CHAPTER 62E

HEALTH CARE

COMPREHENSIVE HEALTH INSURANCE

62E.01 CITATION.

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

History: *1976 c 296 art 1 s 1*

62E.02 DEFINITIONS.

Subdivision 1. **Application.** For the purposes of sections 62E.01 to 62E.16, the terms and phrases defined in this section have the meanings given them.

Subd. 2. **Employer.** "Employer" means any person, partnership, association, trust, estate or corporation, including the state of Minnesota or any agency, instrumentality or governmental subdivision thereof, which employs ten or more individuals who are residents of this state.

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

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

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

Subd. 6. **Commissioner.** "Commissioner" means the commissioner of commerce.

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

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

Subd. 9. **Plan of health coverage.** "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of self insurance, individual acci-

dent and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract.

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

Subd. 11. **Accident and health insurance policy or policy.** "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical and medical care. "Policy" does not include coverage which is (1) limited to disability or income protection coverage, (2) automobile medical payment coverage, (3) supplemental to liability insurance, (4) designed solely to provide payments on a per diem, fixed indemnity or nonexpense incurred basis, (5) credit accident and health insurance issued pursuant to chapter 62B, (6) designed solely to provide dental or vision care, (7) blanket accident and sickness insurance as defined in section 62A.11, or (8) accident only coverage issued by licensed and tested insurance agents or solicitors which provides reasonable benefits in relation to the cost of covered services. The provisions of clause (4) shall not apply to hospital indemnity coverage which is sold by an insurer to an applicant who is not then currently covered by a qualified plan.

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

Subd. 13. **Eligible person.** "Eligible person" means an individual who is currently and has been a resident of Minnesota for the six months immediately preceding the date of receipt by the association or its writing carrier of a completed certificate of eligibility and who meets the enrollment requirements of section 62E.14.

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

Subd. 15. **Medicare.** "Medicare" means part A and part B of the United States Social Security Act, title XVIII, as amended, United States Code, title 42, sections 1394, et seq.

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

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

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

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

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

Subd. 21. **Self-insurer.** "Self-insurer" means an employer or an employee welfare benefit fund or plan which directly or indirectly provides a plan of health coverage to its employees and administers the plan of health coverage itself or through an insurer, trust or agent except to the extent of accident and health insurance premium, subscriber contract charges or health maintenance organization contract charges. "Self-insurer" does not include an employer engaged in the business of providing health care services to the public which provides health care services directly to its employees at no charge to them.

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

Subd. 23. **Contributing member.** "Contributing member" means those companies regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; fraternal benefit societies regulated under chapter 64B; the private employers insurance program established in section 43A.317, effective July 1, 1993; and joint self-insurance plans regulated under chapter 62H. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization shall be considered to be accident and health insurance premiums.

History: *1976 c 296 art 1 s 2; 1977 c 409 s 4-7; 1979 c 272 s 1,2; 1981 c 318 s 13; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1985 c 49 s 41; 1986 c 444; 1987 c 268 art 2 s 17; 1987 c 384 art 2 s 1; art 3 s 47; 1988 c 612 s 27; 1992 c 549 art 3 s 13; 1992 c 564 art 1 s 34,54*

62E.03 DUTIES OF THE EMPLOYER.

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

Subd. 2. [Repealed, 1Sp1985 c 14 art 1 s 59]

History: *1976 c 296 art 1 s 3; 1977 c 409 s 8; 1986 c 444*

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.

History: *1979 c 272 s 3*

62E.04 DUTIES OF INSURERS.

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

Subd. 2. **Medicare supplement plan.** An insurer or fraternal issuing medicare supplement plans in this state shall develop and file with the commissioner a medicare supplement policy which meets the minimum standards of a qualified medicare supplement plan. An insurer or fraternal issuing medicare supplement plans in this

state shall offer a qualified medicare supplement plan to each person who is eligible for coverage and who applies for a medicare supplement plan.

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

Subd. 4. **Major medical coverage.** Each insurer and fraternal shall 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 $500,000. 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.

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

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

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

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.

