CHAPTER 62D

HEALTH MAINTENANCE ORGANIZATIONS

62D.01 CITATION AND PURPOSE.

Subdivision 1. Sections 62D.01 to 62D.24 may be cited as the "health maintenance act of 1973".

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

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

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

History: *1973 c 670 s 1; 1977 c 305 s 45; 1996 c 305 art 1 s 139*

62D.02 DEFINITIONS.

Subdivision 1. For the purposes of sections 62D.01 to 62D.30, unless the context clearly indicates otherwise, the terms defined in this section shall have the meaning here given them.

Subd. 2. [Repealed, 1990 c 538 s 32]

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

Subd. 4. (a) "Health maintenance organization" means a nonprofit corporation organized under chapter 317A, or a local governmental unit as defined in subdivision 11, controlled and operated as provided in sections 62D.01 to 62D.30, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a

fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

(b) Notwithstanding paragraph (a), an organization licensed as a health maintenance organization that accepts payments for health care services on a capitated basis, or under another similar risk sharing agreement, from a program of self–insurance as described in section 60A.02, subdivision 3, paragraph (b), shall not be regulated as a health maintenance organization with respect to the receipt of the payments. The payments are not premium revenues for the purpose of calculating the health maintenance organization's liability for otherwise applicable state taxes, assessments, or surcharges, with the exception of:

(1) the MinnesotaCare provider tax;

(2) the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (e); and

(3) effective July 1, 1995, assessments by the Minnesota comprehensive health association.

This paragraph applies only where:

(1) the health maintenance organization does not bear risk in excess of 110 percent of the self–insurance program's expected costs;

(2) the employer does not carry stop loss, excess loss, or similar coverage with an attachment point lower than 120 percent of the self–insurance program's expected costs;

(3) the health maintenance organization and the employer comply with the data submission and administrative simplification provisions of chapter 62J;

(4) the health maintenance organization and the employer comply with the provider tax pass–through provisions of section 295.582;

(5) the health maintenance organization's required minimum reserves reflect the risk borne by the health maintenance organization under this paragraph, with an appropriate adjustment for the 110 percent limit on risk borne by the community network;

(6) on or after July 1, 1994, but prior to January 1, 1995, the employer has at least 1,500 current employees, as defined in section 62L.02, or, on or after January 1, 1995, the employer has at least 750 current employees, as defined in section 62L.02;

(7) the employer does not exclude any eligible employees or their dependents, both as defined in section 62L.02, from coverage offered by the employer, under this paragraph or any other health coverage, insured or self–insured, offered by the employer, on the basis of the health status or health history of the person.

This paragraph expires December 31, 1997.

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

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

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

Subd. 8. "Health maintenance contract" means any contract whereby a health maintenance organization agrees to provide comprehensive health maintenance services to enrollees, provided that the contract may contain reasonable enrollee copayment provisions. 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.

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

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

Subd. 11. "Local governmental unit" means any statutory or home rule charter city or county.

Subd. 12. "Participating entity" means any of the following persons, providers, companies, or other organizations with which the health maintenance organization has contracts or other agreements:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.11, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner of health;

(2) a health care professional licensed under health-related licensing boards, as defined in section 214.01, subdivision 2, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner of health;

(3) a group, professional corporation, or other organization which provides the services of individuals or entities identified in (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) any person or organization providing administrative, financial, or management services to the health maintenance organization if the total payment for all services exceeds three percent of the gross revenues of the health maintenance organization.

"Participating entity" does not include (a) another health maintenance organization with which a health maintenance organization has made contractual arrangements or (b) any entity with which a health maintenance organization has contracted primarily in order to purchase or lease equipment or space or (c) employees of the health maintenance organization or (d) employees of any participating entity identified in clause (3).

Subd. 13. "Major participating entity" shall include the following:

(1) a participating entity that receives from the health maintenance organization as compensation for services a sum greater than 30 percent of the health maintenance organization's gross annual revenues;

(2) a participating entity providing administrative, financial, or management services to the health maintenance organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health maintenance organization;

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors of the health maintenance organization.

Subd. 14. "Separate health services contracts" means prepaid dental services contracts and other similar types of prepaid health services agreements in which services are provided by participating entities or employees of the health maintenance organization, but does not include contracts subject to chapter 62A or 62C.

Subd. 15. "Net worth" means admitted assets, as defined in section 62D.044, minus liabilities. Liabilities do not include those obligations that are subordinated in the same manner

as preferred ownership claims under section 60B.44, subdivision 10. For purposes of this subdivision, preferred ownership claims under section 60B.44, subdivision 10, include promissory notes subordinated to all other liabilities of the health maintenance organization.

Subd. 16. "Affiliate" means a person or entity controlling, controlled by, or under common control with the person or entity.

History: *1973 c 670 s 2; 1974 c 284 s 1; 1977 c 305 s 45; 1981 c 122 s 1; 1983 c 205 s 1,2; 1983 c 289 s 114 subd 1; 1984 c 464 s 8–11; 1984 c 655 art 1 s 92; 1986 c 444; 1987 c 384 art 2 s 1; 1988 c 612 s 1,2; 1989 c 304 s 137; 1990 c 538 s 12,13; 1993 c 50 s 1; 1994 c 625 art 8 s 5; 1995 c 234 art 7 s 6; 1995 c 258 s 39; 1996 c 305 art 1 s 18*

62D.03 ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS.

Subdivision 1. Notwithstanding any law of this state to the contrary, any nonprofit corporation organized to do so or a local governmental unit may apply to the commissioner of health for a certificate of authority to establish and operate a health maintenance organization in compliance with sections 62D.01 to 62D.30. No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization or health maintenance contract unless the organization has a certificate of authority under sections 62D.01 to 62D.30.

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

Subd. 3. The commissioner of health may require any person providing physician and hospital services with payments made in the manner set forth in section 62D.02, subdivision 4, to apply for a certificate of authority under sections 62D.01 to 62D.30. Any person directed to apply for a certificate of authority shall be subject to the provisions of subdivision 2.

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

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

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

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

(1) all members of the board of directors, or governing body of the local government unit, and the principal officers and shareholders of the applicant organization; and

(2) all members of the board of directors, or governing body of the local government unit, and the principal officers of the major participating entity and each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

The commissioner may by rule identify persons included in the term "principal officers";

(d) a full disclosure of the extent and nature of any contract or financial arrangements between the following:

(1) the health maintenance organization and the persons listed in clause (c)(1);

(2) the health maintenance organization and the persons listed in clause (c)(2);

(3) each major participating entity and the persons listed in clause (c)(1) concerning any financial relationship with the health maintenance organization; and

(4) each major participating entity and the persons listed in clause (c)(2) concerning any financial relationship with the health maintenance organization;

(e) the name and address of each participating entity and the agreed upon duration of each contract or agreement;

(f) a copy of the form of each contract binding the participating entities and the health maintenance organization. Contractual provisions shall be consistent with the purposes of sections 62D.01 to 62D.30, in regard to the services to be performed under the contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health maintenance organization, the nature and extent of risk sharing permissible, and contractual termination provisions;

(g) a copy of each contract binding major participating entities and the health maintenance organization. Contract information filed with the commissioner shall be confidential and subject to the provisions of section 13.37, subdivision 1, clause (b), upon the request of the health maintenance organization.

Upon initial filing of each contract, the health maintenance organization shall file a separate document detailing the projected annual expenses to the major participating entity in performing the contract and the projected annual revenues received by the entity from the health maintenance organization for such performance. The commissioner shall disapprove any contract with a major participating entity if the contract will result in an unreasonable expense under section 62D.19. The commissioner shall approve or disapprove a contract within 30 days of filing.

