policies, financial resources, and staff qualifications.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1110 PROGRAM.

Subpart 1. **Written quality assurance plan.** The health maintenance organization shall have a written quality assurance plan that includes the following:

A. mission statement;

B. philosophy;

C. goals and objectives;

D. organizational structure;

E. staffing and contractual arrangements;

F. a system for communicating information regarding quality assurance activities;

G. the scope of the quality assurance program activities; and

H. a description of peer review activities.

Subp. 2. **Documentation of responsibility.** Quality assurance authority, function, and responsibility shall be delineated in specific documents, including documents such as bylaws, board resolutions, and provider contracts. These documents shall demonstrate that the health maintenance organization has assumed ultimate responsibility for the evaluation of quality of care provided to enrollees, and that the health maintenance organization's governing body has periodically reviewed and approved the quality assurance program activities.

Subp. 3. **Appointed entity.** The governing body shall designate a quality assurance entity that may be a person or persons to be responsible for operation of quality assurance program activities. This entity shall maintain records of its quality assurance activities and shall meet with the governing body at least quarterly.

Subp. 4. **Physician participation.** A physician or physicians designated by the governing body shall advise, oversee, and actively participate in the implementation of the quality assurance program.

Subp. 5. **Staff resources.** There must be sufficient administrative and clinical staff with knowledge and experience to assist in carrying out quality assurance activities. In determining what is sufficient staff support, the commissioner shall consider the number of enrollees, types of enrollees, numbers of providers, the variety of health care services offered by the health maintenance organization, the organizational structure of the health maintenance organization, and the quality assurance staffing levels used by other health care organizations that perform similar health care functions.

Subp. 6. **Delegated activities.** The health maintenance organization may delegate quality assurance activities to providers, review organizations, or other entities. If the health maintenance organization contracts with another organization to conduct quality assurance activities, the health maintenance organization shall have review and reporting requirements developed and implemented to ensure that the organization contracting with the health maintenance organization is fulfilling all delegated quality assurance responsibilities.

Subp. 7. **Information system.** The data collection and reporting system shall support the information needs of the quality assurance program activities. The quality assurance program shall have prompt access to necessary medical record data including data by diagnoses, procedure, patient, and provider.

Subp. 8. **Program evaluation.** An evaluation of the overall quality assurance program shall be conducted at least annually. The results of this evaluation shall be communicated to the governing body. The written quality assurance plan shall be amended when there is no clear evidence that the program continues to be effective in improving care.

Subp. 9. **Complaints.** The quality assurance program shall conduct ongoing evaluation of enrollee complaints that are related to quality of care. Such evaluations shall be conducted according to the steps in part 4685.1120. The data on complaints related to quality of care shall be reported to the appointed quality assurance entity at least quarterly.

Subp. 10. **Utilization review.** The data from the health maintenance organization's utilization review activities shall be reported to the quality assurance program for analysis at least quarterly.

Subp. 11. **Provider qualifications and selection.** The health maintenance organization shall have policies and procedures for provider selection and qualifications. The health maintenance organization shall have policies and procedures for contracting with or hiring staff and providers that are accredited or appropriately trained for their positions or, as in the case of durable medical equipment, offer products that meet standards generally accepted by the medical community.

Subp. 12. **Qualifications.** Any health maintenance organization staff or contractees conducting quality assurance activities must be qualified by virtue of training and experience.

Subp. 13. **Medical records.** The quality assurance entity appointed under subpart 3 shall conduct ongoing evaluation of medical records.

A. The health maintenance organization shall implement a system to assure that medical records are maintained with timely, legible, and accurate documentation of all patient interactions. Documentation must include information regarding patient history, health status, diagnosis, treatment, and referred service notes.

B. The health maintenance organization shall maintain a medical record retrieval system that ensures that medical records, reports, and other documents are readily accessible to the health maintenance organization.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1115 ACTIVITIES.

Subpart 1. **Ongoing quality evaluation.** The health maintenance organization, through the health maintenance organization staff or contracting providers, shall conduct quality evaluation activities according to the steps in part 4685.1120. The quality evaluation activities must address each of the components of the health maintenance organization described in subpart 2.