Subd. 9. **Reduction of benefits because of ERISA services.** No plan of health coverage including, but not limited to, any plan under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461, which covers a Minnesota resident shall deny or reduce benefits because services are rendered to a covered person or dependent who is eligible for or receiving benefits under chapter 256B.

Subd. 10. **Dependent coverage.** A plan of health coverage under the federal Employee Retirement Income Security Act of 1974 (ERISA), United State Code, title 29, sections 1001 to 1461, which covers an employee who is a Minnesota resident must, if it provides dependent coverage, allow dependent children who are eligible for or receiving benefits under chapter 256B and who do not reside with the covered employee to be covered on the same basis as if they reside with the covered employee. Neither the amount of support provided by the employee to the dependent child nor the residency of the child can be used as an excluding or limiting factor for coverage or payment for any health care.

History: *1976 c 296 art 1 s 4; 1977 c 409 s 9,10; 1979 c 174 s 3; 1979 c 272 s 4; 1988 c 689 art 2 s 14,15; 1988 c 704 s 1*

62E.05 CERTIFICATION OF QUALIFIED PLANS.

Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified medicare supplement plan for the

purposes of sections 62E.01 to 62E.16, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All plans of health coverage shall be labeled as "qualified" or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

History: *1976 c 296 art 1 s 5; 1987 c 384 art 2 s 1*

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 $500,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $500,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarially 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 dental, which are rendered by a physician or at the physician's 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 but including scalp hair prostheses worn for hair loss suffered as a result of alopecia areata;

(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;

(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; and

(15) services of an occupational therapist.

(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 section 62A.04, subdivision 3, clause (4);

(2) any charge for treatment for cosmetic purposes other than for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician;

(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 semiprivate room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semiprivate rooms, its most common semiprivate 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 well baby care, effective July 1, 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations.

(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.

(f) Effective August 1, 1985, the minimum benefits of a qualified plan must include, in addition to the benefits specified in clauses (a), (d), and (e), coverage for special dietary treatment for phenylketonuria when recommended by a physician.

(g) Outpatient mental health coverage is subject to section 62A.152, subdivision 2.

Subd. 2. **Number two plan.** A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by subdivision 1 except that the deductible shall not exceed $500 per person.

Subd. 3. **Number one plan.** A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by subdivision 1 except that the deductible shall not exceed $1,000 per person.

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

History: *1975 c 359 s 23; 1976 c 296 art 1 s 6; 1977 c 409 s 11; 1979 c 272 s 5; 1980 c 496 s 3; 1981 c 265 s 2; 1Sp1985 c 9 art 2 s 2; 1986 c 444; 1987 c 202 s 2; 1987 c 337 s 66; 1988 c 704 s 2; 1989 c 330 s 24*

62E.07 QUALIFIED MEDICARE SUPPLEMENT PLAN.

Any plan which provides benefits may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 100 percent of the deductibles required under Medicare and 80 percent of the charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services.

History: *1976 c 296 art 1 s 7; 1989 c 258 s 12; 1992 c 554 art 1 s 14*

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 basis 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, provided that the association shall not discriminate in charging premiums based upon sex.

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.

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: *1976 c 296 art 1 s 8; 1977 c 409 s 12; 1979 c 272 s 6; 1983 c 123 s 1; 1991 c 165 s 2*

62E.081 [Repealed, 1987 c 384 art 3 s 34]

62E.09 DUTIES OF COMMISSIONER.

The commissioner may:

(a) Formulate general policies to advance the purposes of sections 62E.01 to 62E.16;

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

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

(d) Appoint advisory committees;

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

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

(g) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to 62E.16, so that the residents of this state may best avail themselves of the health care benefits provided by these sections;

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

(i) Adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.16. The commissioner may until December 31, 1978 adopt emergency rules.

History: *1976 c 296 art 1 s 9; 1977 c 409 s 13; 1987 c 384 art 2 s 1*

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; joint self-insurance plans regulated under chapter 62H; the private employers insurance program established in section 43A.317, effective July 1, 1993; 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 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.

Subd. 2a. **Appeals.** A person may appeal to the commissioner within 30 days after notice of an action, ruling, or decision by the board.

A final action or order of the commissioner under this subdivision is subject to judicial review in the manner provided by chapter 14.

