

CHAPTER 62E

HEALTH CARE

Sec.	COMPREHENSIVE HEALTH INSURANCE
62E.01	Citation.
62E.02	Definitions.
62E.03	Duties of the employer.
62E.04	Duties of insurers.
62E.05	Certification of qualified plans.
62E.06	Minimum benefits of qualified plan.
62E.07	Qualified medicare supplement plan.
62E.08	State plan premium.
62E.09	Duties of commissioner.
62E.10	Comprehensive health association.
62E.11	Operation of comprehensive plan.
62E.12	Minimum benefits of comprehensive health insurance plan.

Sec.	Administration of plan.
62E.13	Enrollment by an eligible person.
62E.14	Solicitation of eligible persons.
62E.15	Conversion privileges.
62E.16	Dual option.
62E.17	CATASTROPHIC HEALTH EXPENSE PROTECTION
	NOTE: Sections 62E.51 to 62E.55 are effective July 1, 1977.
62E.51	Citation.
62E.52	Definitions.
62E.53	Application for assistance.
62E.54	Duties of commissioner.
62E.55	Appeals.

COMPREHENSIVE HEALTH INSURANCE

62E.01 CITATION. Sections 62E.01 to 62E.17 may be cited as the Minnesota comprehensive health insurance act of 1976.

[1976 c 296 art 1 s 1]

62E.02 DEFINITIONS. Subdivision 1. For the purposes of sections 62E.01 to 62E.17, the terms and phrases defined in this section have the meanings given them.

Subd. 2. "Employer" means any person, partnership, association, trust, estate or corporation, which employs ten or more individuals who are residents of this state.

Subd. 3. "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in chapter 62D.

Subd. 4. "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 62E.06 or the actuarial equivalent of those benefits.

Subd. 5. "Qualified medicare supplement plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 62E.07 or the actuarial equivalent of those benefits.

Subd. 6. "Commissioner" means the commissioner of insurance.

Subd. 7. "Dependent" means a spouse or unmarried child under the age of 19 years, a dependent child who is a student under the age of 25 and financially dependent upon the parent, or a dependent child of any age who is disabled.

Subd. 8. "Employee" means any Minnesota resident who has entered into the employment of or works under contract or service or apprenticeship with any employer. "Employee" does not include a person who has been employed for less than 30 days by his present employer, nor one who is employed less than an average of 30 hours per week by his present employer.

Subd. 9. "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of self insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract.

Subd. 10. "Insurer" means those companies operating pursuant to chapters 62A or 62C and offering or selling policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

Subd. 11. "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical and medical care. "Policy" does not include coverage which is (1) limited to disability or income protection coverage, (2) automobile medical payment coverage, (3) supplemental to liability insurance, (4) sold by fraternal and provides payments on a per diem, daily indemnity or non-expense incurred basis, or (5) credit accident and health insurance issued pursuant to chapter 62B.

MINNESOTA STATUTES 1976

62E.03 HEALTH CARE

1002

Subd. 12. "Health benefits" means benefits offered to employees on an indemnity or prepaid basis which pay the costs of or provide medical, surgical or hospital care.

Subd. 13. "Eligible person" means an individual who is a resident of Minnesota and meets the enrollment requirements of section 62E.14.

Subd. 14. "Minnesota comprehensive health association" or "association" means the association created by section 62E.10.

Subd. 15. "Medicare" means part A and part B of the United States Social Security Act, Title XVIII, as amended, 42 U.S.C. Sections 1394, et seq.

Subd. 16. "Medicare supplement plan" means any plan of insurance protection which provides benefits for the costs of medical, surgical or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by medicare.

Subd. 17. "State plan premium" means the premium determined pursuant to section 62E.08.

Subd. 18. "Writing carrier" means the insurer or insurers and health maintenance organization or organizations selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

Subd. 19. "Fraternal beneficiary association" or "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with chapter 64A.

Subd. 20. "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization coverage offered by the association through the writing carrier.

Subd. 21. "Self insurer" means an employer who directly provides a plan of health coverage to his employees and administers the plan of health coverage himself or through an insurer. "Self insurer" does not include an employer engaged in the business of providing health care services to the public who provides health care services directly to his employees at no charge to them.

Subd. 22. "Self insurance" means a plan of health coverage offered by a self insurer.

