CHAPTER 62D

HEALTH MAINTENANCE ACT OF 1973

62D.01 CITATION AND PURPOSE.

Subdivision 1. Sections 62D.01 to 62D.29 may be cited as the "health maintenance act of 1973".

Subd. 2. (a) Faced with the continuation of mounting costs of health care coupled with its inaccessibility to large segments of the population, the legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services.

(b) It is, therefore, the policy of the state to eliminate the barriers to the organization, promotion, and expansion of health maintenance organizations; to provide for their regulation by the state commissioner of health; and to exempt them from the operation of the insurance and nonprofit health service plan corporation laws of the state except as hereinafter provided.

(c) It is further the intention of the legislature to closely monitor the development of health maintenance organizations in order to assess their impact on the costs of health care to consumers, the accessibility of health care to consumers, and the quality of health care provided to consumers.

History: *1973 c 670 s 1; 1977 c 305 s 45*

62D.02 DEFINITIONS.

Subdivision 1. For the purposes of sections 62D.01 to 62D.29, unless the context clearly indicates otherwise, the terms defined in this section shall have the meaning here given them.

Subd. 2. "Commissioner of insurance" means the commissioner of insurance or his designee.

Subd. 3. "Commissioner of health" means the state commissioner of health or his designee.

Subd. 4. "Health maintenance organization" means a nonprofit corporation organized under chapter 317, controlled and operated as provided in sections 62D.01 to 62D.29, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of such services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

Subd. 5. "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee which sets out the coverage to which he is entitled under the health maintenance contract which covers him.

Subd. 6. "Enrollee" means any person who has entered into, or is covered by, a health maintenance contract.

Subd. 7. "Comprehensive health maintenance services" means a set of comprehensive health services which the enrollees might reasonably require to be maintained in good health including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, outpatient health services and preventive health services. Elective, induced abortion, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility or the office of a physician, shall not be mandatory for any health maintenance organization.

Subd. 8. "Health maintenance contract" means any contract whereby a health maintenance organization agrees to provide comprehensive health maintenance services to enrollees, provided that the contract may contain reasonable enrollee copayment provisions. Any contract may provide for health care services in addition to those set forth in subdivision 7.

Subd. 9. "Provider" means any person who furnishes health services and is licensed or otherwise authorized to render such services in the state.

Subd. 10. "Consumer" means any person other than a person (a) whose occupation involves, or before his retirement involved, the administration of health activities or the providing of health services; (b) who is, or ever was, employed by a health care facility, as a licensed health professional; or (c) who has, or ever had, a direct, substantial financial or managerial interest in the rendering of health service other than the payment of reasonable expense reimbursement or compensation as a member of the board of a health maintenance organization.

History: *1973 c 670 s 2; 1974 c 284 s 1; 1977 c 305 s 45; 1981 c 122 s 1*

62D.03 ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS.

Subdivision 1. Notwithstanding any law of this state to the contrary, any nonprofit corporation organized to do so may apply to the commissioner of health for a certificate of authority to establish and operate a health maintenance organization in compliance with sections 62D.01 to 62D.29. No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization or health maintenance contract unless such organization has a certificate of authority under sections 62D.01 to 62D.29.

Subd. 2. Every person operating a health maintenance organization on July 1, 1973 shall submit an application for a certificate of authority, as provided in subdivision 4, within 90 days of July 1, 1973. Each such applicant may continue to operate until the commissioner of health acts upon the application. In the event that an application is denied, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

Subd. 3. The commissioner of health may require any person providing physician and hospital services with payments made in the manner set forth in section 62D.02, subdivision 4, to apply for a certificate of authority under sections 62D.01 to 62D.29. Any person directed to apply for a certificate of authority shall be subject to the provisions of subdivision 2.

Subd. 4. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, and shall be in a form

prescribed by the commissioner of health. Each application shall include the following:

(a) A copy of the basic organizational document, if any, of the applicant; such as the articles of incorporation, or other applicable documents, and all amendments thereto;

(b) A copy of the bylaws, rules and regulations, or similar document, if any, and all amendments thereto which regulate the conduct of the affairs of the applicant;

(c) A list of the names, addresses, and official positions of the following persons:

All members of the board of directors, and the principal officers of the organization; which shall contain a full disclosure in the application of the extent and nature of any contract or financial arrangements between them and the health maintenance organization, including a full disclosure of any financial arrangements between them and any provider or other person concerning any financial relationship with the health maintenance organization;

(d) A statement generally describing the health maintenance organization, its health care plan or plans, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide enrollees with comprehensive health maintenance services;