Subp. 2. **Scope.** The components of the health maintenance organization subject to evaluation include the following:

A. Clinical components that include the following services:

(1) acute hospital services;

(2) ambulatory health care services;

(3) emergency services;

(4) mental health services;

(5) preventive health care services;

(6) pharmacy services;

(7) chemical dependency services;

(8) other professional health care services provided to enrollees, such as chiropractic, occupational therapy, and speech therapy;

(9) home health care, as applicable;

(10) durable medical equipment, as applicable; and

(11) skilled nursing care, as applicable.

B. Organizational components which are the aspects of the health plan that affect accessibility, availability, comprehensiveness, and continuity of health care, and which include the following:

(1) referrals;

(2) case management;

(3) discharge planning;

(4) appointment scheduling and waiting periods for all types of health care of providers;

(5) second opinions, as applicable;

(6) prior authorizations, as applicable;

(7) provider reimbursement arrangements; and

(8) other systems, procedures, or administrative requirements used by the health maintenance organization that affect delivery of care.

C. Consumer components which are the enrollees' perceptions regarding all aspects of the quality of the health plan's services, and which include:

(1) enrollee surveys;

(2) enrollee complaints; and

(3) enrollee written or verbal comments or questions.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1120 QUALITY EVALUATION STEPS.

Subpart 1. **Problem identification.** The health maintenance organization shall identify the existence of actual or potential quality problems or identify opportunities for improving care through:

A. ongoing monitoring of process, structure, and outcomes of patient care or clinical performance including the consumer components listed under part 4685.1115, subpart 2, item C; and

B. evaluation of the data collected from ongoing monitoring activities to identify problems or potential problems in patient care or clinical performance using criteria developed and applied by health care professionals.

Subp. 2. **Problem selection.** The health maintenance organization shall select problems or potential problems for corrective action or focused study based on the prevalence of the problem and its impact on patient care and professional practices.

Subp. 3. **Corrective action.** The health maintenance organization shall identify and document any recommendations for corrective action designed to address the problem. The documentation of corrective action shall include:

A. measurable objectives for each action, including the degree of expected change in persons or situations;

B. time frames for corrective action; and

C. persons responsible for implementation of corrective action.

Subp. 4. **Evaluation of corrective action.** The quality assurance entity shall monitor the effectiveness of corrective actions until problem resolution occurs. Results of the implemented corrective action must be documented and communicated to the governing body and involved providers.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1125 FOCUSED STUDY STEPS.

Subpart 1. **Focused studies.** As part of its overall quality evaluation activities, the health maintenance organization shall conduct focused studies to acquire information relevant to quality of care. The focused study must be directed at problems, potential problems, or areas with potential for improvements in care. The focused studies shall be included as part of the health maintenance organization's problem identification and selection activities.

Subp. 2. **Topic identification and selection.** The health maintenance organization shall select topics for focused study that must be justified based on any of the following considerations:

A. areas of high volume;

B. areas of high risk;

C. areas where problems are expected or where they have occurred in the past;

D. areas that can be corrected or where prevention may have an impact;

E. areas that have potential adverse health outcomes; and

F. areas where complaints have occurred.

Subp. 3. **Study.** The health maintenance organization shall document the study methodology employed, including:

A. the focused study question;

B. the sample selection;

C. data collection;

D. criteria; and

E. measurement techniques.

Subp. 4. **Corrective actions.** Any corrective actions implemented to address problems identified through focused studies shall follow the requirements defined in part 4685.1120, subparts 3 and 4.

Subp. 5. **Other studies.** An activity in which the health maintenance organi-

zation participates that meets any of the criteria in subparts 2 to 4 may satisfy in part or in total the focused study requirements. Examples of other activities that may satisfy the focused study requirements include external audits conducted by the professional review organization or other review organizations, multiple health plan surveys, or quality assurance studies across the community.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1130 FILED WRITTEN PLAN AND WORK PLAN.

Subpart 1. **Written plan.** The health maintenance organization shall file its written quality assurance plan, as described in part 4685.1110, subpart 1, with the commissioner, before being granted a certificate of authority.

Subp. 2. **Annual work plan.** The health maintenance organization shall annually file a proposed work plan with the commissioner on or before November 1 of every year. The proposed work plan must meet the requirements of items A and B.

A. The work plan shall give a detailed description of the proposed quality evaluation activities that will be conducted in the following year. The quality evaluation activities shall address the components of the health care delivery system defined in part 4685.1115, subpart 2. The quality evaluation activities shall be conducted according to the steps in part 4685.1120.