Within 120 days of the anniversary of the implementation of each contract, the health maintenance organization shall file a document detailing the actual expenses incurred and reported by the major participating entity in performing the contract in the preceding year and the actual revenues received from the health maintenance organization by the entity in payment for the performance.

Contracts implemented prior to April 25, 1984, shall be filed within 90 days of April 25, 1984. These contracts are subject to the provisions of section 62D.19, but are not subject to the prospective review prescribed by this clause, unless or until the terms of the contract are modified. Commencing with the next anniversary of the implementation of each of these contracts immediately following filing, the health maintenance organization shall, as otherwise required by this subdivision, file annual actual expenses and revenues;

(h) a statement generally describing the health maintenance organization, its health maintenance contracts and separate health service contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide enrollees with comprehensive health maintenance services and separate health services;

(i) a copy of the form of each evidence of coverage to be issued to the enrollees;

(j) a copy of the form of each individual or group health maintenance contract and each separate health service contract which is to be issued to enrollees or their representatives;

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

(l) a description of the proposed method of marketing the plan, a schedule of proposed charges, and a financial plan which includes a three–year projection of the expenses and income and other sources of future capital;

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

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

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

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

(q) a copy of any agreement between the health maintenance organization and an insurer or nonprofit health service corporation regarding reinsurance, stop–loss coverage, insol-

vency coverage, or any other type of coverage for potential costs of health services, as authorized in sections 62D.04, subdivision 1, clause (f), 62D.05, subdivision 3, and 62D.13;

(r) a copy of the conflict of interest policy which applies to all members of the board of directors and the principal officers of the health maintenance organization, as described in section 62D.04, subdivision 1, paragraph (g). All currently licensed health maintenance organizations shall also file a conflict of interest policy with the commissioner within 60 days after August 1, 1990, or at a later date if approved by the commissioner;

(s) a copy of the statement that describes the health maintenance organization's prior authorization administrative procedures;

(t) a copy of the agreement between the guaranteeing organization and the health maintenance organization, as described in section 62D.043, subdivision 6; and

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

History: *1973 c 670 s 3; 1977 c 305 s 45; 1983 c 205 s 3,4; 1984 c 464 s 12; 1984 c 641 s 2; 1985 c 248 s 21,22; 1987 c 384 art 2 s 1; 1988 c 612 s 3; 1990 c 538 s 14*

62D.04 ISSUANCE OF CERTIFICATE AUTHORITY.

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

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

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

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

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

(e) demonstrated that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner of health shall require the amounts of net worth and working capital required in section 62D.042, the deposit required in section 62D.041, and in addition shall consider:

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

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

(3) agreements with providers for the provision of health care services;

(f) demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care; provided, however, that the requirement in this paragraph shall not prohibit the following:

(1) a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds $5,000 in any year, (ii) for the cost of providing comprehensive health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization, or (iii) for not more than 95 percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed 105 percent of its income for such fiscal years; and

(2) a health maintenance organization from having a provision in a group health maintenance contract allowing an adjustment of premiums paid based upon the actual health services utilization of the enrollees covered under the contract, except that at no time during the life of the contract shall the contract holder fully self–insure the financial risk of health care services delivered under the contract. Risk sharing arrangements shall be subject to the requirements of sections 62D.01 to 62D.30;

(g) demonstrated that it has made provisions for and adopted a conflict of interest policy applicable to all members of the board of directors and the principal officers of the health maintenance organization. The conflict of interest policy shall include the procedures described in section 317A.255, subdivisions 1 and 2. However, the commissioner is not precluded from finding that a particular transaction is an unreasonable expense as described in section 62D.19 even if the directors follow the required procedures; and

(h) otherwise met the requirements of sections 62D.01 to 62D.30.

Subd. 2. Within 90 days after the receipt of the application for a certificate of authority, the commissioner of health shall determine whether or not the applicant meets the requirements of this section. If the commissioner of health determines that the applicant meets the requirements of sections 62D.01 to 62D.30, the commissioner shall issue a certificate of authority to the applicant. If the commissioner of health determines that the applicant is not qualified, the commissioner shall so notify the applicant and shall specify the reason or reasons for such disqualification.

Subd. 3. Except as provided in section 62D.03, subdivision 2, no person who has not been issued a certificate of authority shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts or literature. Provided, however, that persons who are operating under a contract with, operating in association with, enrolling enrollees for, or otherwise authorized by a health maintenance organization licensed under sections 62D.01 to 62D.30 to act on its behalf may use the terms "health maintenance organization" or "HMO" for the limited purpose of denoting or explaining their association or relationship with the authorized health maintenance organization. No health maintenance organization which has a minority of consumers as members of its board of directors shall use the words "consumer controlled" in its name or in any way represent to the public that it is controlled by consumers.

Subd. 4. Upon being granted a certificate of authority to operate as a health maintenance organization, the organization must continue to operate in compliance with the standards set forth in subdivision 1. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority, in accordance with sections 62D.15 to 62D.17.

Subd. 5. **Participation; government programs.** Health maintenance organizations shall, as a condition of receiving and retaining a certificate of authority, participate in the medical assistance, general assistance medical care, and MinnesotaCare programs. A health maintenance organization is required to submit proposals in good faith to serve individuals eligible for the above programs in a geographic region of the state if, at the time of publication of a request for proposal, the percentage of recipients in the public programs in the region who are enrolled in the health maintenance organization is less than the health maintenance organization's percentage of the total number of individuals enrolled in health maintenance organizations in the same region. Geographic regions shall be defined by the commissioner of human services in the request for proposals.

History: *1973 c 670 s 4; 1977 c 305 s 45; 1984 c 464 s 13; 1985 c 248 s 23; 1986 c 444; 1987 c 130 s 1; 1987 c 384 art 2 s 1; 1988 c 612 s 4; 1990 c 538 s 15; 1994 c 625 art 8 s 6; 1996 c 451 art 5 s 1*

62D.041 PROTECTION IN THE EVENT OF INSOLVENCY.

Subdivision 1. **Definition.** (a) For the purposes of this section, the term "uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency, and that are not guaranteed, insured, or assumed by a person other than the health maintenance organization.

(b) For purposes of this section, if a health maintenance organization offers supplemental benefits as described in section 62D.05, subdivision 6, "uncovered expenditures" excludes any expenditures attributable to the supplemental benefit.

Subd. 2. **Required deposit.** Each health maintenance organization shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, bankable funds in the amount required in this section. The com-

missioner may allow a health maintenance organization's deposit requirement to be funded by a guaranteeing organization, as defined in section 62D.043.

Subd. 3. **Amount for beginning organizations.** (a) Organizations that obtain a certificate of authority after April 25, 1988, shall deposit, before receiving a certificate of authority, $500,000. The health maintenance organization shall provide the commissioner with evidence of the deposit before receiving a certificate of authority.

(b) By April 1 of the year following the organization's first 12 months of operation under a certificate of authority, an organization shall deposit an amount equal to the difference between the initial deposit and 33 percent of its uncovered expenditures in its first 12 months of operation.

(c) By April 1 of subsequent years, an organization shall deposit an amount equal to the difference between the amount on deposit and 33 percent of its uncovered expenditures in the preceding calendar year.

Subd. 4. **Amount for existing organizations.** By December 31, 1989, an organization that has received a certificate of authority on or before April 25, 1988, shall have on deposit an amount equal to the larger of:

(a) 33 percent of its uncovered expenditures in the preceding calendar year; or

(b) $500,000.

By April 1 of each subsequent year, an organization shall deposit an amount equal to the difference between the amount on deposit and 33 percent of its uncovered expenditures in the preceding calendar year.