In lieu of the appeal to the commissioner, a person may seek judicial review of the board's action.

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 14.001 to 14.69.

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.

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 325D.49 to 325D.66.

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 is exempt from the administrative procedure act but, to the extent authorized by law to adopt rules, the association may use the provisions of section 14.38, subdivisions 5 to 9.

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, 1993.

History: *1976 c 296 art 1 s 10; 1977 c 409 s 14-16; 1979 c 272 s 7; 1981 c 253 s 23; 1982 c 424 s 130; 1Sp1985 c 10 s 63; 1987 c 337 s 67-69; 1987 c 384 art 2 s 1; 1988 c 612 s 28; 1990 c 422 s 10; 1990 c 523 s 2; 1991 c 165 s 3,4; 1991 c 264 s 1; 1992 c 549 art 3 s 14; 1992 c 554 art 1 s 15; 1992 c 564 art 1 s 35; art 4 s 11*

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.

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 85 percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than 15 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 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.

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. [Repealed, 1987 c 268 art 2 s 38]

Subd. 9. Each contributing member that terminates individual health coverage for reasons other than (a) nonpayment of premium; (b) failure to make copayments; (c) enrollee moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and does not provide or arrange for replacement coverage that meets the requirements of section 62D.121; shall pay a special assessment to the state plan based upon the number of terminated individuals who join the comprehensive health insurance plan as authorized under section 62E.14, subdivisions 1, paragraph (d), and 6. Such a contributing member shall pay the association an amount equal to the average cost of an enrollee in the state plan in the year in which the member terminated enrollees multiplied by the total number of terminated enrollees who enroll in the state plan.

The average cost of an enrollee in the state comprehensive health insurance plan shall be determined by dividing the state plan's total annual losses by the total number of enrollees from that year. This cost will be assessed to the contributing member who has terminated health coverage before the association makes the annual determination of each contributing member's liability as required under this section.

In the event that the contributing member is terminating health coverage because of a loss of health care providers, the commissioner may review whether or not the special assessment established under this subdivision will have an adverse impact on the contributing member or its enrollees or insureds, including but not limited to causing the contributing member to fall below statutory net worth requirements. If the commissioner determines that the special assessment would have an adverse impact on the contributing member or its enrollees or insureds, the commissioner may adjust the amount of the special assessment, or establish alternative payment arrangements to the state plan. For health maintenance organizations regulated under chapter 62D, the commissioner of health shall make the determination regarding any adjustment in the special assessment and shall transmit that determination to the commissioner of commerce.

Subd. 10. Any contributing members who have terminated individual health plans and do not provide or arrange for replacement coverage that meets the requirements of section 62D.121, and whose former insureds or enrollees enroll in the state comprehensive health insurance plan with a waiver of the preexisting conditions pursuant to section 62E.14, subdivisions 1, paragraph (d), and 6, will be liable for the costs of any preexisting conditions of their former enrollees or insureds treated during the first six months of coverage under the state plan. The liability for preexisting conditions will be assessed before the association makes the annual determination of each contributing member's liability as required under this section.

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.

Subd. 12. **Funding.** Notwithstanding subdivision 5, the claims expenses and operating and administrative expenses of the association incurred on or after January 1, 1994 shall be paid from the health care access account established in section 16A.724, to the extent appropriated for that purpose by the legislature. Any such expenses not paid from that account shall be paid as otherwise provided in this section. All contributing members shall adjust their premium rates to fully reflect funding provided under this subdivision. The commissioner of commerce or the commissioner of health, as appropriate, shall require contributing members to prove compliance with this rate adjustment requirement.

History: *1976 c 296 art 1 s 11; 1977 c 409 s 17; 1979 c 272 s 8; 1982 c 426 s 1; 1984 c 514 art 2 s 2; 1986 c 444; 1988 c 434 s 17,18; 1991 c 54 s 1; 1991 c 264 s 2; 1992 c 549 art 3 s 15,16; 1992 c 564 art 1 s 36*

NOTE: Subdivision 9, as amended by Laws 1992, chapter 549, article 3, section 15, and subdivision 12, as added by section 16, are effective July 1, 1993. See Laws 1992, chapter 549, article 3, section 24.

