CHAPTER 62E

HEALTH CARE

62E.08 STATE PLAN PREMIUM.

[For text of subds 1 and 2, see M.S.1990]

Subd. 3. **Determination of rates.** Premium rates under this section must be determined annually. These rates are effective July 1 of each year and must be based on a survey of approved rates of insurers in effect, or to be in effect, on April 1 of the same calendar year.

History: *1991 c 165 s 2*

62E.10 COMPREHENSIVE HEALTH ASSOCIATION.

[For text of subd 1, see M.S.1990]

Subd. 2. **Board of directors; organization.** The board of directors of the association shall be made up of nine members as follows: five insurer directors selected by participating members, subject to approval by the commissioner; four public directors selected by the commissioner, at least two of whom must be plan enrollees. Public members may include licensed insurance agents. 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 directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Insurer directors may be reimbursed from the money of the association for expenses incurred by them as directors, 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.

[For text of subds 2a and 3, see M.S.1990]

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, except that during any portion of a meeting during which an enrollee's appeal of an action of the writing carrier is being heard, that portion of the meeting must be closed at the enrollee's request.

[For text of subds 6 to 8, see M.S.1990]

Subd. 9. **Experimental delivery method.** The association may petition the commissioner of commerce for a waiver to allow the experimental use of alternative means of health care delivery. The commissioner may approve the use of the alternative means the commissioner considers appropriate. The commissioner may waive any of the requirements of this chapter and chapters 60A, 62A, and 62D in granting the waiver. The commissioner may also grant to the association any additional powers as are necessary to facilitate the specific waiver, including the power to implement a provider payment schedule.

This subdivision is effective until August 1, 1992.

History: *1991 c 165 s 3,4; 1991 c 264 s 1*

62E.101 MANAGED CARE DELIVERY METHOD.

The association may form a preferred provider network or contract with an existing provider network to deliver the services and benefits provided for in the plans of health coverage offered. If the association does not contract with an existing provider network, the association may adopt a provider payment schedule and negotiate provider payment rates subject to the approval of the commissioner.

History: *1991 c 165 s 5*

62E.11 OPERATION OF COMPREHENSIVE PLAN.

[For text of subds 1 to 4, see M.S.1990]

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 contributing 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. Payments made by the state to a contributing member for medical assistance or general assistance medical care services according to chapters 256B and 256D shall be excluded when determining a contributing member's total premium.

[For text of subds 6 to 10, see M.S.1990]

Subd. 11. **Rate increase or benefit change.** The association must hold a public meeting to hear public comment at least two weeks before filing a rate increase or benefit change with the commissioner. Notice of the public meeting to hear public comment must be mailed at least two weeks before the meeting to all plan enrollees.

History: *1991 c 54 s 1; 1991 c 264 s 2*

62E.12 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN.

The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan, a number two qualified plan and basic and extended basic Medicare supplement plans. The requirement that a policy issued by the association must be a qualified plan is satisfied if the association contracts with a preferred provider network and the level of benefits for services provided within the network satisfies the requirements of a qualified plan. If the association uses a preferred provider network, payments to nonparticipating providers must meet the minimum requirements of section 72A.20, subdivision 15. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier. Notwithstanding the provisions of section 62E.06 the state plan shall exclude coverage of services of a private duty nurse other than on an inpatient basis and any charges for treatment in a hospital located outside of the state of Minnesota in which the covered person is receiving treatment for a mental or nervous disorder, unless similar treatment for the mental or nervous disorder is medically necessary, unavailable in Minnesota and provided upon referral by a licensed Minnesota medical practitioner.

History: *1991 c 165 s 6*

62E.13 ADMINISTRATION OF PLAN.

[For text of subds 1 to 10, see M.S.1990]

Subd. 11. **Classification of PPO agreement data.** If the writing carrier uses its own provider agreements for the association's preferred provider network in lieu of agreements exclusively between the association and the providers, then the terms and conditions of those agreements are nonpublic data as defined in section 13.02, subdivision 9.

History: *1991 c 165 s 7*

62E.14 ENROLLMENT BY AN ELIGIBLE PERSON.

[For text of subds 1 to 4b, see M.S.1990]

Subd. 4c. **Waiver of preexisting conditions for persons whose coverage is terminated or who exceed the maximum lifetime benefit.** A Minnesota resident may enroll in the comprehensive health plan with a waiver of the preexisting condition limitation described in subdivision 3 if that person applies for coverage within 90 days of termination of prior coverage and if the termination is for reasons other than fraud or nonpayment of premiums.

For purposes of this subdivision, termination of prior coverage includes exceeding the maximum lifetime benefit of existing coverage.

Coverage in the comprehensive health plan is effective on the date of termination of prior coverage. The availability of conversion rights does not affect a person's rights under this subdivision.

This section does not apply to prior coverage provided under policies designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or policies providing only accident coverage.

Subd. 4d. **Insurer insolvency; waiver of preexisting conditions.** A Minnesota resident who is otherwise eligible may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition limitation described in subdivision 3, if that person applies for coverage within 90 days of termination of prior coverage due to the insolvency of the insurer.

Coverage in the comprehensive insurance plan is effective on the date of termination of prior coverage. The availability of conversion rights does not affect a person's rights under this subdivision.

[For text of subds 5 and 6, see M.S.1990]

History: *1991 c 165 s 8; 1991 c 325 art 21 s 6*

62E.19 PAYMENTS FOR PREEXISTING CONDITIONS.

Subdivision 1. **Employer liability.** An employer is liable to the association for the costs of any preexisting conditions of the employer's former employees or their dependents during the first six months of coverage under the state comprehensive health insurance plan under the following conditions:

(1) the employer has terminated or laid off employees and is required to meet the notice requirements under section 268.976, subdivision 3;

(2) the employer has failed to provide, arrange for, or make available continuation health insurance coverage required to be provided under federal or state law to employees or their dependents; and

(3) the employer's former employees or their dependents enroll in the state comprehensive health insurance plan with a waiver of the preexisting condition limitation under section 62E.14, subdivision 4a or 5; or

(4) the employer has terminated or allowed the employer's plan of health insurance coverage to lapse within 90 days prior to the date of termination or layoff of an employee; and

(5) the employer's former employees or their dependents enroll in the state comprehensive health insurance plan with a waiver of the preexisting condition limitation under section 62E.14, subdivision 4a or 5.

The employer shall pay a special assessment to the association for the costs of the preexisting conditions. The special assessment may be assessed before the association makes the annual determination of each contributing member's liability as required under this chapter. The association may enforce the obligation to pay the special assessment by action, as a claim in an insolvency proceeding, or by any other method not prohibited by law.

If the association makes the special assessment permitted by this subdivision, the association may also make any assessment of contributing members otherwise permitted by law, without regard to the special assessment permitted by this subdivision. Contributing members must pay the assessment, subject to refund or adjustment in the event of receipt by the association of any portion of the special assessment.

[For text of subd 2, see M.S.1990]

History: *1991 c 199 art 1 s 11*