Subd. 5. [Repealed, 1988 c 612 s 32]

Subd. 5a. **Waiver of additional deposit.** In any year when the amount determined according to this section is zero or less than zero, the commissioner shall not require the organization to make any additional deposit.

Subd. 6. [Repealed, 1988 c 612 s 32]

Subd. 6a. **Withdrawal of deposit.** If the amount previously deposited by the organization under this section exceeds the amount required under this section by more than $50,000 for a continuous 12–month period, the commissioner shall allow the organization to withdraw the portion of the deposit that exceeds by more than $50,000 the amount required to be on deposit for the organization, unless the commissioner determines that release of a portion of the deposit could be hazardous to enrollees, creditors, or the general public. An organization shall not apply for the withdrawal more than once in each calendar year.

Subd. 6b. **Evidence of deposit.** An organization shall provide the commissioner with evidence of every deposit made on or before the date of the deposit.

Subd. 7. **Control of over deposits.** All income from deposits shall belong to the depositing organizations and shall be paid to it as it becomes available.

Subd. 8. [Repealed, 1988 c 612 s 32]

Subd. 9. **Letter of credit.** A health maintenance organization may satisfy one–half of its deposit requirement through use of a letter of credit issued by a bank authorized to do business in this state, provided that:

(1) nothing more than a demand for payment is necessary for payment;

(2) the letter of credit is irrevocable;

(3) according to its terms, the letter of credit cannot expire without due notice from the issuer and the notice must occur at least 60 days before the expiration date and be in the form of a written notice to the commissioner;

(4) the letter of credit is issued or confirmed by a bank which is a member of the federal reserve system;

(5) the letter of credit is unconditional, is not contingent upon reimbursement to the bank or the bank's ability to perfect any lien or security interest, and does not contain references to any other agreements, documents, or entities;

(6) the letter of credit designates the commissioner as beneficiary; and

(7) the letter of credit may be drawn upon after insolvency of the health maintenance organization.

Subd. 10. **Supplemental deposit.** A health maintenance organization offering supplemental benefits as described in section 62D.05, subdivision 6, must maintain an additional deposit in the first year such benefits are offered equal to $50,000. At the end of the second year such benefits are offered, the health maintenance organization must maintain an additional deposit equal to $150,000. At the end of the third year such benefits are offered and every year thereafter, the health maintenance organization must maintain an additional deposit of $250,000.

History: *1984 c 464 s 14; 1985 c 248 s 24; 1988 c 612 s 5–13; 1989 c 282 art 2 s 3,4; 1990 c 538 s 16*

62D.042 NET WORTH AND WORKING CAPITAL REQUIREMENTS.

Subdivision 1. **Definitions.** (a) For purposes of this section, "guaranteeing organization" means an organization that has agreed to make necessary contributions or advancements to the health maintenance organization to maintain the health maintenance organization's statutorily required net worth.

(b) For this section, "working capital" means current assets minus current liabilities.

(c) For purposes of this section, if a health maintenance organization offers supplemental benefits as described in section 62D.05, subdivision 6, "expenses" does not include any expenses attributable to the supplemental benefit.

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.

Subd. 3. **Phase–in for existing organizations.** (a) Organizations that obtained a certificate of authority on or before April 25, 1988, have until December 31, 1993, to establish a net worth of at least 8–1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

(b) By December 31, 1989, organizations shall have a net worth of at least one–fifth of 8–1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

(c) By December 31, 1990, organizations shall have a net worth of at least two–fifths of 8–1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

(d) By December 31, 1991, organizations shall have a net worth of at least three–fifths of 8–1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

(e) By December 31, 1992, organizations shall have a net worth of at least four–fifths of 8–1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

Subd. 4. **Reduction for reinsurance.** In calculating expenses for purposes of the net worth requirement, a health maintenance organization may subtract 90 percent of the cost of premiums it pays for insurance coverage specified in section 62D.04, subdivision 1, clause (f).

Subd. 5. **Guaranteeing organization.** (a) The commissioner may determine that it is in the best interests of an organization's enrollees and the public to allow an organization's net worth requirement to be satisfied by a guaranteeing organization. The commissioner shall consider the net worth of a guaranteeing organization, the number of organizations it guaran-

tees, whether it is a governmental entity with power to tax, and other factors the commissioner considers relevant. If the commissioner allows a guaranteeing organization to satisfy the net worth requirement of more than one health maintenance organization, the guaranteeing organization must maintain the required net worth of the guaranteed health maintenance organizations on an aggregate basis.

(b) A health maintenance organization that requests the commissioner to allow a guaranteeing organization to satisfy its net worth or deposit requirement shall provide the commissioner with the guaranteeing organization's financial records and other relevant information when the request is made and annually by April 1, and must continue to do so upon request by the commissioner.

(c) No provider may be compelled to serve as a guaranteeing organization.

Subd. 6. **Working capital.** A health maintenance organization must maintain a positive working capital.

Subd. 7. **Plans of correction.** If the working capital or net worth is less than the required minimum, operations must be adjusted to correct the net worth or working capital, according to a written plan proposed by the organization and approved by the commissioner. The commissioner may take action against the organization under chapter 60B or under the suspension and penalty provisions of sections 62D.15, 62D.16, and 62D.17 if:

(1) an organization does not propose a plan to correct its working capital or net worth within a reasonable time;

(2) an organization violates a plan that has been approved;

(3) the commissioner determines that an improper working capital or net worth status cannot be corrected within a reasonable time; or

(4) the commissioner determines that the organization is in such financial condition that the transaction of further business would be hazardous to its enrollees, its creditors, or the public.

History: *1988 c 612 s 14; 1989 c 282 art 2 s 5; 1993 c 345 art 2 s 1; 1995 c 234 art 7 s 7*

62D.043 GUARANTEEING ORGANIZATIONS.

Subdivision 1. **Definition.** For purposes of this section, a "guaranteeing organization" means an organization that has agreed to assume the responsibility for the obligation of the health maintenance organization's net worth requirement.

Subd. 2. **Responsibilities of guaranteeing organization.** Upon an order of rehabilitation or liquidation, a guaranteeing organization shall transfer funds to the commissioner in the amount necessary to satisfy the net worth requirement.

Subd. 3. **Requirements for guaranteeing organization.** (a) An organization's net worth requirement may be guaranteed provided that the guaranteeing organization:

(1) transfers into a restricted asset account cash or securities permitted by section 61A.28, subdivisions 2, 5, and 6, in an amount necessary to satisfy the net worth requirement. Restricted asset accounts shall be considered admitted assets for the purpose of determining whether a guaranteeing organization is maintaining sufficient net worth. Permitted securities shall not be transferred to the restricted asset account in excess of the limits applied to the health maintenance organization, unless approved by the commissioner in advance;

(2) designates the restricted asset account specifically for the purpose of funding the health maintenance organization's net worth requirement;

(3) maintains positive working capital subsequent to establishing the restricted asset account, if applicable;

(4) maintains net worth, retained earnings, or surplus in an amount in excess of the amount of the restricted asset account, if applicable, and allows the guaranteeing organization:

(i) to remain a solvent business organization, which shall be evaluated on the basis of the guaranteeing organization's continued ability to meet its maturing obligations without selling substantially all its operating assets and paying debts when due; and

(ii) to be in compliance with any state or federal statutory net worth, surplus, or reserve requirements applicable to that organization or lesser requirements agreed to by the commissioner; and

(5) fulfills requirements of clauses (1) to (4) by April 1 of each year.

(b) The commissioner may require the guaranteeing organization to complete the requirements of paragraph (a) more frequently if the amount necessary to satisfy the net worth requirement increases during the year.