[1976 c 296 art 1 s 2]

62E.03 DUTIES OF THE EMPLOYER. Subdivision 1. Each employer who provides or makes available to his employees a plan of health coverage shall make available to his employees employed in this state a plan or combination of plans which have been certified by the commissioner as a number two qualified plan. If the plan of health coverage does not meet the requirements of section 62E.06 for a number two qualified plan, the employer shall make available a supplemental plan of health benefits which, when combined with the existing plan of health benefits, constitutes a number two coverage plan. The plan or combinations of plans may be financed from funds contributed solely by the employer or solely by the employees or any combination thereof. The plans may consist of self insurance, health maintenance contracts, group policies or individual policies or any combination thereof.

Subd. 2. In the event that an employer fails to make available at least a number two qualified plan of health benefits to his employees employed in this state, none of the employer's costs for health benefits shall qualify as an income tax deduction pursuant to section 290.09, subdivision 2, clause (a)(1). In the case of an employer who meets the requirements of section 297A.25, subdivision 1, clause (p) if the employer fails to make available at least a number two qualified plan to his employees, the employer shall lose his status as an exempt organization under section 297A.25, subdivision 1, clause (p).

[1976 c 296 art 1 s 3]

62E.04 DUTIES OF INSURERS. Subdivision 1. **Individual policies.** For each type of qualified plan described in section 62E.06, an insurer or fraternal issuing individual policies of accident and health insurance in this state, other than group conversion policies, shall develop and file with the commissioner an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in this state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

Subd. 2. Medicare supplement plan. An insurer or fraternal issuing medicare supplement plans in this state shall develop and file with the commissioner a medicare supplement policy which meets the minimum standards of a qualified medicare supplement plan. An insurer or fraternal issuing medicare supplement plans in this state shall offer a qualified medicare supplement plan to each person who is eligible for coverage and who applies for a medicare supplement plan.

Subd. 3. Group policies. For each type of qualified plan described in section 62E.06, an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner a group policy which provides for each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in this state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

Subd. 4. Major medical coverage. Each insurer and fraternal shall include coverage of major medical costs in every unqualified policy of accident and health insurance, unless the applicant for a new or renewal policy declines the coverage in writing. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of \$5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum life-time limit of \$250,000.

Subd. 5. Effect of non-compliance. No policy of accident and health insurance may be issued or renewed in this state 180 days after July 1, 1976 by an insurer or a fraternal which has not complied with the requirements of this section.

Subd. 6. Reinsurance allowed. An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in their own name and reinsuring the risk and administration of the coverages with the association in accordance with section 62E.10, subdivision 7, clauses (e) and (f).

Subd. 7. Underwriting standards may apply. Nothing in this section shall require an insurer or fraternal to offer or issue a policy to any person who does not meet the underwriting or membership requirements of the insurer or fraternal.

[1976 c 296 art 1 s 4]

62E.05 CERTIFICATION OF QUALIFIED PLANS. Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified medicare supplement plan for the purposes of sections 62E.01 to 62E.17, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All plans of health coverage shall be labelled as "qualified" or "non-qualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

[1976 c 296 art 1 s 5]

62E.06 MINIMUM BENEFITS OF QUALIFIED PLAN. Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A and 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed \$150 per person. The coverage shall include a limitation of \$3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage may be subject to a maximum lifetime benefit of not less than \$250,000. Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) Hospital services;

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

(3) Drugs requiring a physician's prescription;

(4) Services of a nursing home for not more than 120 days in a year if the services commence within 14 days following confinement of at least three days in a hos-

pital for the same condition;

- (5) Service of a home health agency up to a maximum of 180 visits per year;
- (6) Use of radium or other radioactive materials;
- (7) Oxygen;
- (8) Anesthetics;
- (9) Prostheses;
- (10) Rental or purchase, as appropriate, of durable medical equipment;
- (11) Diagnostic X-rays and laboratory tests;
- (12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth; and
- (13) Services of a physical therapist.

(b) Covered expenses for the services and articles specified in this subdivision do not include the following:

- (1) Any charge for any care for any injury or disease either (i) arising out of an injury in the course of employment and subject to a worker's compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance or medicare;
- (2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;
- (3) Any charge for travel other than travel by ambulance to the nearest health care institution qualified to treat the illness or injury;
- (4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician;
- (5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and
- (6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(c) Effective January 1, 1980, the minimum benefits for a qualified plan shall include, in addition to those benefits specified in clause (a), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

- (1) Well baby care;
- (2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician; and
- (3) Multiphasic screening and other diagnostic testing. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

Subd. 2. Number two plan. A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by the laws of this state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed \$500 per person.