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 and a number two qualified plan, except that the maximum lifetime benefit on these plans shall be $1,000,000, and an extended basic plan and a basic Medicare plan as described in sections 62A.31 to 62A.44 and 62E.07. 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: *1976 c 296 art 1 s 12; 1980 c 565 s 1; 1Sp1985 c 10 s 64; 1991 c 165 s 6; 1992 c 554 art 1 s 16; 1992 c 564 art 4 s 12*

62E.13 ADMINISTRATION OF PLAN.

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

Subd. 2. 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.

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

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

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

Subd. 6. All claims shall be paid by the writing carrier pursuant to the provisions of sections 62E.01 to 62E.16, and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

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

Subd. 8. The writing carrier shall at all times when carrying out its duties under sections 62E.01 to 62E.16 be considered an agent of the association and the commissioner with civil liability subject to the provisions of section 3.751.

Subd. 9. [Repealed, 1987 c 268 art 2 s 38]

Subd. 10. Premiums received by the writing carrier for the comprehensive health insurance plan are exempt from the provisions of section 60A.15.

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: *1976 c 296 art 1 s 13; 1977 c 409 s 18,19; 1979 c 272 s 9; 1986 c 444; 1987 c 384 art 2 s 1; 1988 c 719 art 2 s 3; 1991 c 165 s 7*

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, list of residences for the immediately preceding six months and length of time at current 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 preexisting 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 one association member 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;

(d) If the applicant has been terminated from individual health coverage which does not provide replacement coverage, evidence that no replacement coverage that meets the requirements of section 62D.121 was offered, and evidence of termination of individual health coverage by an insurer, nonprofit health service plan corporation, or health maintenance organization provided that the contract or policy has been terminated for reasons other than (1) failure to pay the charge for health care coverage; (2) failure to make copayments required by the health care plan; (3) enrollee moving out of the area served; or (4) a materially false statement or misrepresentation by the enrollee in the application for membership; and

(e) 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.

Subd. 2. **Writing carrier's response.** Within 30 days of receipt of the certificate described in subdivision 1, the writing carrier shall either reject the application for failing to comply with the requirements in subdivision 1 or forward the eligible person a notice of acceptance and billing information. Insurance shall be effective immediately upon receipt of the first month's state plan premium, and shall be retroactive to the date of the application, if the applicant otherwise complies with the requirements of sections 62E.01 to 62E.16.

Subd. 3. **Preexisting conditions.** No person who obtains coverage pursuant to this section shall be covered for any preexisting condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of an application except as provided under subdivisions 4, 5, and 6.

Subd. 3a. **Waiver of preexisting condition.** A person may enroll in the comprehensive health plan with a waiver of the preexisting condition limitation described in section 62E.14, subdivision 3, provided that the person meets the following requirements:

(1) group coverage was provided through a rehabilitation facility defined in section 268A.01, subdivision 6, and coverage was terminated;

(2) all other eligibility requirements for enrollment in the comprehensive health plan are met; and

(3) coverage is applied for within 90 days of termination of previous coverage.

Subd. 4. **Waiver of preexisting conditions for Medicare supplement plan enrollees.** Notwithstanding the above, any Minnesota resident holder of a policy or certificate of Medicare supplement coverages pursuant to sections 62A.315 and 62A.316, or Medicare supplement plans previously approved by the commissioner, may enroll in the comprehensive health insurance plan as described in section 62E.07, with a waiver of the preexisting condition as described in subdivision 3, without interruption in coverage, provided, the policy or certificate has been terminated by the insurer for reasons other than nonpayment of premium and, provided further, that the option to enroll in the plan is exercised within 30 days of termination of the existing contract.

Coverage in the state plan for purposes of this section shall be effective on the date of termination upon completion of the proper application and payment of the required premium. The application must include evidence of termination of the existing policy or certificate.

