premiums. Nothing in this paragraph shall prohibit the commissioner from disapproving a form which meets the requirements of this paragraph but which the commissioner determines still provides benefits which are unreasonable in relation to the benefits charged. The commissioner may until December 31, 1978, exercise emergency power for the purpose of implementing the minimum anticipated loss ratio requirement, and for this purpose may adopt emergency rules as provided in section 15.0412, subdivision 5. Notwithstanding the expiration of the commissioner's emergency power, any emergency rule adopted by him prior to the expiration of his emergency power may remain effective for the periods authorized in section 15.0412, subdivision 5.

If the commissioner notifies an insurer which has filed any form that the form does not comply with the provisions of this section or sections 62A.03 to 62A.05 and section 72A.20, it shall be unlawful thereafter for the insurer to issue the form or use it in connection with any policy. In the notice the commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

[*For text of subds 4 to 6, see M.S.1978*]

[*1979 c 207 s 1*]

62A.045 Payments to welfare recipients.

No policy of accident and sickness insurance shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving medical assistance pursuant to chapter 256B or services pursuant to sections 252.27; 260.251, subdivision 1a; 261.27; or 393.07, subdivision 1 or 2.

[*1979 c 174 s 1*]

62A.22 Refusal to provide coverage because of option under workers' compensation.

No insurer offering an individual or group policy of accident or health coverage in this state shall refuse to provide or renew accident or health coverage because the insured has an option to elect workers' compensation coverage pursuant to section 176.012.

[*1979 c 92 s 1*]

CHAPTER 62C. NONPROFIT HEALTH SERVICE PLAN CORPORATIONS ACT

Sec.
62C.141 Payments to welfare recipients.

62C.141 Payments to welfare recipients.

No service plan corporation shall deliver, issue for delivery, or renew any subscriber's contract which contains any provision denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for or receiving medical assistance pursuant to chapter 256B or services pursuant to sections 252.27; 260.251, subdivision 1a; 261.27; or 393.07, subdivision 1 or 2.

[*1979 c 174 s 2*]

CHAPTER 62D. HEALTH MAINTENANCE ACT OF 1973

Sec.
62D.22 Statutory construction and relationship to other laws.
62D.30 Demonstration projects.

62D.22 Statutory construction and relationship to other laws.

[*For text of subds 1 to 6, see M.S.1978*]

Subd. 7. A licensed health maintenance organization shall be deemed to be a prepaid group practice plan for the purposes of chapter 43 and shall be allowed to partici-

62D.22 HEALTH MAINTENANCE ACT OF 1973

pate as a carrier for state employees subject to any negotiated labor agreement and reasonable restrictions applied to all carriers.

[*For text of subds 8 and 9, see M.S.1978*]

[*1979 c 332 art 1 s 57*]

62D.30 Demonstration projects.

Subdivision 1. The commissioner of health may establish demonstration projects to allow health maintenance organizations to extend coverage to:

(a) Individuals enrolled in Part A or Part B, or both, of the medicare program, Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.;

(b) Groups of fewer than 50 employees where each group is covered by a single group health policy;

(c) Individuals who are not eligible for enrollment in any group health maintenance contracts; and

(d) Low income population groups.

For purposes of this section, the commissioner of health may waive compliance with minimum benefits pursuant to sections 62A.151 and 62D.02, subdivision 7, full financial risk pursuant to section 62D.04, subdivision 1, clause (f), open enrollment pursuant to section 62D.10, and to applicable rules if there is reasonable evidence that the rules prohibit the operation of the demonstration project. The commissioner shall provide for public comment before any statute or rule is waived.

Subd. 2. A demonstration project must provide health benefits equal to or exceeding the level of benefits provided in Title XVIII of the Social Security Act and an out of hospital prescription drug benefit. The out of hospital prescription drug benefit may be waived by the commissioner if the health maintenance organization presents evidence satisfactory to the commissioner that the inclusion of the benefit would restrict the operation of the demonstration project.

Subd. 3. A health maintenance organization electing to participate in a demonstration project shall apply to the commissioner for approval on a form developed by the commissioner. The application shall include at least the following:

(a) A statement identifying the population that the project is designed to serve;

(b) A description of the proposed project including a statement projecting a schedule of costs and benefits for the enrollee;

(c) Reference to the sections of Minnesota Statutes and department of health rules for which waiver is requested;

(d) Evidence that application of the requirements of applicable Minnesota Statutes and department of health rules would, unless waived, prohibit the operation of the demonstration project;

(e) Evidence that another arrangement is available for assumption of full financial risk if full financial risk is waived under subdivision 1;

(f) An estimate of the number of years needed to adequately demonstrate the project's effects; and

(g) Other information the commissioner may reasonably require.

Subd. 4. The commissioner shall approve, deny, or refer back to the health maintenance organization for modification, the application for a demonstration project within 60 days of receipt from the health maintenance organization.

Subd. 5. The commissioner may approve an application for a demonstration project for a maximum of six years, with an option to renew.

Subd. 6. Each health maintenance organization for which a demonstration project is approved shall annually file a report with the commissioner summarizing the project's experience at the same time it files its annual report required by section 62D.08. The report shall be on a form developed by the commissioner and shall be separate from the annual report required by section 62D.08.

Subd. 7. The commissioner may rescind approval of a demonstration project if the commissioner makes any of the findings listed in section 62D.15, subdivision 1, with respect to the project for which it has not been granted a specific exemption, or if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

[*1979 c 268 s 1*]

CHAPTER 62E. HEALTH CARE

Sec.		Sec.	
62E.02	Definitions.	62E.10	Comprehensive health association.
62E.035	Self insurer identification and reporting.	62E.11	Operation of comprehensive plan.
62E.04	Duties of insurers.	62E.13	Administration of plan.
62E.06	Minimum benefits of qualified plan.	62E.14	Enrollment by an eligible person.
62E.08	State plan premium.		

62E.02 Definitions.

[For text of subds 1 to 9, see M.S.1978]

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

[For text of subds 11 to 22, see M.S.1978]

Subd. 23. "Contributing member" means those companies operating pursuant to chapter 62A, paying premium taxes pursuant to section 60A.15, and offering, selling, issuing, or renewing policies or contracts of accident and health insurance.

[*1979 c 272 s 1,2*]

62E.035 Self insurer identification and reporting.

The commissioner shall require self insurers to report annually that they are engaged in self insurance business. These reports shall be for the previous calendar year and shall include the self insurer's total cost of self insurance and other information the commissioner may by rule require relating to the self insurer's plan of health coverage. Upon request of the commissioner, the commissioner of revenue shall cooperate with the commissioner in the identification of self insurers, and shall modify forms and promulgate rules as may be necessary to identify self insurers. In adopting the forms and rules promulgated pursuant to this section the commissioner of revenue shall consult with the commissioner.

[*1979 c 272 s 3*]

62E.04 Duties of insurers.

[For text of subds 1 to 3, see M.S.1978]

Subd. 4. **Major medical coverage.** Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every applicant who applies to the insurer or fraternal for a new unqualified policy at the time of application and annually to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal. 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 lifetime limit of $250,000. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.