In determining the level of quality evaluation activities necessary to address each of the components of the health plan, the commissioner shall consider the number of enrollees, the number of providers, the age of the health plan, and the level of quality evaluation activities conducted by health care organizations that perform similar functions.

B. The work plan shall give a description of the proposed focused studies to be conducted in the following year. The focused studies shall be conducted according to the steps in part 4685.1125. The description of the proposed studies shall include the following elements:

(1) topic to be studied;

(2) rationale for choosing topic for study according to part 4685.1125, subpart 1;

(3) benefits expected to be gained by conducting the study;

(4) study methodology;

(5) sample size and sampling methodology;

(6) criteria to be used for evaluation; and

(7) approval by the health maintenance organization's medical director or qualified director of health services designated by the governing body.

Each health maintenance organization shall annually complete a minimum of three focused studies. The focused study sample shall be representative of all health maintenance organization enrollees who exhibit characteristics of the issue being studied.

Subp. 3. **Amendments to plan.** The health maintenance organization may change its written quality assurance plan and proposed work plan by filing notice with the commissioner 30 days before modifying its quality assurance program or activities. If the commissioner does not disapprove of the modifications within 30 days of submission, the modifications are considered approved.

Subp. 4. **Plan review.** The commissioner shall review the health maintenance organization's annual proposed work plan to determine if it meets the criteria established in parts 4685.1100 to 4685.1130. If the commissioner does not disapprove the plan within 30 days of its submission, it is considered approved.

Subp. 5. **Extension to filing annual work plan.** The commissioner may, upon a health maintenance organization's showing of good faith efforts to meet the

November 1 deadlines, grant an extension of up to 90 days for a health maintenance organization filing an annual work plan due November 1, 1989. The extension will not be granted for work plan filings in succeeding years.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1700 REQUIREMENTS FOR COMPLAINT SYSTEM.

Subpart 1. **Health maintenance organization's internal complaint system.** A health maintenance organization's internal complaint system is considered reasonable and acceptable to the commissioner of health if the following procedures are followed.

A. If a complainant orally notifies a health maintenance organization that the complainant wishes to register a complaint, the health mamtenance organization shall promptly provide a complaint form that includes:

(1) the telephone number of member services, or other departments, or persons equipped to advise complainants;

(2) the address to which the form must be sent;

(3) a description of the health maintenance organization's internal complaint system and time limits applicable to that system; and

(4) the telephone number to call to inform the commissioner of health.

B. A health maintenance organization shall provide for informal discussions, consultations, conferences, or correspondence between the complainant and a person with the authority to resolve or recommend the resolution of the complaint. Within 30 days after receiving the written complaint, the health maintenance organization must notify the complainant in writing of its decision and the reasons for it. If the decision is partially or wholly adverse to the complainant, the notification must advise the complainant of the right to appeal according to item C, including the complainant's option for a written reconsideration or a hearing, the right to arbitrate according to item D, and the right to notify the commissioner. If the health maintenance organization cannot make a decision within 30 days due to circumstances outside the control of the health maintenance organization, the health maintenance organization may take up to an additional 14 days to notify the complainant provided the health maintenance organization informs the complainant in advance of the extension of the reasons for the delay.

C. If a complainant notifies the health maintenance organization in writing of the complainant's desire to appeal the health maintenance organization's initial decision, the health maintenance organization shall provide the complainant the option of a hearing or a written reconsideration.

(1) If the complainant chooses a hearing, a person or persons with authority to resolve or recommend the resolution of the complaint shall preside, but the person or persons presiding must not be solely the same person or persons who made the decision under item B;

(2) if the complainant chooses a written reconsideration, a person or persons with authority to resolve the complaint shall investigate the complaint, but the person or persons investigating must not be solely the same person or persons who made the decision under item B;

(3) hearings and written reconsiderations shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons, as is deemed necessary by the person or persons investigating the complaint in the case of a reconsideration, or presiding person or persons in the case of a hearing for a fair appraisal and resolution of the complaint;

(4) in the case of a written reconsideration, a written notice of all

key findings shall be given the complainant within 30 days of the health maintenance organization's receipt of the complainant's written notice of appeal; and

(5) in the case of a hearing, concise written notice of all key findings shall be given the complainant within 45 days after the health maintenance organization receives the complainant's written notice of appeal.