Subd. 4a. **Waiver of preexisting conditions for Minnesota residents.** A person may enroll in the comprehensive health plan with a waiver of the preexisting condition limitation described in subdivision 3, provided that the following requirements are met:

(1) the person is a Minnesota resident eligible to enroll in the comprehensive health plan;

(2) the person:

(a) would be eligible for continuation under federal or state law if continuation coverage were available or were required to be available;

(b) would be eligible for continuation under clause (a) except that the person was exercising continuation rights and the continuation period required under federal or state law has expired; or

(c) is eligible for continuation of health coverage under federal or state law;

(3) continuation coverage is not available; and

(4) the person applies for coverage within 90 days of termination of prior coverage from a policy or plan.

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.

Subd. 4b. **Waiver of preexisting conditions for persons covered by retiree plans.** A

person who was covered by a retiree health care plan may enroll in the comprehensive health plan with a waiver of the preexisting condition limitation described in subdivision 3, provided that the following requirements are met:

(1) the person is a Minnesota resident eligible to enroll in the comprehensive health plan;

(2) the person was covered by a retiree health care plan from an employer and the coverage is no longer available to the person; and

(3) the person applies for coverage within 90 days of termination of prior 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 section.

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.

Subd. 5. **Terminated employees.** An employee who is voluntarily or involuntarily terminated or laid off from employment and unable to exercise the option to continue coverage under section 62A.17 may enroll, within 60 days of termination or layoff, with a waiver of the preexisting condition limitation set forth in subdivision 3 and a waiver of the evidence of rejection set forth in subdivision 1, paragraph (c).

Subd. 6. **Termination of individual policy or contract.** A Minnesota resident who holds an individual health maintenance contract, individual nonprofit health service corporation contract, or an individual insurance policy previously approved by the commissioners of health or commerce, may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition as described in subdivision 3, without interruption in coverage, provided (1) no replacement coverage that meets the requirements of section 62D.121 was offered by the contributing member, and (2) the policy or contract has been terminated for reasons other than (a) nonpayment of premium; (b) failure to make copayments required by the health care plan; (c) moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and, provided further, that the option to enroll in the plan is exercised within 30 days of termination of the existing policy or contract.

Coverage allowed under this section is effective when the contract or policy is terminated and the enrollee has completed the proper application and paid the required premium or fee.

Expenses incurred from the preexisting conditions of individuals enrolled in the state plan under this subdivision must be paid by the contributing member canceling coverage as set forth in section 62E.11, subdivision 10.

The application must include evidence of termination of the existing policy or certificate as required in subdivision 1.

Subd. 7. **Terminations of conversion policies.** (a) A Minnesota resident who is covered by a conversion policy or contract of health coverage may enroll in the comprehensive health plan with a waiver of the preexisting condition limitation in subdivision 3 and a waiver of the evidence of rejection in subdivision 1, paragraph (c), at any time for any reason during the term of coverage.

(b) A Minnesota resident who was covered by a conversion policy or contract of health coverage may enroll in the comprehensive health plan with a waiver of the preexisting condition limitation in subdivision 3 and a waiver of the evidence of rejection in subdivision 1, paragraph (c), if that person applies for coverage within 90 days after termination of the conversion policy or contract coverage regardless of: (1) the reasons for the termination; or (2) the party terminating coverage.

(c) Coverage under this subdivision is effective upon termination of prior coverage if the enrollee has submitted a completed application and paid the required premium or fee.

History: *1976 c 296 art 1 s 14; 1977 c 409 s 20; 1979 c 272 s 10; 1984 c 592 s 48; 1986 c 455 s 14; 1986 c 458 s 2; 1987 c 337 s 70; 1987 c 384 art 2 s 1; 1988 c 434 s 19-21; 1988 c 612 s 29,31; 1989 c 258 s 13; 1990 c 523 s 3-5; 1991 c 165 s 8; 1991 c 325 art 21 s 6; 1992 c 564 art 1 s 37*

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

No employee, or dependent of an employee, of an employer who offers a health benefit plan, under which the employee or dependent is eligible to enroll under chapter 62L, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation or exclusion under the employer's health benefit plan. This section does not apply to persons enrolled in the comprehensive health association as of June 30, 1993.

History: *1992 c 549 art 3 s 17*

NOTE: This section, as added by Laws 1992, chapter 549, article 3, section 17, is effective July 1, 1993. See Laws 1992, chapter 549, article 3, section 24.