Subd. 3. Number one plan. A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by the laws of this state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed \$1,000 per person.

Subd. 4. Health maintenance plans. A health maintenance organization which provides the services required by chapter 62D shall be deemed to be providing a number three qualified plan.

MINNESOTA STATUTES 1976

1005

HEALTH CARE 62E.10

62E.07 QUALIFIED MEDICARE SUPPLEMENT PLAN. Any plan which provides benefits to persons over the age of 65 years may be certified as a qualified medicare supplement plan if the plan is designed to supplement medicare and provides coverage of 50 percent of the deductible and copayment required under medicare and 80 percent of the charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by medicare. The coverage shall include a limitation of \$1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than \$100,000.

[1976 c 296 art 1 s 7]

62E.08 STATE PLAN PREMIUM. Subdivision 1. For the first year of operation of the comprehensive health insurance plan the association shall establish the following premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the number one qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

(b) The premium for the number two qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in Minnesota;

(c) The premium for a qualified medicare supplement plan shall be the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified medicare supplement plan; and

(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

Subd. 2. For the second and subsequent years the schedule of premiums for membership in the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

[1976 c 296 art 1 s 8]

62E.09 DUTIES OF COMMISSIONER. The commissioner may:

(a) Formulate general policies to advance the purposes of sections 62E.01 to 62E.17; the commissioner may also adopt, promulgate, repeal, and amend rules pursuant to the rule making provisions of chapter 15, to carry out the provisions of sections 62E.01 to 62E.17;

(b) Supervise the creation of the Minnesota comprehensive health association within the limits described in section 62E.10;

(c) Approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged;

(d) Appoint advisory committees;

(e) Conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(f) Contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs;

(g) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to 62E.17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections; and

(h) Contract with insurers and others for administrative services.

[1976 c 296 art 1 s 9]

62E.10 COMPREHENSIVE HEALTH ASSOCIATION. Subdivision 1. **Creation.** There is established a comprehensive health association with membership consisting of all insurers, self insurers, fraternal and health maintenance organizations licensed or authorized to do business in this state.

Subd. 2. **Board of directors; organization.** The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of

the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Subd. 3. Mandatory membership. All members shall maintain their membership in the association as a condition of doing business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

Subd. 4. Open meetings. All meetings of the association, its board, and any committees of the association shall comply with the provisions of section 471.705.

Subd. 5. Contract of reinsurance. All members shall enter into a contract with the association according to terms specified in section 11. The contract of reinsurance shall be executed on or before January 1, 1977, for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

Subd. 6. Antitrust exemption. In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325.8011 to 325.8028.

Subd. 7. General powers. The association may:

- (a) Exercise the powers granted to insurers under the laws of this state;
- (b) Sue or be sued;
- (c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);
- (d) Establish administrative and accounting procedures for the operation of the association;
- (e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by sections 62E.04 and 62E.16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:
 - (1) Individual qualified plans, excluding group conversions;
 - (2) Group conversions;
 - (3) Group qualified plans with fewer than 50 employees or members; and
 - (4) Major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the adminis-

MINNESOTA STATUTES 1976

1007

HEALTH CARE 62E.13

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[1976 c 296 art 1 s 10]

62E.11 OPERATION OF COMPREHENSIVE PLAN. Subdivision 1. Upon certification as an eligible person in the manner provided by section 62E.14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

Subd. 2. Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

Subd. 3. Not less than 87-1/2 percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than 12-1/2 percent shall be used for the payment of agent referral fees as authorized in section 62E.15, subdivision 3 and for payment of the writing carrier's direct and indirect expenses, as specified in section 62E.13, subdivision 7.

Subd. 4. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services pursuant to section 62E.07, clauses (e) and (f) shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 5. Each member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with section 62E.10, subdivision 5. Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the excess costs of the state plan in an amount equal to the ratio of the member's total cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of Minnesota residents as divided into the total cost of self insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of Minnesota residents, as determined by the commissioner. The reinsurance contract shall provide for a retroactive determination of each member's liability and payment due within 30 days after each renewal date of the reinsurance contract. Failure by a member to tender to the association the assessed reinsurance payment within 30 days of notification by the association shall be grounds for termination of the member's membership.

Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

[1976 c 296 art 1 s 11]

62E.12 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN. The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan, a number two qualified plan and a qualified medicare supplement plan. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

[1976 c 296 art 1 s 12]

62E.13 ADMINISTRATION OF PLAN. Subdivision 1. Any member of the association may submit to the commissioner the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the comprehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

Subd. 2. Upon the commissioner's approval of the policy forms and contracts submitted pursuant to section 62A.10, the association shall select policies and contracts submitted by a member or members of the association to be the comprehensive health insurance plan. This selection shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the

plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract.

Subd. 3. The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. Six months prior to the expiration of each three year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subdivision 2 in selecting a writing carrier for the subsequent three year period.

Subd. 4. The writing carrier shall provide to all eligible persons enrolled in the plan an individual certificate, setting forth a statement as to the insurance protection to which he is entitled, with whom claims are to be filed and to whom benefits are payable. The certificate shall indicate that coverage was obtained through the association.

Subd. 5. The writing carrier shall submit to the association and the commissioner on a monthly basis a report on the operation of the state plan. Specific information to be contained in this report shall be determined by the association prior to the effective date of the state plan.

Subd. 6. All claims shall be paid by the writing carrier pursuant to the provisions of sections 62E.01 to 62E.17, and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

Subd. 7. The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses shall include, but need not be limited to, a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses shall not include costs directly related to the original submission of policy forms prior to selection as the writing carrier.

Subd. 8. The writing carrier shall at all times when carrying out its duties under sections 62E.01 to 62E.17 be considered an agent of the association and the commissioner with civil liability subject to the provisions of section 3.751.

Subd. 9. Premiums received by the writing carrier for the comprehensive health insurance plan are specifically exempted from the provisions of section 60A.15.

[1976 c 296 art 1 s 13]

62E.14 ENROLLMENT BY AN ELIGIBLE PERSON. Subdivision 1. **Certificate, contents.** The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

- (a) Name, address, age, and length of time at residence of the applicant;
- (b) Name, address, and age of spouse and children if any, if they are to be insured;
- (c) Evidence of rejection, or a requirement of restrictive riders, or a pre-existing conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least two association members within six months of the date of the certificate; and
- (d) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan.

Subd. 2. **Writing carrier's response.** Within 30 days of receipt of the certificate described in subdivision 1, the writing carrier shall either reject the application for failing to comply with the requirements in subdivision 1 or forward the eligible person a notice of acceptance and billing information. Insurance shall be effective immediately upon receipt of the first month's state plan premium, and shall be retroactive to

the date of the application, if the applicant otherwise complies with the requirements of sections 62E.01 to 62E.17.

Subd. 3. **Pre-existing conditions.** No person who obtains coverage pursuant to this section shall be covered for any pre-existing condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of an application.

[1976 c 296 art 1 s 14]

62E.15 SOLICITATION OF ELIGIBLE PERSONS. Subdivision 1. The association pursuant to a plan approved by the commissioner shall disseminate appropriate information to the residents of this state regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio and television, as well as publication in appropriate state offices and publications.

Subd. 2. The association shall devise and implement means of maintaining public awareness of the provisions of sections 62E.01 to 62E.17 and shall administer these sections in a manner which facilitates public participation in the state plan.

Subd. 3. The writing carrier shall pay an agent's referral fee of \$25 to each insurance agent who refers an applicant to the state plan, if the application is accepted. Selling or marketing of qualified state plans shall not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for the state plan.

Subd. 4. Every insurer which rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the applicant of the existence of the state plan, the requirements for being accepted in it, and the procedure for applying to it.

[1976 c 296 art 1 s 15]

62E.16 CONVERSION PRIVILEGES. Every program of self insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state, shall include, in addition to the provisions required by section 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions regardless of the reason for leaving the group. The person leaving the group may exercise his right to conversion within 30 days of leaving the group. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue his coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived. An individual conversion contract issued by a health maintenance organization shall not be deemed to be an individual enrollment contract for the purposes of section 62D.10.

[1976 c 296 art 1 s 16]

62E.17 DUAL OPTION. Subdivision 1. An employer who employs in this state, on the average during a calendar quarter, 100 employees or more, other than employees engaged in seasonal employment as defined in section 268.07, subdivision 5, and who offers a health benefits plan to employees, whether (i) purchased from an insurer or a health maintenance organization, or (ii) provided on a self insured basis, shall, upon the next renewal of the health benefits plan contract, offer his employees a dual option to obtain health benefits through either an accident and health insurance policy or a health maintenance organization contract if one is available. An option need not be provided if less than 25 employees select that option.