Subd. 4. **Exceptions to requirements.** When a guaranteeing organization is a governmental entity, subdivision 3 is not applicable. The commissioner may consider factors which provide evidence that the governmental entity is a financially reliable guaranteeing organization. Similarly, when a guaranteeing organization is a Minnesota–licensed health maintenance organization, health service plan corporation, or insurer, subdivision 3, paragraphs (1) and (2), are not applicable.

Subd. 5. **Amounts needed to meet net worth requirements.** The amount necessary for a guaranteeing organization to satisfy the health maintenance organization's net worth requirement shall be the lesser of:

(1) an amount needed to bring the health maintenance organization's net worth to the amount required by section 62D.042; or

(2) an amount agreed to by the guaranteeing organization.

Subd. 6. **Consolidated calculations for guaranteed health maintenance organizations.** If a guaranteeing organization guarantees one or more health maintenance organizations, the guaranteeing organization may calculate the amount necessary to satisfy the health maintenance organizations' net worth requirements on a consolidated basis. Liabilities of the health maintenance organization to the guaranteeing organization must be subordinated in the same manner as preferred ownership claims under section 60B.44, subdivision 10.

Subd. 7. **Agreement between guaranteeing organization and health maintenance organization.** A written agreement between the guaranteeing organization and the health maintenance organization must include the commissioner as a party and include the following provisions:

(1) any or all of the funds needed to satisfy the health maintenance organization's net worth requirement shall be transferred, unconditionally and upon demand, according to subdivision 2;

(2) the arrangement shall not terminate for any reason without the commissioner being notified of the termination at least nine months in advance. The arrangement may terminate earlier if net worth requirements will be satisfied under other arrangements, as approved by the commissioner;

(3) the guaranteeing organization shall pay or reimburse the commissioner for all costs and expenses, including reasonable attorney fees and costs, incurred by the commissioner in connection with the protection, defense, or enforcement of the guarantee;

(4) the guaranteeing organization shall waive all defenses and claims it may have or the health maintenance organization may have pertaining to the guarantee including, but not limited to, waiver, release, res judicata, statute of frauds, lack of authority, usury, illegality;

(5) the guaranteeing organization waives present demand for payment, notice of dishonor or nonpayment and protest, and the commissioner shall not be required to first resort for payment to other sources or other means before enforcing the guarantee;

(6) the guarantee may not be waived, modified, amended, terminated, released, or otherwise changed except as provided by the guarantee agreement, and as provided by applicable statutes;

(7) the guaranteeing organization waives its rights under the Federal Bankruptcy Code, United States Code, title 11, section 303, to initiate involuntary proceedings against the health maintenance organization and agrees to submit to the jurisdiction of the commissioner and Minnesota state courts in any rehabilitation or liquidation of the health maintenance organization;

(8) the guarantee shall be governed by and construed and enforced according to the laws of the state of Minnesota; and

(9) the guarantee must be approved by the commissioner.

Subd. 8. **Submission of guaranteeing organization's financial statements.** Health maintenance organizations shall submit to the commissioner the guaranteeing organization's audited financial statements annually by April 1 or at a different date if agreed to by the commissioner. The health maintenance organization shall also provide other relevant financial information regarding a guaranteeing organization as may be requested by the commissioner.

Subd. 9. **Performance as guaranteeing organization voluntary.** No provider may be compelled to serve as a guaranteeing organization.

Subd. 10. **Guarantor status in rehabilitation or liquidation.** Any or all of the funds in excess of the amounts needed to satisfy the health maintenance organization's obligations as of the date of an order of liquidation or rehabilitation shall be returned to the guaranteeing organization in the same manner as preferred ownership claims under section 60B.44, subdivision 10.

History: *1990 c 538 s 17*

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: *1988 c 612 s 15; 1990 c 538 s 18; 1991 c 286 s 1; 1991 c 325 art 10 s 11; 1995 c 202 art 1 s 25*

62D.045 INVESTMENT RESTRICTIONS.

Subdivision 1. **Restrictions.** Funds of a health maintenance organization shall be invested only in securities and property designated by law for investment by domestic life insurance companies, except that money may be used to purchase real estate, including leasehold estates and leasehold improvements, for the convenient accommodation of the organization's business operations, including the home office, branch offices, medical facilities, and field office operations, on the following conditions:

(1) a parcel of real estate acquired under this subdivision may include excess space for rent to others if it is reasonably anticipated that the excess will be required by the organization for expansion or if the excess is reasonably required in order to have one or more buildings that will function as an economic unit;

(2) the real estate may be subject to a mortgage; and

(3) the purchase price of the asset, including capitalized permanent improvements, less depreciation spread evenly over the life of the property or less depreciation computed on any basis permitted under the Internal Revenue Code and its regulations, or the organization's equity, plus all encumbrances on the real estate owned by a company under this subdivision, whichever is greater, does not exceed 20 percent of its admitted assets, except if, when calculated in combination with the assets described in section 62D.044, clause (17), the total of said assets and the real estate assets described hereunder do not exceed the total combined percent limitations allowable under this section and section 62D.044, clause (17), or, if permitted by the commissioner upon a finding that the percentage of the health maintenance organization's admitted assets is insufficient to provide convenient accommodation for the organization's business. However, a health maintenance organization that owns property used in the delivery of medical services for its enrollees may invest an additional 20 percent of its admitted assets in real estate, not requiring the permission of the commissioner.

Subd. 2. **Authorization and written investment policy required.** A health maintenance organization shall not make or engage in a loan or investment unless the loan or investment has been authorized or ratified by the board of directors or by a committee supervising investments and loans. In addition, a health maintenance organization must comply with section 60A.112.

Subd. 3. **Limits on commissions.** A health maintenance organization shall not pay a commission or brokerage for the purchase or sale of real or personal property that exceeds usual and customary commissions or brokerage at the time and place of the purchases or sales. Information regarding payments of commissions and brokerage must be maintained by the health maintenance organization.

Subd. 4. **Officer's conflict of interest.** A health maintenance organization shall not knowingly, directly or indirectly, invest in or loan upon any real or personal property, in

which any principal officer or director of the organization has a financial interest. An organization shall not make a loan to a principal officer or director of the organization.

Subd. 5. **Exemption.** This section shall not apply to a health maintenance organization which has a city or county as a guaranteeing organization.

History: *1988 c 612 s 16; 1991 c 286 s 2; 1991 c 325 art 10 s 12; art 18 s 2*

NOTE: The last sentence of section 62D.045, subdivision 1, was also amended by Laws 1991, chapter 286, section 2, to read as follows: "However, a health maintenance organization that owns real estate used in the delivery of medical services for its enrollees may invest an additional 20 percent of its admitted assets in real estate, not requiring the permission of the commissioner."

62D.05 POWERS OF HEALTH MAINTENANCE ORGANIZATIONS.

Subdivision 1. Any nonprofit corporation or local governmental unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.30, operate as a health maintenance organization.

Subd. 2. A health maintenance organization may enter into health maintenance contracts in this state and engage in any other activities consistent with sections 62D.01 to 62D.30 which are necessary to the performance of its obligations under such contracts or authorize its representatives to do so.

Subd. 3. A health maintenance organization may contract with providers of health care services to render the services the health maintenance organization has promised to provide under the terms of its health maintenance contracts, may, subject to section 62D.12, subdivision 11, enter into separate prepaid dental contracts, or other separate health service contracts, may, subject to the limitations of section 62D.04, subdivision 1, clause (f), contract with insurance companies and nonprofit health service plan corporations for insurance, indemnity or reimbursement of its cost of providing health care services for enrollees or against the risks incurred by the health maintenance organization, may contract with insurance companies and nonprofit health service plan corporations for insolvency insurance coverage, and may contract with insurance companies and nonprofit health service plan corporations to insure or cover the enrollees' costs and expenses in the health maintenance organization, including the customary prepayment amount and any copayment obligations.