62E.15 SOLICITATION OF ELIGIBLE PERSONS.

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

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

Subd. 3. The writing carrier shall pay an agent's referral fee of $50 to each insurance agent who refers an applicant to the state plan, if the application is accepted. Selling or marketing of qualified state plans shall not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for the state plan.

Subd. 4. Every insurer and health maintenance organization which rejects or applies underwriting restrictions to an applicant for a plan of health coverage shall: (1) provide the applicant with a written notice of rejection or the underwriting restrictions applied to the applicant in a manner consistent with the requirements in section 72A.499; (2) notify the applicant of the existence of the state plan, the requirements

for being accepted in it, and the procedure for applying to it; and (3) provide the applicant with written materials explaining the state plan in greater detail. This written material shall be provided by the association to every insurer at no charge.

Subd. 5. **Initial notification.** Every insurer and health maintenance organization before issuing a conversion policy or contract of health insurance shall:

(1) notify the applicant of the existence of the state plan, the requirements for being accepted in it, the procedure for applying to it, and the plan rates; and

(2) provide the applicant with written materials explaining the state plan in greater detail. This written material shall be provided by the association to every insurer and health maintenance organization at no charge.

Subd. 6. **Annual notification.** Every insurer and health maintenance organization which provides health coverage to an insured through a conversion plan shall annually:

(1) notify the insured of the existence of the state plan, the requirements for being accepted in it, the procedure for applying to it, and the plan rates; and

(2) provide the applicant with written materials explaining the state plan in greater detail. This written material shall be provided by the association to every insurer and health maintenance organization at no charge.

Subd. 7. **Conversion rates.** For Medicare supplement conversion policies issued prior to August 1, 1992, the requirements of subdivisions 5 and 6 apply only when the conversion rates offered to the applicant by the insurer or health maintenance organization exceed the association rates.

History: *1976 c 296 art 1 s 15; 1984 c 592 s 49; 1990 c 523 s 6; 1992 c 564 art 1 s 38-41*

62E.16 POLICY CONVERSION RIGHTS.

Every program of self-insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state, shall include, in addition to the provisions required by section 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions if the individual insured leaves the group regardless of the reason for leaving the group or if an employer member of a group ceases to remit payment so as to terminate coverage for its employees, or upon cancellation or termination of the coverage for the group except where uninterrupted and continuous group coverage is otherwise provided to the group. If the health maintenance organization has canceled coverage for the group because of a loss of providers in a service area, the health maintenance organization shall arrange for other health maintenance or indemnity conversion options that shall be offered to enrollees without the addition of underwriting restrictions. The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. The person may exercise this right to conversion within 30 days of leaving the group or within 30 days following receipt of due notice of cancellation or termination of coverage of the group or of the employer member of the group and upon payment of premiums from the date of termination or cancellation. Due notice of cancellation or termination of coverage for a group or of the employer member of the group shall be provided to each employee having coverage in the group by the insurer, self-insurer or health maintenance organization canceling or terminating the coverage except where reasonable evidence indicates that uninterrupted and continuous group coverage is otherwise provided to the group. Every employer having a policy of group accident and health insurance, group subscriber or contract of coverage by a health maintenance organization shall, upon request, provide the insurer or health maintenance organization a list of the names and addresses of covered employees. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue coverage under the same or a different contract without the addition of underwriting restrictions until the individual would have ceased to have been

entitled to coverage had the individual in whose name the contract was issued lived. An individual conversion contract issued by a health maintenance organization shall not be deemed to be an individual enrollment contract for the purposes of section 62D.10.

History: *1976 c 296 art 1 s 16; 1977 c 335 s 1; 1Sp1985 c 10 s 65; 1986 c 444; 1988 c 434 s 22; 1992 c 564 art 1 s 42*

62E.17 [Repealed, 1Sp1985 c 9 art 2 s 104]

62E.18 HEALTH INSURANCE FOR RETIRED EMPLOYEES NOT ELIGIBLE FOR MEDICARE.