D. A health maintenance organization shall provide the opportunity for impartial arbitration of any complaint which is unresolved by the mechanisms set forth in item B. Arbitration must be conducted according to the American Arbitration Association Minnesota Health Maintenance Organization Arbitration Rules, as amended and in effect November 1, 1988. These rules are incorporated by reference and are available for inspection at the State Law Library, 117 University Avenue, Saint Paul, Minnesota 55155.

The American Arbitration Association Minnesota Health Maintenance Organization Arbitration Rules are subject to changes by the American Arbitration Association. Only those rules in effect November 1, 1988, are incorporated by reference.

If the subject of the complaint relates to a malpractice claim, the complaint shall not be subject to arbitration.

The judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction under Minnesota Statutes, sections 572.16 and 572.21.

E. If a complaint involves a dispute about an immediately and urgently needed service that the health maintenance organization claims is experimental, not medically necessary, or otherwise not generally accepted by the medical profession, and that the health maintenance organization has not yet provided to the complainant, the procedures in items A to D do not apply. The health maintenance organization must use an expedited dispute resolution process appropriate to the particular situation.

(1) By the end of the next business day after the complaint is registered, the health maintenance organization shall notify the commissioner of the nature of the complaint, the decision of the health maintenance organization, if any, and a description of the review process used or being used.

(2) If a decision is not made by the end of the next business day following the registration of the complaint, the health maintenance organization shall notify the commissioner of its decision by the end of the next business day following its decision.

(3) For purposes of this item, complaints need not be in writing.

F. A health maintenance organization must notify enrollees of the existence of its complaint system, including the procedure in item E, and must clearly and thoroughly describe the procedural steps of that system in:

(1) the evidence of coverage required by Minnesota Statutes, section 62D.07; and

(2) enrollee handbooks, if used by the health maintenance organization.

Subp. 2. **Dispute resolution by commissioner.** A complainant may at any time submit a complaint to the commissioner, who may either independently investigate the complaint or refer it to the health maintenance organization for further review. If the commissioner refers the complaint to the health maintenance organization, the health maintenance organization must notify the commissioner in writing of its decision and the reasons for the decision within 30 days after receiving the commissioner's initial correspondence to the health maintenance organization, unless otherwise ordered by the commissioner. If the health maintenance organization cannot make a decision within 30 days due to circumstances outside its control, the health maintenance organization may take up to an additional 14 days to notify the commissioner if the health maintenance organization notifies

the commissioner in advance of the extension and the reasons for the delay. If the health maintenance organization's decision is partially or wholly adverse to the complainant, the complainant may pursue a hearing or written reconsideration and arbitration according to subpart 1, items C and D. After investigating a complaint, or reviewing the health maintenance organization's decision, the commissioner may order a remedy as authorized by Minnesota Statutes, sections 62D.15, 62D.16, and 62D.17.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1800 [Repealed, 14 SR 903]

4685.1900 RECORDS OF COMPLAINTS.

Subpart 1. **Record requirements.** Every health maintenance organization shall maintain a record of each complaint filed with it during the prior five years. The record shall, where applicable, include:

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

B. all correspondence relating to informal discussions, consultations, or conferences held relative to each complaint; a brief written summary of all informal discussions, consultations, conferences, or correspondence held relative to each complaint that includes the date or dates on which each such informal discussion, consultation, conference, or correspondence occurred and their outcomes.

C. a copy of the hearing or reconsideration findings given the complainant;

D. a copy of the arbitrator's decision; and

E. all documents which have been filed with a court relating to a complaint and all orders and judgments of a court relating to the complaint.

Subp. 2. **Log of complaints.** A health maintenance organization shall keep a single, ongoing log of complaints. The log shall contain the date the complaint was initially submitted; the name, address, and telephone number of the complainant; and the location of the complainant's complaint records.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1910 UNIFORM REPORTING.

Beginning April 1, 1989, health maintenance organizations shall submit as part of the annual report a completed NAIC Blank, subject to the amendments in parts 4685.1930, 4685.1940, and 4685.1950.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.1940 NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #2: STATEMENT OF REVENUE AND EXPENSES.