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

Subd. 5. Each health maintenance organization authorized to operate under sections 62D.01 to 62D.30, or its representative, may accept from governmental agencies, private agencies, corporations, associations, groups, individuals, or other persons payments covering all or part of the cost of health care services provided to enrollees. Any recipient of medical assistance, pursuant to chapter 256B, may make application to join a health maintenance organization which has been approved for medical assistance by the commissioner of human services.

Subd. 6. **Supplemental benefits.** (a) A health maintenance organization may, as a supplemental benefit, provide coverage to its enrollees for health care services and supplies received from providers who are not employed by, under contract with, or otherwise affiliated with the health maintenance organization. Supplemental benefits may be provided if the following conditions are met:

(1) a health maintenance organization desiring to offer supplemental benefits must at all times comply with the requirements of sections 62D.041 and 62D.042;

(2) a health maintenance organization offering supplemental benefits must maintain an additional surplus in the first year supplemental benefits are offered equal to the lesser of $500,000 or 33 percent of the supplemental benefit expenses. At the end of the second year supplemental benefits are offered, the health maintenance organization must maintain an additional surplus equal to the lesser of $1,000,000 or 33 percent of the supplemental benefit expenses. At the end of the third year benefits are offered and every year after that, the health maintenance organization must maintain an additional surplus equal to the greater of $1,000,000 or 33 percent of the supplemental benefit expenses. When in the judgment of the

commissioner the health maintenance organization's surplus is inadequate, the commissioner may require the health maintenance organization to maintain additional surplus;

(3) claims relating to supplemental benefits must be processed in accordance with the requirements of section 72A.201; and

(4) in marketing supplemental benefits, the health maintenance organization shall fully disclose and describe to enrollees and potential enrollees the nature and extent of the supplemental coverage, and any claims filing and other administrative responsibilities in regard to supplemental benefits.

(b) The commissioner may, pursuant to chapter 14, adopt, enforce, and administer rules relating to this subdivision, including: rules insuring that these benefits are supplementary and not substitutes for comprehensive health maintenance services by addressing percentage of out–of–plan coverage; rules relating to the establishment of necessary financial reserves; rules relating to marketing practices; and other rules necessary for the effective and efficient administration of this subdivision. The commissioner, in adopting rules, shall give consideration to existing laws and rules administered and enforced by the department of commerce relating to health insurance plans.

History: *1973 c 670 s 5; 1983 c 205 s 5; 1984 c 464 s 15; 1984 c 654 art 5 s 58; 1987 c 337 s 64; 1987 c 384 art 2 s 1; 1988 c 612 s 17; 1989 c 282 art 2 s 6*

62D.06 GOVERNING BODY.

Subdivision 1. The governing body of any health maintenance organization which is a nonprofit corporation may include enrollees, providers, or other individuals; provided, however, that after a health maintenance organization which is a nonprofit corporation has been authorized under sections 62D.01 to 62D.30 for one year, at least 40 percent of the governing body shall be composed of consumers elected by the enrollees from among the enrollees.

After a health maintenance organization which is a local governmental unit has been authorized under sections 62D.01 to 62D.30 for one year, an enrollee advisory body shall be established. The enrollees who make up this advisory body shall be elected by the enrollees from among the enrollees.

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

History: *1973 c 670 s 6; 1974 c 284 s 10; 1977 c 305 s 45; 1983 c 205 s 6; 1987 c 384 art 2 s 1; 1988 c 592 s 1*

62D.07 EVIDENCE OF COVERAGE.

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

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

Subd. 3. Contracts and evidences of coverage shall contain:

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

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

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

(2) any exclusions or limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature and requirements for referrals, prior authorizations, and second opinions;

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

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

(5) a description of the health maintenance organization's method for resolving enrollee complaints and a statement identifying the commissioner as an external source with whom grievances may be registered.

(c) On the cover page of the evidence of coverage and contract, a clear and complete statement of enrollees' rights as consumers. The statement must be in bold print and captioned "Important Consumer Information and Enrollee Bill of Rights" and must include but not be limited to the following provisions in the following language or in substantially similar language approved in advance by the commissioner:

CONSUMER INFORMATION

(1) COVERED SERVICES: Services provided by (name of health maintenance organization) will be covered only if services are provided by participating (name of health maintenance organization) providers or authorized by (name of health maintenance organization). Your contract fully defines what services are covered and describes procedures you must follow to obtain coverage.

(2) PROVIDERS: Enrolling in (name of health maintenance organization) does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of (name of health maintenance organization), you must choose among remaining (name of the health maintenance organization) providers.

(3) REFERRALS: Certain services are covered only upon referral. See section (section number) of your contract for referral requirements. All referrals to non–(name of health maintenance organization) providers and certain types of health care providers must be authorized by (name of health maintenance organization).

(4) EMERGENCY SERVICES: Emergency services from providers who are not affiliated with (name of health maintenance organization) will be covered only if proper procedures are followed. Your contract explains the procedures and benefits associated with emergency care from (name of health maintenance organization) and non–(name of health maintenance organization) providers.

(5) EXCLUSIONS: Certain services or medical supplies are not covered. You should read the contract for a detailed explanation of all exclusions.

(6) CONTINUATION: You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your contract.

(7) CANCELLATION: Your coverage may be canceled by you or (name of health maintenance organization) only under certain conditions. Your contract describes all reasons for cancellation of coverage.

ENROLLEE BILL OF RIGHTS

(1) Enrollees have the right to available and accessible services including emergency services, as defined in your contract, 24 hours a day and seven days a week;

(2) Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;

(3) Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law;

(4) Enrollees have the right to file a grievance with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers;

(5) Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force;

(6) Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law; and

(7) Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

Subd. 4. A grace period of 31 days shall be granted for payment of each premium for an individual health maintenance contract falling due after the first premium, during which period the contract shall continue in force. Individual health maintenance organization contracts shall clearly state the existence of the grace period.

Subd. 5. Individual health maintenance contracts shall state that any person may cancel the contract within ten days of its receipt and have the premium paid refunded if, after examination of the contract, the individual is not satisfied with it for any reason. The individual is responsible for repaying the health maintenance organization for any services rendered or claims paid by the health maintenance organization during the ten days.

Subd. 6. The contract and evidence of coverage shall clearly explain the conditions upon which a health maintenance organization may terminate coverage.

Subd. 7. The contract and evidence of coverage shall clearly explain continuation and conversion rights afforded to enrollees.

Subd. 8. Individual and group contract holders shall be given 30 days' advance, written notice of any change in subscriber fees or benefits.

Subd. 9. Individual health maintenance organization contracts shall be delivered to enrollees no later than the date coverage is effective. For enrollees with group contracts, an evidence of coverage shall be delivered or issued for delivery not more than 15 days from the date the health maintenance organization is notified of the enrollment or the effective date of coverage, whichever is later.

Subd. 10. An individual health maintenance organization contract and an evidence of coverage must contain a department of health telephone number that the enrollee can call to register a complaint about a health maintenance organization.

History: *1973 c 670 s 7; 1977 c 305 s 45; 1984 c 464 s 16–19; 1986 c 444; 1988 c 434 s 3; 1988 c 592 s 2*

62D.08 ANNUAL REPORT.

Subdivision 1. A health maintenance organization shall, unless otherwise provided for by rules adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted under clauses (a), (b), (e), (f), (g), (i), (j), (l), (m), (n), (o), (p), (q), (r), (s), and (t) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within 60 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Subd. 2. Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of health covering the preceding calendar year. However, utilization data required under subdivision 3, clause (c), shall be filed on or before July 1.