(e) A copy of the form of each evidence of coverage to be issued to the enrollees;

(f) A copy of the form of each individual or group health maintenance contract which is to be issued to enrollees or their representatives;

(g) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement may be deemed to satisfy this requirement;

(h) (1) A description of the proposed method of marketing the plan, (2) a schedule of proposed charges, and (3) a financial plan which includes a three year projection of the expenses and income and other sources of future capital;

(i) A statement reasonably describing the geographic area or areas to be served and the type or types of enrollees to be served;

(j) A description of the complaint procedures to be utilized as required under section 62D.11;

(k) A description of the procedures and programs to be implemented to meet the requirements of section 62D.04, subdivision 1, clauses (b) and (c) and to monitor the quality of health care provided to enrollees;

(l) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 62D.06;

(m) Such other information as the commissioner of health may reasonably require to be provided.

History: *1973 c 670 s 3; 1977 c 305 s 45*

62D.04 ISSUANCE OF CERTIFICATE AUTHORITY.

Subdivision 1. Upon receipt of an application for a certificate of authority, the commissioner of health shall determine whether the applicant for a certificate of authority has:

(a) Demonstrated the willingness and potential ability to assure that health care services will be provided in such a manner as to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(b) Arrangements for an ongoing evaluation of the quality of health care;

(c) A procedure to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the quality, availability and accessibility of its services, and such other matters as may be reasonably required by regulation of the commissioner of health;

(d) Reasonable provisions for emergency and out of area health care services;

(e) Demonstrated that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner of health may consider either the standards of clauses (1) and (2), or the standards of clauses (3) and (4), whichever the applicant shall elect:

(1) The financial soundness of its arrangements for health care services and the proposed schedule of charges used in connection therewith;

(2) The adequacy of its working capital;

(3) Arrangements which will guarantee for a reasonable period of time the continued availability or payment of the cost of health care services in the event of discontinuance of the health maintenance organization; and

(4) Agreements with providers for the provision of health care services;

(f) Demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care; provided, however, that the requirement in this paragraph shall not prohibit a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds $5,000 in any year, (ii) for the cost of providing comprehensive health care services to its members on a non-elective emergency basis, or while they are outside the area served by the organization, or (iii) for not more than 95 percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed 105 percent of its income for such fiscal years; and

(g) Otherwise met the requirements of sections 62D.01 to 62D.29.

Subd. 2. Within 90 days after the receipt of the application for a certificate of authority, the commissioner of health shall determine whether or not the applicant meets the requirements of this section. If the commissioner of health determines that the applicant meets the requirements of sections 62D.01 to 62D.29, he shall issue a certificate of authority to the applicant. If the commissioner of health determines that the applicant is not qualified, he shall so notify the applicant and shall specify the reason or reasons for such disqualification.

Subd. 3. Except as provided in section 62D.03, subdivision 2, no person who has not been issued a certificate of authority shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts or literature. Provided, however, that persons who are operating under a contract with, operating in association with, enrolling enrollees for, or otherwise authorized by a health maintenance organization licensed under sections 62D.01 to 62D.29 to act on its behalf may use the terms "health maintenance organization" or "HMO" for the limited purpose of denoting or explaining their association or relationship with the authorized health maintenance organization. No health maintenance organization which has a minority of consumers as members of its board of directors shall use the words "consumer controlled" in its name or in any way represent to the public that it is controlled by consumers.

History: *1973 c 670 s 4; 1977 c 305 s 45*

62D.05 POWERS OF HEALTH MAINTENANCE ORGANIZATIONS.

Subdivision 1. Any nonprofit corporation may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.29, operate as a health maintenance organization.

Subd. 2. A health maintenance organization may enter into health maintenance contracts in this state and engage in any other activities consistent with sections 62D.01 to 62D.29 which are necessary to the performance of its obligations under such contracts or authorize its representatives to do so.

Subd. 3. A health maintenance organization may contract with providers of health care services to render the services the health maintenance organization has promised to provide under the terms of its health maintenance contracts, may, subject to the limitations of section 62D.04, subdivision 1, clause (f), contract with insurance companies and nonprofit health service plan corporations for insurance, indemnity or reimbursement of its cost of providing health care services for enrollees or against the risks incurred by the health maintenance organization and may contract with insurance companies and nonprofit health service plan corporations to insure or cover the enrollees' costs and expenses in the health maintenance organization, including the customary prepayment amount and any co-payment obligations.