Subpart 1. **Separate statements.** The NAIC Blank for health maintenance organizations is amended by requiring the submission of a separate STATEMENT OF REVENUE AND EXPENSES for each of the following:

A. the health maintenance organization's total operations;

B. each demonstration project, as described under Minnesota Statutes, section 62D.30;

C. any Medicare risk enrollee contracts authorized by section 1876 of the Social Security Act; and

D. any other Medicare contracts.

Subp. 2. **Other expenses.** Report #2: STATEMENT OF REVENUE AND EXPENSES is amended by adding line 19a, Other Expenses.

Subp. 3. **Additional administrative expenses.** Report #2: STATEMENT OF REVENUE AND EXPENSES is amended by adding line 25a, Additional Administrative Expenses.

Subp. 4. **Uncovered expenses.** Report #2: STATEMENT OF REVENUE AND EXPENSES is amended by requiring a schedule of uncovered expenses.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.1950 NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #4: ENROLLMENT AND UTILIZATION TABLE.

Subpart 1. **Additional columns.** Report #4: ENROLLMENT AND UTILIZATION TABLE is amended by adding the following columns:

A. 9a, Total Ambulatory Encounters for Period for Mental health; and

B. 9b, Total Ambulatory Encounters for Period for Chemical Dependency.

Subp. 2. **Total members at end of period.** The Report #4: ENROLLMENT AND UTILIZATION TABLE is amended by requiring the itemization of Cumulative Member Months for Period by gender and five-year age increments, and Total Members at End of Period by gender, by five-year age increments, and by county, for the health maintenance organization's Minnesota health maintenance contract enrollment, Medicare risk contract enrollment authorized by section 1876 of the Social Security Act, any other Medicare contract enrollment, and each demonstration project.

Subp. 3. **Type of service.** Report #4: ENROLLMENT AND UTILIZATION TABLE is amended by requiring the itemization of Total Patient Days Incurred, Annualized Hospital Days per 1,000 Enrollees, and Average Length of Stay by five-year age increments and by the following types of service for Minnesota health maintenance contracts, Minnesota health maintenance Medicare risk contracts, authorized by section 1876 of the Social Security Act, any other Medicare contract enrollment, and each demonstration project:

A. medical/surgical, in a hospital;

B. obstetrical/gynecological, in a hospital;

C. mental health, in a hospital or other health care facility;

D. chemical dependency, in a hospital or other health care facility; and

E. other services provided in health care facilities other than hospitals.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.1980 QUARTERLY REPORTS.

The following sections of the NAIC Blank shall be submitted as the health maintenance organization's quarterly reports:

A. NAIC Reports #1, #2, #3; and

B. a description of the enrollment data included in NAIC report #4.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

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 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.

D. A listing of participating entities grouped by county, including the name, complete address, and clinic name, if applicable, of each health care provider and a description of each health care provider's specialty. This listing shall be submitted on forms prescribed by the commissioner.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.08; 62D.11; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 903*

4685.2250 USE OF FILED MATERIAL.

When a health maintenance organization modifies any documents as described in Minnesota Statutes, section 62D.08, subdivision 1, it shall not implement the modifications until notice of the modifications has been filed with the commissioner and the filing is approved, or deemed approved.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.2800 FEES.

Subpart 1. **Filing fees.** Every filing submitted to the commissioner by a health maintenance organization subject to Minnesota Statutes, sections 62D.01 to 62D.29 shall be accompanied by the following fees:

A. for filing an application for a certificate of authority, $1,500;

B. for filing each annual report, $200;

C. for filing a quarterly report, $50;

D. for filing each amendment to a certificate of authority, including the filings required under Minnesota Statutes, section 62D.08, subdivision 1, $50;

E. for each examination, the costs, including staff salaries and fringe benefits and indirect costs, incurred in preparing for and conducting the examination and preparing the subsequent report. The commissioner shall provide the health maintenance organization an itemized statement at the time of billing.

For the purpose of this item, indirect costs include costs attributable to:

(1) supplies;

(2) professional and technical services;

(3) electronic data processing;

(4) variable telephone usage;

(5) correspondence delivery;

(6) travel and subsistence; and

(7) general overhead, including building rental, telephone systems, executive office services, personnel services, administrative services, and financial management.

The fee charged for the examination must be calculated by totaling staff salaries, fringe benefits, and the costs described in subitems (1) to (6) and adding the percentage of general overhead, described in subitem (7), attributable to the specific examination; and

F. for all other filings, $100. These filings include:

(1) requests for waiver of open enrollment;

(2) demonstration project applications; and

(3) expense and revenue reports required under Minnesota Statutes, section 62D.03, subdivision 4, clause (g).