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

(a) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

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

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

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

(e) A separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; and

(f) Such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.30.

Subd. 4. Any health maintenance organization which fails to file a verified report with the commissioner on or before April 1 of the year due shall be subject to the levy of a fine up to $500 for each day the report is past due. This failure will serve as a basis for other disciplinary action against the organization, including suspension or revocation, in accordance with sections 62D.15 to 62D.17. The commissioner may grant an extension of the reporting deadline upon good cause shown by the health maintenance organization. Any fine levied or disciplinary action taken against the organization under this subdivision is subject to the *contested case and judicial review provisions of sections 14.57 to 14.69.*

Subd. 5. Every health maintenance organization shall inform the commissioner of any change in the information described in section 62D.03, subdivision 4, clause (e), including any change in address, any modification of the duration of any contract or agreement, and any addition to the list of participating entities, within ten working days of the notification of the change. Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner 120 days before the effective date. When the health maintenance organization terminates a provider for cause, death, disability, or loss of license, the health maintenance organization must notify the commissioner within three working days of the date the health maintenance organization sends out or receives the notice of cancellation, discontinuance, or termination. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to $200 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14. The levy of a fine does not preclude the commissioner from using other penalties described in sections 62D.15 to 62D.17.

Subd. 6. A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization for the first three quarters of the year on forms prescribed by the commissioner. The statements are due 30 days after the end of the quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall be submitted at the request of the commissioner.

History: *1973 c 670 s 8; 1974 c 284 s 2; 1977 c 305 s 45; 1983 c 289 s 114 subd 1; 1984 c 464 s 20–23; 1984 c 655 art 1 s 92; 1985 c 248 s 70; 1986 c 444; 1987 c 130 s 2; 1987 c 329 s 21; 1987 c 384 art 2 s 1; 1988 c 434 s 4,5; 1988 c 612 s 18; 1990 c 538 s 19–21*

62D.09 INFORMATION TO ENROLLEES.

Subdivision 1. (a) Any written marketing materials which may be directed toward potential enrollees and which include a detailed description of benefits provided by the health maintenance organization shall include a statement of consumer information and rights as described in section 62D.07, subdivision 3, paragraphs (b) and (c). Prior to any oral marketing presentation, the agent marketing the plan must inform the potential enrollees that any complaints concerning the material presented should be directed to the health maintenance organization, the commissioner of health, or, if applicable, the employer.

(b) Detailed marketing materials must affirmatively disclose all exclusions and limitations in the organization's services or kinds of services offered to the contracting party, including but not limited to the following types of exclusions and limitations:

(1) health care services not provided;

(2) health care services requiring copayments or deductibles paid by enrollees;

(3) the fact that access to health care services does not guarantee access to a particular provider type; and

(4) health care services that are or may be provided only by referral of a physician.

(c) No marketing materials may lead consumers to believe that all health care needs will be covered. All marketing materials must alert consumers to possible uncovered expenses with the following language in bold print: "THIS HEALTH CARE PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES; READ YOUR CONTRACT CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED." Immediately following the disclosure required under paragraph (b), clause (3), consumers must be given a telephone number to use to contact the health maintenance organization for specific information about access to provider types.

(d) The disclosures required in paragraphs (b) and (c) are not required on billboards or image, and name identification advertisement.

Subd. 2. The application for coverage by the health maintenance organization shall be accompanied by the statement of consumer information and rights as described in section 62D.07, subdivision 3, paragraph (c).

Subd. 3. Every health maintenance organization or its representative shall annually, before June 1, provide to its enrollees the following: (1) a summary of its most recent annual financial statement including a balance sheet and statement of receipts and disbursements; (2) a description of the health maintenance organization, its health care plan or plans, its facilities and personnel, any material changes therein since the last report; (3) the current evidence of coverage or contract; and (4) a statement of consumer information and rights as described in section 62D.07, subdivision 3, paragraph (c).

Subd. 4. Health maintenance organizations which issue contracts to persons who are covered by title XVIII of the Social Security Act (Medicare) must give the applicant, at the time of application, an outline containing at least the following information:

(1) a description of the principal benefits and coverage provided in the contract, including a clear description of nursing home and home care benefits covered by the health maintenance organization;

(2) a statement of the exceptions, reductions, and limitations contained in the contract;

(3) the following language: "This contract does not cover all skilled nursing home care or home care services and does not cover custodial or residential nursing care. Read your contract carefully to determine which nursing home facilities and home care services are covered by your contract, and what procedures you must follow to receive these benefits.";

(4) a statement of the renewal provisions including any reservation by the health maintenance organization of the right to change fees;

(5) a statement that the outline of coverage is a summary of the contract issued or applied for and that the contract should be read to determine governing contractual provisions; and

(6) a statement explaining that the enrollee's Medicare coverage is altered by enrollment with the health maintenance organization, if applicable.

Subd. 5. Health maintenance organizations shall provide enrollees with a list of the names and locations of participating providers to whom enrollees have direct access without referral no later than the effective date of enrollment or date the evidence of coverage is issued and upon request. Health maintenance organizations need not provide the names of their employed providers.

Subd. 6. Any list of providers issued by the health maintenance organization shall include the date the list was published and contain a bold type notice in a prominent location on the list of providers with the following language, or substantially similar language approved in advance by the commissioner:

"Enrolling in (name of health maintenance organization) does not guarantee services by a particular provider on this list. If you wish to be certain of receiving care from a specific provider listed, you should contact that provider to ask whether or not the provider is still a (name of health maintenance organization) provider and whether or not the provider is accepting additional patients."

Subd. 7. Every health maintenance organization shall provide the information described in section 62D.07, subdivision 3, paragraphs (b) and (c), to enrollees or their representatives on request, within a reasonable time. Information on how to obtain referrals, prior authorization, or second opinion shall be given to the enrollee or an enrollee's representative in person or by telephone within one business day following the day the health maintenance organization or its representative receives the request for information.

Subd. 8. Each health maintenance organization shall issue a membership card to its enrollees. The membership card must:

(1) identify the health maintenance organization;

(2) include the name, address, and telephone number to call if the enroller has a complaint;

(3) include the telephone number to call or the instruction on how to receive authorization for emergency care; and

(4) include the telephone number to call to appeal to the commissioner of health.

History: *1973 c 670 s 9; 1984 c 464 s 24; 1985 c 248 s 25; 1986 c 444; 1988 c 434 s 6; 1988 c 592 s 3–5*

62D.10 PROVISIONS APPLICABLE TO ALL HEALTH PLANS.

Subdivision 1. The provisions of this section shall be applicable to nonprofit prepaid health care plans regulated under chapter 317A, and health maintenance organizations regulated pursuant to sections 62D.01 to 62D.30, both of which for purposes of this section shall be known as "health plans".

Subd. 2. [Repealed, 1984 c 464 s 46]

Subd. 3. A health plan providing health maintenance services or reimbursement for health care costs to a specified group or groups may limit the open enrollment in each group plan to members of such group or groups, but after it has been in operation 24 months shall have an annual open enrollment period of at least 14 days during which it shall accept all otherwise eligible individuals in the order in which they apply for enrollment in a manner which does not discriminate on the basis of age, sex, race, health, or economic status. The health maintenance organization shall notify potential enrollees of any limitations on the number of new enrollees to be accepted. "Specified groups" may include, but shall not be limited to:

(a) Employees of one or more specified employers;

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

(c) Members of one or more specified associations;

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

(e) Members of an existing group insurance policy.

Subd. 4. A health plan may apply to the commissioner of health for a waiver of the requirements of this section or for authorization to impose such underwriting restrictions upon

open enrollment as are necessary (a) to preserve its financial stability, (b) to prevent excessive adverse selection by prospective enrollees, or (c) to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The commissioner of health upon a showing of good cause, shall approve or upon failure to show good cause shall deny such application within 30 days of the receipt thereof from the health plan. The commissioner of health may, in accordance with chapter 14, promulgate rules to implement this section.