Subd. 4. A health maintenance organization may contract with other persons for the provision of services, including, but not limited to, managerial and administration, marketing and enrolling, data processing, actuarial analysis, and billing services. If contracts are made with insurance companies or nonprofit health service plan corporations, such companies or corporations must be authorized to transact business in this state.

Subd. 5. Each health maintenance organization authorized to operate under sections 62D.01 to 62D.29, or its representative, may accept from governmental agencies, private agencies, corporations, associations, groups, individuals, or other persons payments covering all or part of the cost of health care services provided to enrollees. Any recipient of medical assistance, pursuant to chapter 256B, may make application to join a health maintenance organization which has been approved for medical assistance by the commissioner of public welfare.

History: *1973 c 670 s 5*

62D.06 GOVERNING BODY.

Subdivision 1. The governing body of any health maintenance organization may include enrollees, providers, or other individuals; provided, however, that after a health maintenance organization has been authorized under sections 62D.01 to 62D.29 for one year, at least 40 percent of the governing body shall be composed of consumers elected by the enrollees from among the enrollees.

Subd. 2. The governing body shall establish a mechanism to afford the enrollees an opportunity to express their opinions in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms as may be prescribed or permitted by the commissioner of health.

History: *1973 c 670 s 6; 1974 c 284 s 10; 1977 c 305 s 45*

62D.07 EVIDENCE OF COVERAGE.

Subdivision 1. Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. The health maintenance organization or its designated representative shall issue the evidence of coverage.

Subd. 2. No evidence of coverage or amendment thereto shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment thereto has been filed with the commissioner of health pursuant to sections 62D.03 or 62D.08.

Subd. 3. An evidence of coverage shall contain:

(a) No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which are untrue, misleading or deceptive as defined in section 62D.12, subdivision 1; and

(b) A clear, concise and complete statement of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(2) Any exclusions or limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(3) Where and in what manner information is available as to how services, including emergency and out of area services, may be obtained;

(4) The total amount of payment and copayment, if any, for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates; and

(5) A description of the health maintenance organization's method for resolving enrollee complaints.

Subd. 4. Any subsequent approved change in an evidence of coverage shall be issued to each enrollee.

History: *1973 c 670 s 7; 1977 c 305 s 45*

62D.08 ANNUAL REPORT.

Subdivision 1. A health maintenance organization shall, unless otherwise provided for by regulations adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted under clauses (a), (b), (e), (f), (i), (j), (k), (l), and (m) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within 30 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Subd. 2. Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of health and to the commissioner of insurance covering the preceding calendar year.

Subd. 3. Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, and (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment;

(b) The number of new enrollees enrolled during the year, the number of enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) A summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c) in such form as may be required by the commissioner of health;

(d) A report of the names and residence addresses of all persons set forth in section 62D.03, subdivision 4, clause (c) who were associated with the health maintenance organization during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (c); and

(e) Such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out his duties under sections 62D.01 to 62D.29.

History: *1973 c 670 s 8; 1974 c 284 s 2; 1977 c 305 s 45*

62D.09 INFORMATION TO ENROLLEES.

Every health maintenance organization or its representative shall annually, before April 1, provide to its enrollees a summary of: Its most recent annual financial statement including a balance sheet and statement of receipts and disbursements; a description of the health maintenance organization, its health care plan or plans, its facilities and personnel, any material changes therein since the last report, and the current evidence of coverage.

History: *1973 c 670 s 9*

62D.10 PROVISIONS APPLICABLE TO ALL HEALTH PLANS.

Subdivision 1. The provisions of this section shall be applicable to nonprofit prepaid health care plans regulated under chapter 317, and health maintenance organizations regulated pursuant to sections 62D.01 to 62D.29, both of which for purposes of this section shall be known as "health plans".

Subd. 2. Once a health plan has been in operation 24 months, it shall thereafter have an annual open enrollment period of at least one month during which it shall accept enrollees up to a minimum of five percent of its current enrollment, exclusive of enrollees in group plans, in the order in which they apply for enrollment. A health plan may require a pre-enrollment physical examination and may impose reasonable underwriting restrictions.

Subd. 3. A health plan providing health maintenance services or reimbursement for health care costs to a specified group or groups may limit the open enrollment in each group plan to members of such group or groups, but after it has been in operation 24 months shall have an annual open enrollment period of at least one month during which it accepts enrollees from the members of each group up to a minimum of five percent of its current enrollment in each group plan. "Specified groups" may include, but shall not be limited to:

(a) Employees of one or more specified employers;

(b) Members of one or more specified labor unions;

(c) Members of one or more specified associations;

(d) Patients of physicians providing services through a health care plan who had previously provided services outside the health care plan; and

(e) Members of an existing group insurance policy.

