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

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.

62E.04 HEALTH CARE

[For text of subds 5 to 7, see M.S.1978]

Subd. 8. **Reduction of benefits because of other services.** No policy of accident and health insurance shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving benefits pursuant to chapters 256B and 256D, or sections 62E.51 to 62E.55 or 252.27; 260.251, subdivision 1a; 261.27; 393.07, subdivision 1 or 2.

[*1979 c 174 s 3; 1979 c 272 s 4*]

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 shall be subject to a maximum lifetime benefit of not less than $250,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $250,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarily equivalent benefit.

(b) 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 would qualify as reimbursable services under medicare;

(5) Services of a home health agency if the services would qualify as reimbursable services under medicare;

(6) Use of radium or other radioactive materials;

(7) Oxygen;

(8) Anesthetics;

(9) Prostheses other than dental;

(10) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

(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;

(13) Services of a physical therapist; and

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.

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

(1) Any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' 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, medicare or any other governmental program except as otherwise provided by law;

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

(3) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare;

(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, provided, however, that if the institution does not have semi-private rooms, its most common semi-private room charge shall be considered to be 90 percent of its lowest private room charge;

(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.

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(1) Well baby care, effective July 1, 1980;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician, effective July 1, 1982;

(3) Multiphasic screening and other diagnostic testing, effective July 1, 1982. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

[For text of subds 2 to 4, see M.S.1978]

[1979 c 272 s 5]

62E.08 State plan premium.

Subdivision 1. The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the number one qualified plan shall be up to a maximum of 125 percent of 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 up to a maximum of 125 percent of 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 up to a maximum of 125 percent of 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.

The five insurers whose rates are used to establish the premium for each type of coverage offered by the association shall be determined by the commissioner on the ba-

sis of information provided by all insurers annually at the commissioner's request, concerning the number of individual qualified plans and qualified medicare supplement plans or actuarially equivalent plans offered by the insurer and rates charged by the insurer for each type of plan offered by the insurer. In determining the insurers whose rates shall be used in establishing the premium, the commissioner shall utilize generally accepted actuarial principles and structurally compatible rates. Subject to this subdivision, the commissioner shall include any insurer operating pursuant to chapter 62C in establishing the premium. In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles.

Subd. 2. Subject to subdivision 1, the schedule of premiums for coverage under the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

[*1979 c 272 s 6*]

62E.10 Comprehensive health association.

Subdivision 1. **Creation; tax exemption.** There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers, self insurers, fraternals and health maintenance organizations licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

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. In determining voting rights at members' meetings, 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. In approving 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 accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 15.041 to 15.052.

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. [Repealed, 1979 c 272 s 11]

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. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. 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 administration.

Subd. 8. **Department of state exemption.** The association shall be exempt from the provisions of chapter 15.

[*1979 c 272 s 7*]

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 contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contrib-

uting member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner.

Subd. 6. The association shall make an annual determination of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the contributing members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Subd. 7. 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.

Subd. 8. Any annual fiscal year end or interim assessment levied against a contributing member may be offset, in an amount equal to the assessment paid to the association, against the income tax or the premium tax payable by that contributing member pursuant to section 60A.15 for the year in which the annual fiscal year end or interim assessment is levied. The commissioner of revenue shall annually, on or before January 15, report to the chairmen of the senate finance, house appropriations, senate commerce and house financial institutions and insurance committees as to the total amount of income tax or premium tax offset claimed by contributing members during the preceding calendar year.

[*1979 c 272 s 8*]

NOTE: The provisions of subdivision 8 shall expire July 1, 1981. See Laws 1979, Chapter 272, Section 12.

62E.13 Administration of plan.

[*For text of subd 1, see M.S.1978*]

Subd. 2. The association may select policies and contracts, or parts thereof, submitted by a member or members of the association, or by the association or others, to develop specifications for bids from any members which wish to be selected as a writing carrier to administer the state plan. The selection of the writing carrier 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.

[*For text of subds 3 to 9, see M.S.1978*]

[*1979 c 272 s 9*]

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 shall enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

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

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

(c) Evidence of rejection, a requirement of restrictive riders, a rate up, or a 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, or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk; and

(d) A designation of the coverage desired.

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

[*For text of subds 2 and 3, see M.S.1978*]

[*1979 c 272 s 10*]

CHAPTER 64A. FRATERNAL BENEFICIARY ASSOCIATIONS

Sec.
64A.221 Payment to welfare recipients.

64A.221 Payment to welfare recipients.

No association authorized to do business in this state which provides or pays for any health care benefits shall issue any certificate which contains any provision denying or reducing benefits because services are rendered to a certificate holder or beneficiary 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 4*]

CHAPTER 65A. FIRE AND RELATED INSURANCE

65A.01 Minnesota standard fire insurance policy.

[*For text of subds 1 and 2, see M.S.1978*]

Subd. 2a. **Facsimile signatures authorized.** On any policy of insurance regulated under this chapter, the signature of an officer or agent of the insurer may be a facsimile signature.

[*For text of subds 3 to 6, see M.S.1978*]

[*1979 c 115 s 2*]

65A.08 Special provisions.

Subdivision 1. [Repealed, 1979 c 175 s 1]

[*For text of subds 2 to 6, see M.S.1978*]