A Minnesota resident who is age 65 or over and is not eligible for the health insurance benefits of the federal Medicare program is entitled to purchase the benefits of a qualified plan, one or two, offered by the Minnesota comprehensive health association without any of the limitations set forth in section 62E.14, subdivision 1, paragraph (c), and subdivision 3.

History: *1987 c 337 s 71*

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.

Subd. 2. **Exemption.** Subdivision 1 does not apply to a termination of or failure to implement an employee health benefit plan which results from or occurs during a strike or lockout, nor does it apply to employee health benefit plans separately provided by an employee organization or bargaining agent, regardless of any financial contribution to the plan by the employer.

History: *1990 c 523 s 7; 1991 c 199 art 1 s 11*

CATASTROPHIC HEALTH EXPENSE PROTECTION

62E.51 CITATION.

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

History: *1976 c 296 art 3 s 1*

62E.52 DEFINITIONS.

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

Subd. 2. "Eligible person" means any person who is a resident of Minnesota and who, while a resident of Minnesota, has been found by the commissioner to have incurred an obligation to pay:

(1) qualified expenses for that person and any dependents in any 12 consecutive months exceeding:

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

(b) $2,500, whichever is greater; or

(2) qualified nursing home expenses for that person and any dependents in any 12 consecutive months exceeding 20 percent of household income.

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

Subd. 3a. "Qualified nursing home expense" includes any charge incurred for nursing home services after 36 months of continuous care provided to a person 64 years of age or younger in long-term care facilities.

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

Subd. 5. "Household income" means the gross income of an eligible person and all dependents 23 years of age or older for the calendar year preceding the year in which an application is filed pursuant to section 62E.53.

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

Subd. 7. "Commissioner" means the commissioner of human services.

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

History: *1976 c 296 art 3 s 2; 1977 c 448 s 1-3; 1984 c 654 art 5 s 58; 1986 c 444*

NOTE: Laws 1979, Chapter 336, Section 2, Subdivision 4, reads in part:

"Notwithstanding the provisions of Minnesota Statutes, Sections 62E.52, Subdivision 2, Clause (1) and 62E.53, Subdivision 2, Clause (1), the appropriation for catastrophic health insurance includes funds which shall be used, under the Minnesota catastrophic health expense protection act of 1976, to increase payments for the qualified expenses of any eligible person and any dependents in any 12 consecutive months. The payment in 1980 shall not exceed 30 percent of household income up to $15,000, plus 40 percent of household income between $15,000 and $25,000, plus 50 percent of household income in excess of $25,000. The payment in 1981 shall not exceed 20 percent of household income up to $15,000, plus 25 percent of household income between $15,000 and $25,000, plus 30 percent of household income in excess of $25,000.

Notwithstanding the provisions of Minnesota Statutes, Sections 62E.52, Subdivision 3a and 62E.53, Subdivision 2, Clause (2), the appropriation for catastrophic health insurance includes funds which shall be used, under the Minnesota catastrophic health expense protection act of 1976, to increase payments for qualified nursing home expenses in fiscal years 1980 and 1981 to include any charges incurred for nursing home services after 24 months of continuous care provided to a person 64 years of age or younger in long-term care facilities."

62E.53 APPLICATION FOR ASSISTANCE.

Subdivision 1. All persons who believe that they are or will become an eligible per-

son may submit an application for state assistance to the commissioner. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the 12 month period for computing expenses began.

Subd. 2. If the commissioner determines that an applicant is an eligible person, the commissioner shall pay

(1) 90 percent of all qualified expenses of the eligible person and dependents in excess of:

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

(b) $2,500;

whichever is greater for the 12-month period in which the applicant becomes an eligible person and

(2) all qualified nursing home expenses of the eligible person and dependents in excess of 20 percent of household income. Provided, however, that the payment of qualified nursing home expenses shall not be made until the end of the fiscal year. If the appropriation for the payment of qualified nursing home expenses is inadequate to pay all qualified nursing home expenses, the commissioner shall prorate the payments among all eligible persons in proportion to their share of the total of the qualified nursing home expenses of all eligible persons.

