CHAPTER 62D

HEALTH MAINTENANCE ORGANIZATIONS

62D.02 DEFINITIONS.

[For text of subds 1 to 7, see M.S.1994]

Subd. 8. "Health maintenance contract" means any contract whereby a health maintenance organization agrees to provide comprehensive health maintenance services to enrollees, provided that the contract may contain reasonable enrollee copayment provisions. An individual or group health maintenance contract may contain the copayment and deductible provisions specified in this subdivision. Copayment and deductible provisions in group contracts shall not discriminate on the basis of age, sex, race, length of enrollment in the plan, or economic status; and during every open enrollment period in which all offered health benefit plans, including those subject to the jurisdiction of the commissioners of commerce or health, fully participate without any underwriting restrictions, copayment and deductible provisions shall not discriminate on the basis of preexisting health status. In no event shall the sum of the annual copayments and deductible exceed the maximum out–of–pocket expenses allowable for a number three qualified plan under section 62E.06, nor shall that sum exceed $5,000 per family. The annual deductible must not exceed $1,000 per person. The annual deductible must not apply to preventive health services as described in Minnesota Rules, part 4685.0801, subpart 8. Where sections 62D.01 to 62D.30 permit a health maintenance organization to contain reasonable copayment provisions for preexisting health status, these provisions may vary with respect to length of enrollment in the plan. Any contract may provide for health care services in addition to those set forth in subdivision 7.

[For text of subds 9 to 16, see M.S.1994]

History: *1995 c 234 art 7 s 6; 1995 c 258 s 39*

62D.042 NET WORTH AND WORKING CAPITAL REQUIREMENTS.

[For text of subd 1, see M.S.1994]

Subd. 2. **Beginning organizations.** (a) Beginning organizations shall maintain net worth of at least 8–1/3 percent of the sum of all expenses expected to be incurred in the 12 months following the date the certificate of authority is granted, or $1,500,000, whichever is greater.

(b) After the first full calendar year of operation, organizations shall maintain net worth of at least 8–1/3 percent and at most 16–2/3 percent of the sum of all expenses incurred during the most recent calendar year, but in no case shall net worth fall below $1,000,000.

(c) Notwithstanding paragraphs (a) and (b), any health maintenance organization owned by a political subdivision of this state, which has a higher than average percentage of enrollees who are enrolled in medical assistance or general assistance medical care, may exceed the maximum net worth limits provided in paragraphs (a) and (b), with the advance approval of the commissioner.

[For text of subds 3 to 7, see M.S.1994]

History: *1995 c 234 art 7 s 7*

62D.044 ADMITTED ASSETS.

"Admitted assets" includes the following:

(1) petty cash and other cash funds in the organization's principal or official branch office that are under the organization's control;

(2) immediately withdrawable funds on deposit in demand accounts, in a bank or trust company organized and regularly examined under the laws of the United States or any state, and insured by an agency of the United States government, or like funds actually in the principal or official branch office at statement date, and, in transit to a bank or trust company with authentic deposit credit given before the close of business on the fifth bank working day following the statement date;

(3) the amount fairly estimated as recoverable on cash deposited in a closed bank or trust company, if the assets qualified under this section before the suspension of the bank or trust company;

(4) bills and accounts receivable that are collateralized by securities in which the organization is authorized to invest;

(5) premiums due from groups or individuals that are not more than 90 days past due;

(6) amounts due under reinsurance arrangements from insurance companies authorized to do business in this state;

(7) tax refunds due from the United States or this state;

(8) principal and interest accrued on mortgage loans not exceeding in aggregate one year's total due and accrued principal and interest on an individual loan;

(9) the rents due to the organization on real and personal property, directly or beneficially owned, not exceeding the amount of one year's total due and accrued rent on each individual property;

(10) principal and interest or rents accrued on conditional sales agreements, security interests, chattel mortgages, and real or personal property under lease to other corporations that do not exceed the amount of one year's total due and accrued interest or rent on an individual investment;

(11) the fixed required principal and interest due and accrued on bonds and other evidences of indebtedness that are not in default;