Subp. 2. **Renewal fee.** The renewal fee for a certificate of authority is $10,000 for each health maintenance organization plus 35 cents for each person enrolled in the health maintenance organization on December 31 of the preceding year.

Statutory Authority: *MS s 62D.08 subd 3; 62D.20; 62D.21; 62D.211*

History: *13 SR 2609*

4685.3300 PERIODIC FILINGS.

Subpart 1. [Repealed, 14 SR 901]

Subp. 1a. **Final form.** Copies of all contracts, contract forms or documents and their amendments which are required to be filed with the commissioner according to Minnesota Statutes, section 62D.08, subdivision 1, must be submitted in final typewritten form. However, minor legible handwritten changes to the typewritten form may be accepted.

Subp. 2. [Repealed, 14 SR 901]

Subp. 2a. **Insufficient information.** A filing shall be disapproved if supporting information is necessary to determine whether the filed material meets all standards in this chapter or Minnesota Statutes, chapter 62D, and supporting information does not accompany the filing, or the supporting information is not adequate.

In the disapproval letter, the commissioner shall specify the supporting information required, and the health maintenance organization may refile the additional information as an amended filing according to the provisions of subpart 7.

Subp. 3. **Filing of contract.** The filing of any contracts or evidences of coverage under 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 to allow the commissioner of health to determine the impact and reasonableness of the copayment provisions.

Subp. 4. [Repealed, 14 SR 901]

Subp. 4a. **Form identification.** Each contract, contract form or document and their amendments, filed for approval must contain the health maintenance organization's name, address, and telephone number and must be identified by a unique form number in the lower left hand corner on the first page of the form. If applicable, the health maintenance organization shall identify the filing as either a group or individual contract or evidence of coverage.

Subp. 5. [Repealed, 14 SR 901]

Subp. 5a. **Duplicate copies.** Each contract form or document and its amendments filed with the commissioner must be submitted in duplicate with a cover letter indicating the name and telephone number of the contact person for the health maintenance organization, and the address to which the commissioner's decision shall be mailed.

Subp. 6. **Approval or disapproval.** One copy of each contract form or document and its amendments, filed with the commissioner must be stamped approved or disapproved and returned to the health maintenance organization within 30 days after the commissioner's receipt of the filing. If disapproved, the specific reason for denial shall be stated in writing by the commissioner or authorized representative.

Subp. 7. **Amended filings.** A filing that has been disapproved may be amended and refiled with the commissioner without a filing fee, provided the health maintenance organization submits the amended filing to the commissioner within 30 days after the health maintenance organization receives notice of disapproval. An amended filing shall only address the issues that were the subject of the disapproval. When refiling an amended filing, the health maintenance organization shall use the same identification number that was used on the original filing.

When the health maintenance organization files an amended filing, it shall submit two copies of the amended filing. One copy must be stamped approved or disapproved and returned to the health maintenance organization within 30 days after the commissioner's receipt of the amended filing under subpart 7.

Subp. 8. **Endorsements.** When filing an endorsement, amendment, or rider, the health maintenance organization shall indicate the form number or numbers with which the endorsement, amendment, or rider will be used.

Subp. 9. **Service area expansion.** The filing of a request to expand a service area must be accompanied by sufficient supporting documentation including the following:

A. a detailed map with the proposed service area outlined;

B. provider locations charted on the map;

C. a description of driving distances, using major transportation routes, from the borders of the proposed service area to the participating providers;

D. a description of the providers' hours of operation;

E. evidence that the physicians have admitting privileges at the hospitals that enrollees in the new service area will use;

F. a list of providers in the new service area with the name, address, and specialty of every provider;

G. evidence of contractual arrangements with providers. Acceptable evidence is a copy of the signature page of the provider contract, or a sworn affidavit that states that the providers are under contract with the health maintenance organization; and

H. any other information relating to documentation of service area, facility, and personnel availability and accessibility to allow a determination of compliance with part 4685.1000.

Subp. 10. **Marked up copies.** Any filing that amends or replaces a previously approved filing shall be accompanied by a copy of the previously approved filing with any changes, additions, or deletions noted.

Subp. 11. **Notice of participating entity changes.** Any notice of an addition or deletion of a participating entity must be submitted on forms prescribed by the commissioner, or approved for use by the commissioner.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*