Subd. 2. An employer may make the dual offers through an insurer, a health maintenance organization or on a self insured basis. If an offer is made on a self insured basis, the accident and health insurance type of coverage or health maintenance organization type of coverage shall meet the requirements of the laws of this state as to the services covered or benefits provided, but need not otherwise be approved by the commissioner or the board of health.

Subd. 3. No insurer shall make acceptance of its offer to provide insurance coverage contingent on acceptance by the employer of health maintenance organization

MINNESOTA STATUTES 1976

62E.51 HEALTH CARE

1010

coverage by a particular health maintenance organization. No health maintenance organization shall make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. No offer to provide the accident and health insurance policy and the health maintenance organization contract shall combine the two in a single price package.

Subd. 4. The board of health, in consultation with the commissioner, shall adopt rules to implement the provisions of this section.

[1976 c 296 art 1 s 17]

CATASTROPHIC HEALTH EXPENSE PROTECTION

NOTE: Sections 62E.51 to 62E.55 are effective July 1, 1977.

62E.51 CITATION. Sections 62E.51 to 62E.55 may be cited as the Minnesota catastrophic health expense protection act of 1976.

[1976 c 296 art 3 s 1]

62E.52 DEFINITIONS. Subdivision 1. For the purposes of sections 62E.51 to 62E.55, the terms defined in this section have the meanings given them.

Subd. 2. "Eligible person" means any person who is a resident of Minnesota and who, while a resident of Minnesota, has been found by the commissioner to have incurred an obligation to pay qualified expenses for himself and any dependents in any 12 consecutive months exceeding:

(a) 40 percent of his household income up to \$15,000, plus 50 percent of his household income between \$15,000 and \$25,000, plus 60 percent of his household income in excess of \$25,000; or

(b) \$2,500, whichever is greater.

Subd. 3. "Qualified expense" means any charge incurred subsequent to July 1, 1977 for a health service which is included in the list of covered services described in section 62E.06, subdivision 1, and for which no third party is liable.

Subd. 4. "Dependent" means a spouse or unmarried child under the age of 19 years, a child who is a student under the age of 25 and financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

Subd. 5. "Household income" means the gross income of an eligible person and all his dependents for the calendar year preceding the year in which an application is filed pursuant to section 62E.53.

Subd. 6. "Gross income" means income as defined in section 290A.03, subdivision 3.

Subd. 7. "Commissioner" means the commissioner of public welfare.

Subd. 8. "Third party" means any person other than the eligible person or his dependents.

[1976 c 296 art 3 s 2]

62E.53 APPLICATION FOR ASSISTANCE. Subdivision 1. Any person who believes that they are or will become an eligible person may submit an application for state assistance to the commissioner. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the 12 month period for computing expenses began.

Subd. 2. If the commissioner determines that an applicant is an eligible person, he shall pay 90 percent of all qualified expenses of the eligible person and his dependents in excess of:

(a) 40 percent of his household income under \$15,000, plus 50 percent of his household income between \$15,000 and \$25,000, plus 60 percent of his household income in excess of \$25,000; or

(b) \$2,500;

whichever is greater for the 12 month period in which the applicant becomes an eligible person. If the commissioner determines that the charge for a health service is excessive, he may limit his payment to the usual and customary charge for that ser-

vice. If the commissioner determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. To the extent feasible, the commissioner shall contract with a review organization as defined in section 145.61, in making any determinations as to whether or not a charge is excessive. To the extent feasible, the commissioner shall contract with a review organization as defined in section 145.61, in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

[1976 c 296 art 3 s 3]

62E.54 DUTIES OF COMMISSIONER. Subdivision 1. The commissioner shall:

- (a) Promulgate reasonable rules to implement sections 62E.51 to 62E.55.
- (b) Establish application forms and procedures for the use of persons seeking to be declared an eligible person; and
- (c) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

Subd. 2. The commissioner may:

(a) Enter into contracts with the United States or any state agency, instrumentality or political subdivision for the purpose of coordinating the program established by sections 62E.51 to 62E.55, with other programs which provide or pay for the delivery of health services;

(b) Enter into contracts with third parties to perform some or all of the duties imposed on the commissioner by sections 62E.53 and 62E.54.

[1976 c 296 art 3 s 4]

62E.55 APPEALS. The final decision of the commissioner denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to chapter 15.

[1976 c 296 art 3 s 5]