Subd. 5. Any fee charged by a health maintenance organization for the process of determining an applicant's eligibility, and any other application fee charged, shall be refunded with interest to the applicant if the applicant is not accepted for enrollment in the health maintenance organization, or credited with interest to the applicant's premiums due if the applicant is accepted for enrollment in the organization.

Subd. 6. Health maintenance organization contracts under section 62D.04, subdivision 1, shall include a clear statement of the risk sharing arrangement.

History: *1973 c 670 s 10; 1974 c 284 s 3,4; 1977 c 305 s 45; 1977 c 409 s 3; 1982 c 424 s 130; 1984 c 464 s 25,26; 1987 c 130 s 3; 1987 c 384 art 2 s 1; 1989 c 304 s 137*

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

Subdivision 1. **Termination of coverage.** No health maintenance contract which, in addition to covering an enrollee, also covers the enrollee's spouse shall contain a provision for termination of coverage for a spouse covered under the health maintenance contract solely as a result of a break in the marital relationship.

Subd. 2. **Conversion privilege.** Every health maintenance contract, as described in subdivision 1 shall contain a provision allowing a former spouse and dependent children of an enrollee, without providing evidence of insurability, to obtain from the health maintenance organization at the expiration of any continuation of coverage required under subdivision 2a or sections 62A.146 and 62D.105, an individual health maintenance contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the health maintenance organization within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate fee. A contract providing reduced benefits at a reduced fee may be accepted by the former spouse and dependent children in lieu of the optional coverage otherwise required by this subdivision. The individual health maintenance contract shall be renewable at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual contract shall apply to the former spouse's original age at entry and shall apply equally to all similar contracts issued by the health maintenance organization.

Subd. 2a. **Continuation privilege.** Every health maintenance contract as described in subdivision 1 shall contain a provision which permits continuation of coverage under the contract for the enrollee's former spouse and children upon entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) the date the enrollee's former spouse becomes covered under another group plan or Medicare; or

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

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the enrollee on a monthly basis to the group contract holder to be paid to the health maintenance organization. The contract must require the group contract holder to, upon request, provide the enrollee with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the fee charged exceed 102 percent of the cost to the plan for the period of coverage for other similarly situated spouses and dependent children when the marital relationship has not dissolved, regardless of whether the cost is paid by the employer or employee.

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

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

History: *1977 c 186 s 3; 1982 c 555 s 10; 1982 c 642 s 16; 1984 c 464 s 27,28; 1988 c 434 s 7; 1990 c 403 s 10; 1992 c 564 art 4 s 10*

62D.102 MINIMUM BENEFITS.

(a) In addition to minimum requirements established in other sections, all group health maintenance contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage for at least ten hours of treatment over a 12–month period with a copayment not to exceed the greater of $10 or 20 percent of the applicable usual and customary charge for mental or nervous disorder consultation, diagnosis and treatment services delivered while the enrollee is not a bed patient in a hospital and at least 75 percent of the cost of the usual and customary charges for any additional hours of ambulatory mental health treatment during the same 12–month benefit period for serious or persistent mental or nervous disorders. Prior authorization may be required for an extension of coverage beyond ten hours of treatment. This prior authorization must be based upon the severity of the disorder, the patient's risk of deterioration without ongoing treatment and maintenance, degree of functional impairment, and a concise treatment plan. Authorization for extended treatment may be limited to a maximum of 30 visit hours during any 12–month benefit period.

(b) For purposes of this section, covered treatment for a minor includes treatment for the family if family therapy is recommended by a health maintenance organization provider. For purposes of determining benefits under this section, "hours of treatment" means treatment rendered on an individual or single–family basis. If treatment is rendered on a group basis, the hours of covered group treatment must be provided at a ratio of no less than two group treatment sessions to one individual treatment hour. For a health maintenance contract that is offered as a companion to a health insurance subscriber contract, the benefits for mental or nervous disorders must be calculated in aggregate for the health maintenance contract and the health insurance subscriber contract.

History: *1984 c 641 s 3; 1987 c 337 s 65; 1988 c 689 art 2 s 12*

62D.103 SECOND OPINION RELATED TO CHEMICAL DEPENDENCY AND MENTAL HEALTH.

A health maintenance organization shall promptly evaluate the treatment needs of any enrollee who is seeking treatment for a problem related to chemical dependency or mental health conditions. In the event that the health maintenance organization or a participating provider determines that no type of structured treatment is necessary, the enrollee shall be immediately entitled to a second opinion paid for by the health maintenance organization, by a health care professional qualified in diagnosis and treatment of the problem and not affiliated with the health maintenance organization. The health maintenance organization or participating provider shall consider the second opinion but is not obligated to accept the conclusion of the second opinion. The health maintenance organization or participating provider shall document its consideration of the second opinion.

History: *1984 c 641 s 4*

62D.104 REQUIRED OUT–OF–AREA CONVERSION.

Enrollees who have individual health maintenance organization contracts and who have become nonresidents of the health maintenance organization's service area but remain residents of the state of Minnesota shall be given the option, to be arranged by the health maintenance organization if an agreement with an insurer can reasonably be made, of a number three qualified plan, a number two qualified plan, or a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, or, if such enrollees are covered by title XVIII of the Social Security Act (Medicare), they shall be given the option of a Medicare supplement plan as provided by chapter 62A.

This option shall be made available at the enrollee's expense, without further evidence of insurability and without interruption of coverage.

If a health maintenance organization cannot make arrangements for conversion coverage, the health maintenance organization shall notify enrollees of health plans available in other service areas.

History: *1988 c 434 s 8; 1989 c 258 s 9*

62D.105 COVERAGE OF CURRENT SPOUSE AND CHILDREN.

Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to covering the enrollee also provides coverage to the spouse and dependent children of the enrollee shall: (1) permit the spouse and dependent children to elect to continue coverage when the enrollee becomes enrolled for benefits under title XVIII of the Social Security Act (Medicare); and (2) permit the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan.

Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be continued until the earlier of the following dates:

(1) the date coverage would otherwise terminate under the contract;

(2) 36 months after continuation by the spouse or dependent was elected; or

(3) the date the spouse or dependent children become covered under another group health plan or Medicare.

If coverage is provided under a group policy, any required fees for the coverage shall be paid by the enrollee on a monthly basis to the group contract holder for remittance to the health maintenance organization. In no event shall the fee charged exceed 102 percent of the cost to the plan for such coverage for other similarly situated spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

History: *1988 c 434 s 9*

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.

Subd. 1a. Where a complaint involves a dispute about a health maintenance organization's coverage of a service, the commissioner may review the complaint and any information and testimony necessary in order to make a determination and order the appropriate remedy pursuant to sections 62D.15 to 62D.17.

Subd. 1b. **Expedited resolution of complaints about urgently needed service.** In addition to any remedy contained in subdivision 1a, when a complaint involves a dispute about a health maintenance organization's coverage of an immediately and urgently needed service, the commissioner may also order the health maintenance organization to use an expedited system to process the complaint.

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

Subd. 3. **Denial of service.** Within a reasonable time after receiving an enrollee's written or oral communication to the health maintenance organization concerning a refusal of service or inadequacy of services, the health maintenance organization shall provide the enrollee with a written statement of the reason for the refusal of service, and a statement ap-

proved by the commissioner of health which explains the health maintenance organization complaint procedures, and in the case of Medicare enrollees, which also explains Medicare appeal procedures.

Subd. 4. **Coverage of service.** A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained.