Subd. 4. A health plan may apply to the commissioner of health for a waiver of the requirements of this section or for authorization to impose such underwriting restrictions upon open enrollment as are necessary (a) to preserve its financial stability, (b) to prevent excessive adverse selection by prospective enrollees, or (c) to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The commissioner of health upon a showing of good cause, shall approve or upon failure to show good cause shall deny such

application within 30 days of the receipt thereof from the health plan. The commissioner of health may, in accordance with chapter 14, promulgate rules to implement this section.

History: *1973 c 670 s 10; 1974 c 284 s 3,4; 1977 c 305 s 45; 1977 c 409 s 3; 1982 c 424 s 130*

62D.101 CONTINUATION AND CONVERSION PRIVILEGES FOR FORMER SPOUSES AND CHILDREN.

Subdivision 1. **Termination of coverage.** No health maintenance contract which, in addition to covering an enrollee, also covers the enrollee's spouse shall contain a provision for termination of coverage for a spouse covered under the health maintenance contract solely as a result of a break in the marital relationship except by reason of an entry of a valid decree of dissolution of marriage between the parties.

Subd. 2. **Conversion privilege.** Every health maintenance contract, other than a contract whose continuance is contingent upon continued employment or membership, which contains a provision for termination of coverage of the spouse upon dissolution of marriage shall contain a provision allowing a former spouse and dependent children of an enrollee, without providing evidence of insurability, to obtain from the health maintenance organization at the expiration of any continuation of coverage required under subdivision 2a or section 62A.146, or upon termination of coverage by reason of an entry of a valid decree of dissolution which does not require the health maintenance organization to provide continued coverage for the former spouse, an individual health maintenance contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the health maintenance organization within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate fee. A contract providing reduced benefits at a reduced fee may be accepted by the former spouse and dependent children in lieu of the optional coverage otherwise required by this subdivision. The individual health maintenance contract shall be renewable at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under Title XVIII of the Social Security Act, as amended. Any revisions in the table of rate for the individual contract shall apply to the former spouse's original age at entry, and shall apply equally to all similar contracts issued by the health maintenance organization.

Subd. 2a. **Continuation privilege.** Every health maintenance contract, other than a contract whose continuance is contingent upon continued employment or membership, shall contain a provision which permits continuation of coverage under the contract for the enrollee's former spouse and children upon entry of a valid decree of dissolution of marriage, if the decree requires the enrollee to provide continued coverage for those persons. The coverage may be continued until the earlier of the following dates:

(a) The date of remarriage of either the enrollee or the enrollee's former spouse; or

(b) The date coverage would otherwise terminate under the health maintenance contract.

Subd. 3. **Application.** Subdivision 1 applies to every health maintenance contract which is delivered, issued for delivery, renewed or amended on or after July 19, 1977.

Subdivisions 2 and 2a apply to every health maintenance contract which is delivered, issued for delivery, renewed, or amended on or after March 1, 1983.

History: *1977 c 186 s 3; 1982 c 555 s 10; 1982 c 642 s 16*

62D.11 COMPLAINT SYSTEM.

Subdivision 1. Every health maintenance organization shall establish and maintain a complaint system including an impartial arbitration provision, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services. Arbitration shall be subject to chapter 572, except (a) in the event that an enrollee elects to litigate his complaint prior to submission to arbitration, and (b) no medical malpractice damage claim shall be subject to arbitration unless agreed to by both parties subsequent to the event giving rise to the claim.

Subd. 2. The health maintenance organization shall maintain a record of each written complaint filed with it for three years and the commissioner of health shall have access to the records.

History: *1973 c 670 s 11; 1974 c 284 s 5; 1977 c 305 s 45*

62D.12 PROHIBITED PRACTICES.

Subdivision 1. No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Each health maintenance organization shall be subject to sections 72A.17 to 72A.321, relating to the regulation of trade practices, except (a) to the extent that the nature of a health maintenance organization renders such sections clearly inappropriate and (b) that enforcement shall be by the commissioner of health and not by the commissioner of insurance. Every health maintenance organization shall be subject to sections 325.79 and 325.907.

Subd. 2. No health maintenance organization may cancel or fail to renew the coverage of an enrollee except for (a) failure to pay the charge for health care coverage; (b) termination of the health care plan; (c) termination of the group plan; (d) enrollee moving out of the area served; (e) enrollee moving out of an eligible group; (f) failure to make copayments required by the health care plan; or (g) other reasons established in regulations promulgated by the commissioner of health. An enrollee shall be given 30 days notice of any cancellation or nonrenewal.