Subd. 3. The commissioner shall by rule establish procedures for determining whether and to what extent qualified expenses are reasonable charges. Unless otherwise provided for by rule charges shall be reviewed for reasonableness by the same procedures used to review and limit reimbursement under the provisions of chapter 256B. If the commissioner determines that the charge for a health service is excessive, the commissioner may limit payment to the reasonable charge for that service. If the commissioner determines that a health service provided to an eligible person was not medically necessary, the commissioner may refuse to pay for the service. The commissioner may contract with a review organization as defined in section 145.61, in making any determinations as to whether or not a charge is excessive and in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

Subd. 4. No applicant shall be eligible for state assistance under sections 62E.51 to 62E.55 unless the applicant has authorized the commissioner of human services in writing to examine all personal medical records developed while the applicant received the medical care for which state assistance is sought. The commissioner shall use the medical records only for the purpose of investigating whether or not a health services vendor has submitted a claim for reimbursement, a cost report or a rate application which the vendor knows to be false in whole or in part, or in order to determine whether or not the medical care provided to the applicant was medically necessary. This written authorization shall be presented to the vendor of medical care before the commissioner gains access to the records. The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner pursuant to this subdivision.

Subd. 5. Health services provided outside Minnesota to eligible persons are qualified expenses in the following situations:

(1) When it is general practice for residents of Minnesota to use health services beyond the borders of this state; or

(2) When the availability of necessary medical care, services, or supplementary resources make it necessary for an individual to use health services outside the state; or

(3) Where an emergency arises from accident or illness and the individual is outside the state; or

(4) Where the health of the individual would be endangered if the care and services were postponed until the individual returns to Minnesota; or

(5) Where the health of the individual would be endangered if the individual attempted to return to Minnesota in order to receive medical care.

History: *1976 c 296 art 3 s 3; 1977 c 409 s 21; 1977 c 448 s 4; 1980 c 349 s 1; 1980 c 565 s 2; 1984 c 654 art 5 s 58; 1986 c 444*

62E.531 THIRD PARTY LIABILITY.

Subdivision 1. When the commissioner pays for or becomes liable for payments for health services under the provisions of sections 62E.51 to 62E.55, the department of human services shall have a lien for payments and liabilities for the services upon any and all causes of action which accrue to the person to whom the services were furnished, or to the person's legal representatives, as a result of injuries which directly or indirectly led to the incurring of qualified expenses.

The department may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70, and 514.71, except that it shall have one year from the date when the last item of health service was furnished in which to file its verified lien statement. The statement shall be filed with the appropriate court administrator in the county in which the recipient of the services resides or in the county in which the action was filed.

Subd. 2. Where a third party may be liable in whole or in part for payment for health services, the commissioner may consider the charges for the health services to be qualified expenses if the eligible person assigns any rights accruing by virtue of any third party liability to the commissioner to the extent necessary to reimburse the state for any payments made under the provisions of this section.

Subd. 3. Upon furnishing assistance under the provisions of sections 62E.51 to 62E.55, the department of human services shall be subrogated, to the extent of its payments for health services, to any rights the eligible person or a dependent may have under the terms of any plan of health coverage as defined in section 62E.02, subdivision 9. The right of subrogation shall not attach prior to written notice of the exercise of subrogation rights to the issuer of the plan of health coverage.

The attorney general, or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action against the issuer of the plan of health coverage to recover under this subdivision.

History: *1977 c 409 s 22; 1984 c 654 art 5 s 58; 1986 c 444; 1Sp1986 c 3 art 1 s 82*

62E.54 DUTIES OF COMMISSIONER.

Subdivision 1. The commissioner shall:

(a) Promulgate reasonable rules, including emergency rules, to implement sections 62E.51 to 62E.55;

(b) Establish application forms and procedures for the use of persons seeking to be declared an eligible person;

(c) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them; and

(d) Promulgate rules establishing general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, and false statements or representations of material facts by a vendor of health services, and for the imposition of sanctions against a vendor. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivisions 1a to 2.

Subd. 2. The commissioner may:

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

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

History: *1976 c 296 art 3 s 4; 1977 c 409 s 23; 1980 c 349 s 2*

62E.55 APPEALS.

The final decision of the commissioner denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to chapter 14.

History: *1976 c 296 art 3 s 5; 1982 c 424 s 130*