(12) dividends receivable on shares of stock, provided that the market price for valuation purposes does not include the value of the dividend;

(13) the interest on dividends due and payable, but not credited, on deposits in banks and trust companies or on accounts with savings associations;

(14) principal and interest accrued on secured loans that do not exceed the amount of one year's interest on any loan;

(15) interest accrued on tax anticipation warrants;

(16) the amortized value of electronic computer or data processing machines or systems purchased for use in the business of the organization, including software purchased and developed specifically for the organization's use;

(17) the cost of furniture, equipment, and medical equipment, less accumulated depreciation thereon, and medical and pharmaceutical supplies that are used to deliver health care and are under the organization's control, provided such assets do not exceed 30 percent of admitted assets;

(18) amounts currently due from an affiliate that has liquid assets with which to pay the balance and maintain its accounts on a current basis. Any amount outstanding more than three months is not current;

(19) amounts on deposit under section 62D.041;

(20) accounts receivable from participating health care providers that are not more than 60 days past due; and

(21) investments allowed by section 62D.045, except for investments in securities and properties described under section 61A.284.

History: *1995 c 202 art 1 s 25*

62D.106 [Repealed, 1995 c 207 art 10 s 25]

62D.11 COMPLAINT SYSTEM.

Subdivision 1. **Enrollee complaint system.** Every health maintenance organization shall establish and maintain a complaint system, as required under section 62Q.105 to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services. "Provision of health services" includes, but is not limited to, questions of the scope of coverage, quality of care, and administrative operations. The health maintenance organization must inform enrollees that they may choose to use an alternative dispute resolution process. If an enrollee chooses to use an alternative dispute resolution process, the health maintenance organization must participate.

[For text of subds 1a to 4, see M.S.1994]

History: *1995 c 234 art 2 s 1*

62D.12 PROHIBITED PRACTICES.

[For text of subds 1 to 17, see M.S.1994]

Subd. 18. No health maintenance organization shall fail to comply with the special reinstatement privilege provided under section 62A.04, subdivision 2, clause (4), for the Medicare–related coverage referred to in that clause.

History: *1995 c 75 s 2*

62D.181 INSOLVENCY; MCHA ALTERNATIVE COVERAGE.

[For text of subd 1, see M.S.1994]

Subd. 2. **Eligible individuals.** An individual is eligible for alternative coverage under this section if:

(1) the individual had individual health coverage through a health maintenance organization, integrated service network, or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization, integrated service network, or community integrated service network, and the individual has not obtained alternative coverage; or

(2) the individual had group health coverage through a health maintenance organization, integrated service network, or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization, integrated service network, or community integrated service network, and the individual has not obtained alternative coverage.

Subd. 3. **Application and issuance.** If a health maintenance organization, integrated service network, or community integrated service network will be liquidated, individuals eligible for alternative coverage under subdivision 2 may apply to the association to obtain alternative coverage. Upon receiving an application and evidence that the applicant was enrolled in the health maintenance organization, integrated service network, or community integrated service network at the time of an order for liquidation, the association shall issue policies to eligible individuals, without the limitation on preexisting conditions described in section 62E.14, subdivision 3.

[For text of subds 4 and 5, see M.S.1994]

Subd. 6. **Duration.** The duration of alternative coverage issued under this section is:

(1) for individuals eligible under subdivision 2, clause (1), 90 days; and

(2) for individuals eligible under subdivision 2, clause (2), 90 days or the length of time remaining in the group contract with the insolvent health maintenance organization, integrated service network, or community integrated service network, whichever is greater.

[For text of subds 7 and 8, see M.S.1994]

Subd. 9. **Coordination of policies.** If an insolvent health maintenance organization, integrated service network, or community integrated service network has insolvency insur-

ance coverage at the time of an order for liquidation, the association may coordinate the benefits of the policy issued under this section with those of the insolvency insurance policy available to the enrollees. The premium level for the combined association policy and the insolvency insurance policy may not exceed those described in subdivision 5.

History: *1995 c 234 art 1 s 6–9*