Subd. 3. No health maintenance organization may use in its name, contracts, or literature any of the words "insurance", "casualty", "surety", "mutual", or any other words which are descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state; provided, however, that when a health maintenance organization has contracted with an insurance company for any coverage permitted by sections 62D.01 to 62D.29, it may so state.

Subd. 4. No health maintenance contract or evidence of coverage shall provide for the reimbursement of an enrollee other than through a policy of insurance, except to refund payments made by or on behalf of an enrollee; or, with the prior approval of the commissioner of health, payments to enrollees for obligations incurred for non-elective emergency or out-of-area services received; or with prior approval, direct payments to providers for out-of-area, non-elective emergency or referral medical, hospital, or other health services rendered to enrollees.

Subd. 5. The providers under agreement with a health maintenance organization to provide health care services and the health maintenance organization

shall not have recourse against enrollees for amounts above those specified in the evidence of coverage as the periodic prepayment, or copayment, for health care services.

Subd. 6. The rates charged by health maintenance organizations and their representatives shall not discriminate except in accordance with accepted actuarial principles.

Subd. 7. No health maintenance organization shall enroll more than 500,000 persons in the state of Minnesota. A violation of this subdivision shall be treated as a violation of the antitrust act, sections 325.8011 to 325.8028.

Subd. 8. No health maintenance organization shall discriminate in enrollment policy against any person solely by virtue of status as a recipient of medical assistance or medicare.

Subd. 9. No health maintenance organization shall provide for the payment, whether directly or indirectly, of any part of its net earnings, to any person as a dividend or rebate; provided, however, that authorized expenses of a health maintenance organization shall include:

(a) cash rebates to enrollees, or to persons who have made payments on behalf of enrollees; or, when approved by the commissioner of health as provided in subdivision 4, direct payments to enrollees for obligations incurred for non-elective emergency or out-of-area services received; or, with prior approval, direct payments to providers for out-of-area, non-elective emergency or referral medical, hospital, or other health services rendered to enrollees;

(b) free or reduced cost health service to enrollees; or

(c) payments to providers or other persons based upon the efficient provision of services or as incentives to provide quality care. All net earnings shall be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. The commissioner of health shall, pursuant to sections 62D.01 to 62D.29, revoke the certificate of authority of any health maintenance organization in violation of this subdivision.

Subd. 10. No health maintenance contract or evidence of coverage entered into, issued, amended, renewed or delivered on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit to an enrollee or other beneficiary by the amount of, or in any proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, as amended subsequent to the date of commencement of such benefit.

Subd. 11. Any health maintenance organization which includes coverage of comprehensive dental services in its comprehensive health maintenance services shall not include the charge for the dental services in the same rate as the charge for other comprehensive health maintenance services. The rates for dental services shall be computed, stated and bid separately. No employer shall be required to purchase dental services in combination with other comprehensive health services. An employer may purchase dental services separately.

Subd. 12. No health maintenance contract issued or renewed on or after July 1, 1980 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, subdivisions 1 or 2.

History: *1973 c 670 s 12; 1974 c 284 s 8,9; 1975 c 323 s 4; 1976 c 296 art 1 s 18; 1977 c 305 s 45; 1980 c 614 s 74*

62D.13 POWERS OF INSURERS AND NONPROFIT HEALTH SERVICE PLANS.

Notwithstanding any law to the contrary, an insurer or a hospital or medical service plan corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group for group coverage under the insurance laws and the nonprofit health service plan corporation act. Under such contracts, the insurer or nonprofit health service plan corporation may make benefit payments to health maintenance organizations for health care services rendered, or to be rendered, by providers pursuant to the health care plan. Any insurer, or nonprofit health service plan corporation, licensed to do business in this state, is authorized to provide the types of coverages described in section 62D.05, subdivision 3.

History: *1973 c 670 s 13*

62D.14 EXAMINATIONS.

Subdivision 1. The commissioner of health may make an examination of the financial affairs of any health maintenance organization and its contracts, agreements, or other arrangements with providers as often as the commissioner of health deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years.

Subd. 2. The commissioner of health may make an examination concerning the quality of health care services provided to enrollees by any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health care plan as often as the commissioner of health deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years. Provided, that examinations of providers pursuant to this subdivision shall be limited to their dealings with the health maintenance organization and its enrollees.

Subd. 3. In order to accomplish his duties under this section, the commissioner of health shall have the right to:

(a) Inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under such contract; and

(b) Audit and inspect any books and records of a health maintenance organization which pertain to services performed and determinations of amounts payable under such contract.

Subd. 4. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee, or any application obtained from any person, shall be confidential and shall not be disclosed to any person except (a) to the extent that it may be necessary to carry out the purposes of sections 62D.01 to 62D.29; (b) upon the express consent of the enrollee or applicant; (c) pursuant to statute or court order for the production of evidence or the discovery thereof; or (d) in the event of claim or litigation between such person and the provider or health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

Subd. 5. The commissioner of health shall have the power to administer oaths to and examine witnesses, and to issue subpoenas.

Subd. 6. Reasonable expenses of examinations under this section shall be assessed by the commissioner of health against the organization being examined,

and shall be remitted to the commissioner of health for deposit in the general fund of the state treasury.

History: *1973 c 670 s 14; 1977 c 305 s 45*

62D.15 SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY.

Subdivision 1. The commissioner of health may suspend or revoke any certificate of authority issued to a health maintenance organization under sections 62D.01 to 62D.29 if he finds that:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62D.03, unless amendments to such submissions have been filed with and approved by the commissioner of health;

(b) The health maintenance organization issues evidences of coverage which do not comply with the requirements of section 62D.07;

(c) The health maintenance organization is unable to fulfill its obligations to furnish comprehensive health maintenance services as required under its health care plan;

(d) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(e) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section 62D.06;

(f) The health maintenance organization has failed to implement the complaint system required by section 62D.11 in a manner designed to reasonably resolve valid complaints;

(g) The health maintenance organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(h) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(i) The health maintenance organization has otherwise failed to substantially comply with sections 62D.01 to 62D.29 or has submitted false information in any report required hereunder.

Subd. 2. A certificate of authority shall be suspended or revoked only after compliance with the requirements of section 62D.16.

Subd. 3. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

Subd. 4. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner of health may, by written order, permit further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

History: *1973 c 670 s 15; 1977 c 305 s 45*

62D.16 DENIAL, SUSPENSION, AND REVOCATION; ADMINISTRATIVE PROCEDURES.

Subdivision 1. When the commissioner of health has cause to believe that grounds for the denial, suspension or revocation of a certificate of authority exists, he shall notify the health maintenance organization in writing specifically stating the grounds for denial, suspension or revocation and fixing a time of at least 20 days thereafter for a hearing on the matter, except in summary proceedings as provided in section 62D.18.

Subd. 2. After such hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner of health shall take action as is deemed advisable and shall issue written findings which shall be mailed to the health maintenance organization. The action of the commissioner of health shall be subject to judicial review pursuant to chapter 14.

History: *1973 c 670 s 16; 1977 c 305 s 45; 1982 c 424 s 130*

62D.17 PENALTIES AND ENFORCEMENT.

Subdivision 1. The commissioner of health may, in lieu of suspension or revocation of a certificate of authority under section 62D.15, levy an administrative penalty in an amount not less than $100 nor more than $10,000. Reasonable notice in writing to the health maintenance organization shall be given of the intent to levy the penalty and the reasons therefor, and the health maintenance organization shall have a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation, or have an administrative hearing and review of the commissioner of health's determination. Such administrative hearing shall be subject to judicial review pursuant to chapter 14.

Subd. 2. Any person who violates sections 62D.01 to 62D.29 or knowingly submits false information in any report required hereunder shall be guilty of a misdemeanor.

Subd. 3. (a) If the commissioner of health shall, for any reason, have cause to believe that any violation of sections 62D.01 to 62D.29 has occurred or is threatened, the commissioner of health may, before commencing action under sections 62D.15 and 62D.16, and subdivision 1, give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(b) Proceedings under this subdivision shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner of health may deem appropriate under the circumstances.

Subd. 4. (a) The commissioner of health may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of sections 62D.01 to 62D.29.

(b) Within 20 days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of sections 62D.01 to 62D.29 have occurred. Such hearings shall be subject to judicial review as provided by chapter 14.

Subd. 5. In the event of noncompliance with a cease and desist order issued pursuant to subdivision 4, the commissioner of health may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey county district court.

History: *1973 c 670 s 17; 1977 c 305 s 45; 1982 c 424 s 130*

62D.18 REHABILITATION, LIQUIDATION, OR CONSERVATION OF HEALTH MAINTENANCE ORGANIZATION.

The commissioner of insurance may independently, or shall at the request of the commissioner of health, order the rehabilitation, liquidation or conservation of health maintenance organizations. The rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner of insurance and pursuant to chapter 60B, except to the extent that the nature of health maintenance organizations render such law clearly inappropriate.

History: *1973 c 670 s 18; 1977 c 305 s 45*

62D.19 UNREASONABLE EXPENSES.

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner of insurance shall, pursuant to the administrative procedures act, promulgate rules to implement and enforce this section.

History: *1973 c 670 s 19*

62D.20 RULES.

The commissioner of health may, pursuant to chapter 14, promulgate such reasonable rules as are necessary or proper to carry out the provisions of sections 62D.01 to 62D.29. Included among such regulations shall be those which provide minimum requirements for the provision of comprehensive health maintenance services, as defined in section 62D.02, subdivision 7, and reasonable exclusions therefrom. Nothing in such rules shall force or require a health maintenance organization to provide elective, induced abortions, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility, or the office of a physician; the rules shall provide every health maintenance organization the option of excluding or including elective, induced abortions, except as medically necessary to prevent the death of the mother, as part of its comprehensive health maintenance services.

History: *1973 c 670 s 20; 1977 c 305 s 45; 1981 c 122 s 2; 1982 c 424 s 130*

62D.21 FEES.

Every health maintenance organization subject to sections 62D.01 to 62D.29 shall pay to the commissioner of health fees as prescribed by the commissioner of health pursuant to section 144.122 for the following:

(a) Filing an application for a certificate of authority,

(b) Filing an amendment to a certificate of authority,

(c) Filing each annual report, and

(d) Other filings, as specified by regulation.

History: *1973 c 670 s 21; 1975 c 310 s 1; 1977 c 305 s 45*

62D.22 STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS.

Subdivision 1. Except as otherwise provided herein, sections 62D.01 to 62D.29 do not apply to an insurer or nonprofit health service plan corporation licensed and regulated pursuant to the laws governing such corporations in this state.

Subd. 2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Subd. 3. Any health maintenance organization authorized under sections 62D.01 to 62D.29 shall not be deemed to be practicing a healing art.

Subd. 4. To the extent that it furthers the purposes of sections 62D.01 to 62D.29, the commissioner of health shall attempt to coordinate the operations of sections 62D.01 to 62D.29 relating to the quality of health care services with the operations of 42 U.S.C. Sections 1320c to 1320c-20.

Subd. 5. Except as otherwise provided in sections 62D.01 to 62D.29, and except as they eliminate elective, induced abortions, wherever performed, from health or maternity benefits, provisions of the insurance laws and provisions of nonprofit health service plan corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under sections 62D.01 to 62D.29.

Subd. 6. Every health maintenance organization shall be subject to the certificate of need act, sections 145.832 to 145.845 on the same basis as other persons.

Subd. 7. A licensed health maintenance organization shall be deemed to be a prepaid group practice plan for the purposes of chapter 43A and shall be allowed to participate as a carrier for state employees subject to any collective bargaining agreement entered into pursuant to chapter 179 and reasonable restrictions applied to all carriers. The commissioner of employee relations may refuse to allow a health maintenance organization to continue as a carrier if it was selected by less than 200 employees in the preceding benefit year.

Subd. 8. All agents, solicitors, and brokers engaged in soliciting or dealing with enrollees or prospective enrollees of a health maintenance organization, whether employees or under contract to the health maintenance organization, shall be subject to the provisions of section 60A.17, concerning the licensure of health insurance agents, solicitors, and brokers, and lawful regulations thereunder. Medical doctors and others who merely explain the operation of health maintenance organizations shall be exempt from the provisions of section 60A.17. Section 60A.17, subdivision 2, clause (2) shall not apply except as to provide for an examination of an applicant in his knowledge concerning the operations and benefits of health maintenance organizations and related insurance matters.

Subd. 9. Any review of the quality or cost of health care services pursuant to the provisions of sections 62D.01 to 62D.29 shall be subject to the provisions of sections 145.61 to 145.67. For the purposes of this subdivision, and for the purposes of sections 145.61 to 145.67, the term "review committee" shall be deemed to include, in addition to those functions set forth in section 145.61, subdivision 5, any person or committee conducting a review of the quality or cost of health care services pursuant to any provision of sections 62D.01 to 62D.29.

History: *1973 c 670 s 22; 1974 c 284 s 6; 1977 c 305 s 45; 1979 c 332 art 1 s 57; 1980 c 617 s 18; 1981 c 122 s 3; 1981 c 210 s 54; 1Sp1981 c 4 art 1 s 50*

NOTE: Subdivision 6 was repealed by Laws 1982, Chapter 614, Section 12 effective March 15, 1984. See Laws 1982, Chapter 614, Section 13.

62D.23 FILINGS AND REPORTS AS PUBLIC DOCUMENTS.

All applications, filings and reports required under sections 62D.01 to 62D.29 shall be treated as public documents.

History: *1973 c 670 s 23*

62D.24 STATE COMMISSIONER OF HEALTH'S AUTHORITY TO CONTRACT.

The commissioner of health, in carrying out his obligations under sections 62D.01 to 62D.29, may contract with the commissioner of insurance or other qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the commissioner of health.

History: *1973 c 670 s 24; 1977 c 305 s 45*

62D.25 REPORT TO THE LEGISLATURE.

The commissioner of health shall report to the legislature on or before April 1, 1975, as to the following:

(1) The number of applications for certificates of authority which have been filed since July 1, 1973;

(2) The number of certificates of authority granted pursuant to sections 62D.01 to 62D.29;

(3) The number of current enrollees in health maintenance organizations in the state of Minnesota;

(4) The average annual prepayment cost per enrollee in the state of Minnesota;

(5) The conclusions of the commissioner of health as to the effect of health maintenance organizations on the quality of health care services provided to the people of this state;

(6) The conclusions of the commissioner of health as to the effects of health maintenance organizations on health care costs and whether any cost savings are being passed on to enrollees in any form; and

(7) His recommendations as to any changes in sections 62D.01 to 62D.29.

History: *1973 c 670 s 25; 1977 c 305 s 45*

62D.26 PURPOSE.

It is the purpose of sections 62D.26 to 62D.29 to provide financial and technical assistance through planning grants which will stimulate and enable the planning and development of health maintenance organizations designed to efficiently deliver and provide comprehensive health care to groups and areas with the greatest need for care.

History: *1973 c 670 s 26*

62D.27 PLANNING GRANTS AND TECHNICAL ASSISTANCE.

Subdivision 1. The commissioner of health may make planning grants and provide technical assistance to organizations to carry out the purposes of sections 62D.26 to 62D.29. The commissioner of health may specify the terms and conditions for the issuance of planning grants except that no organization may receive more than $50,000 per year for more than two years. A planning grant may be used by the recipient organization as a matching share for any other public or private assistance in planning or implementing a community health maintenance organization.

Subd. 2. Grants made under sections 62D.26 to 62D.29 shall be equally distributed between the area consisting of the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington, and the area consisting of the remainder of the state so that no more than 55 percent of the total sum granted pursuant to sections 62D.26 to 62D.29 goes to either such area.

History: *1973 c 670 s 27; 1977 c 305 s 45*

62D.28 ELIGIBILITY FOR ASSISTANCE.

Subdivision 1. In order to qualify for assistance under sections 62D.01 to 62D.29 an organization must satisfy the criteria established by this section.

Subd. 2. The area for planning and the proposed service area of the health maintenance organization must have insufficient availability of primary health care resources or a substantial population of medically unserved or underserved individuals, as determined by the commissioner of health. A health systems agency, as defined in section 145.833, shall provide technical assistance to the commissioner of health in identifying areas with demographic and geographic health needs.

Subd. 3. The planning organization seeking financial assistance must be a Minnesota nonprofit corporation having a board of directors with a majority composed of health care consumers from the proposed service area, but with additional representation of existing health interests in the area including health providers.

The organization shall cooperate with any health systems agency designated pursuant to section 145.833, subdivision 7, and with other health care providers in the proposed area to be served by the organization in programs or studies for:

(a) Determining and assessing the ongoing health needs of the community, formulating a program to meet such needs, including, but not limited to, an identification of private and public funds which may be available for this purpose;

(b) Coordinating existing health activities where appropriate, and establishing better utilization of existing health facilities, programs, and services, with particular emphasis on health manpower training projects in the area including those for local community residents;

(c) Laying the foundation for a community health maintenance organization; and

(d) Promoting development and expansion of preventive and ambulatory, outpatient services with the objective of replacing crisis medicine with an integrated, comprehensive system of health care.

History: *1973 c 670 s 28; 1974 c 284 s 7; 1977 c 305 s 45; 1Sp1981 c 4 art 1 s 54,55*

62D.29 REPORTS.

Planning organizations receiving assistance under sections 62D.26 to 62D.29 shall furnish to the commissioner of health such timely information and reports as the commissioner of health deems necessary. The organization shall maintain such records and provide access thereto as the commissioner of health deems necessary to verify such information and reports.

History: *1973 c 670 s 29; 1977 c 305 s 45*

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.

History: *1979 c 268 s 1*