History: *1973 c 670 s 11; 1974 c 284 s 5; 1977 c 305 s 45; 1986 c 444; 1988 c 434 s 10; 1988 c 592 s 6,7; 1990 c 538 s 22–24; 1995 c 234 art 2 s 1*

62D.12 PROHIBITED PRACTICES.

Subdivision 1. No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Each health maintenance organization shall be subject to sections 72A.17 to 72A.32, relating to the regulation of trade practices, except (a) to the extent that the nature of a health maintenance organization renders such sections clearly inappropriate and (b) that enforcement shall be by the commissioner of health and not by the commissioner of commerce. Every health maintenance organization shall be subject to sections 8.31 and 325F.69.

Subd. 1a. **Swing–out products.** Notwithstanding subdivision 1, nothing in sections 62A.049, 62A.60, and 72A.201, subdivision 4a, applies to a commercial health policy issued under this chapter as a companion to a health maintenance contract.

Subd. 2. No health maintenance organization may cancel or fail to renew the coverage of an enrollee except for (a) failure to pay the charge for health care coverage; (b) termination of the health care plan; (c) termination of the group plan; (d) enrollee moving out of the area served, subject to section 62A.17, subdivisions 1 and 6, and section 62D.104; (e) enrollee moving out of an eligible group, subject to section 62A.17, subdivisions 1 and 6, and section 62D.104; (f) failure to make copayments required by the health care plan; or (g) other reasons established in rules promulgated by the commissioner of health.

Subd. 2a. Enrollees shall be given 30 days notice of any cancellation or nonrenewal, except that enrollees who are eligible to receive replacement coverage under section 62D.121, subdivision 1, shall receive 90 days notice as provided under section 62D.121, subdivision 5.

Subd. 3. No health maintenance organization may use in its name, contracts, or literature any of the words "insurance," "casualty," "surety," "mutual," or any other words which are descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state; provided, however, that when a health maintenance organization has contracted with an insurance company for any coverage permitted by sections 62D.01 to 62D.30, it may so state.

Subd. 4. No health maintenance contract or evidence of coverage shall provide for the reimbursement of an enrollee other than through a policy of insurance, except as stated in this subdivision:

(a) the health maintenance organization may refund payments made by or on behalf of an enrollee;

(b) the health maintenance organization may make direct payments to enrollees or providers for obligations incurred for nonelective emergency or out–of–area services received.

Subd. 5. The providers under agreement with a health maintenance organization to provide health care services shall not have recourse against enrollees or persons acting on their behalf for amounts above those specified in the evidence of coverage as copayments for health care services. The health maintenance organization shall not have recourse against enrollees or persons acting on their behalf for amounts above those specified in the evidence of coverage as the periodic prepayment, or copayment, for health care services. This subdivision applies but is not limited to the following events:

(1) nonpayment by the health maintenance organization;

(2) insolvency of the health maintenance organization; and

(3) breach of the agreement between the health maintenance organization and the provider.

This subdivision does not limit a provider's ability to seek payment from any person other than the enrollee, the enrollee's guardian or conservator, the enrollee's immediate family members, or the enrollee's legal representative in the event of nonpayment by the health maintenance organization.

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

Subd. 7. [Repealed, 1984 c 464 s 46]

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

Subd. 9. All net earnings of the health maintenance organization shall be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. No health maintenance organization shall provide for the payment, whether directly or indirectly, of any part of its net earnings, to any person as a dividend or rebate; provided, however, that health maintenance organizations may make payments to providers or other persons based upon the efficient provision of services or as incentives to provide quality care. The commissioner of health shall, pursuant to sections 62D.01 to 62D.30, revoke the certificate of authority of any health maintenance organization in violation of this subdivision.

Subd. 9a. Authorized expenses of a health maintenance organization shall include:

(1) cash rebates to enrollees, or to persons who have made payments on behalf of enrollees;

(2) direct payments to enrollees or providers as provided in subdivision 4, clause (b);

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

(4) payments to any organization or organizations selected by the health maintenance organization which are operated for charitable, educational, or religious or scientific purposes.

Subd. 9b. A health maintenance organization shall not enter into an agreement with a hospital in which the hospital agrees to assume the financial risk for services provided by other facilities or providers not owned, operated, or otherwise subject to the control of the hospital assuming the financial risk.

Subd. 10. No health maintenance contract or evidence of coverage entered into, issued, amended, renewed or delivered on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit to an enrollee or other beneficiary by the amount of, or in any proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, as amended subsequent to the date of commencement of such benefit, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, workers' compensation, or any similar federal or state law, as amended subsequent to the date of commencement of that benefit.

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

Subd. 12. [Repealed, 1996 c 310 s 1]

Subd. 13. No health maintenance organization offering an individual or group health maintenance contract shall refuse to provide or renew the coverage because the applicant or enrollee has an option to elect workers' compensation coverage pursuant to section 176.041.

Subd. 14. Each health maintenance organization shall establish a telephone number, which need not be toll free, that providers may call with questions about coverage, prior authorization, and approval of medical services. The telephone number must be staffed by an employee of the health maintenance organization during normal working hours during the

normal work week. After normal working hours, the telephone number must be equipped with an answering machine and recorded message to allow the caller an opportunity to leave a message. The health maintenance organization must respond to questions within 24 hours after they are received, excluding weekends and holidays. At the request of a provider, the health maintenance organization shall provide a copy of the health maintenance contract for enrollees in the provider's service area.

Subd. 15. **Retaliatory action prohibited.** No health maintenance organization may take retaliatory action against a provider solely on the grounds that the provider disseminated accurate information regarding coverage of benefits or accurate benefit limitations of an enrollee's contract or accurate interpreted provisions of the provider agreement that limit the prescribing, providing, or ordering of care.

Subd. 16. [Repealed, 1990 c 538 s 32]

Subd. 17. **Disclosure of commissions.** Any person receiving commissions for the sale of coverage or enrollment in a health plan, as defined in section 62A.011, offered by a health maintenance organization shall, before selling coverage or enrollment, disclose in writing to the prospective purchaser the amount of any commission or other compensation the person will receive as a direct result of the sale. The disclosure may be expressed in dollars or as a percentage of the premium. The amount disclosed need not include any anticipated renewal commissions.

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: *1973 c 670 s 12; 1974 c 284 s 8,9; 1975 c 323 s 4; 1976 c 296 art 1 s 18; 1977 c 305 s 45; 1980 c 614 s 74; 1983 c 289 s 114 subd 1; 1984 c 464 s 30–36; 1984 c 641 s 5; 1984 c 655 art 1 s 92; 1985 c 248 s 70; 1987 c 384 art 2 s 1; 1988 c 434 s 11,12; 1988 c 592 s 8,9; 1988 c 612 s 19,20; 1989 c 330 s 23; 1993 c 345 art 5 s 6; 1994 c 485 s 65; 1994 c 625 art 10 s 13; 1995 c 75 s 2; 1996 c 305 art 1 s 20*

62D.121 REQUIRED REPLACEMENT COVERAGE.

Subdivision 1. When membership of an enrollee who has individual health coverage is terminated by the health maintenance organization for a reason other than (a) failure to pay the charge for health care coverage; (b) failure to make copayments required by the health care plan; (c) enrollee moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership, the health maintenance organization must offer or arrange to offer replacement coverage, without evidence of insurability, without preexisting condition exclusions, and without interruption of coverage.

Subd. 2. If the health maintenance organization has terminated individuals from coverage in a service area, the replacement coverage shall be health maintenance organization coverage issued by the health maintenance organization terminating coverage unless the health maintenance organization can demonstrate to the commissioner that offering health maintenance organization replacement coverage would not be feasible. In making the determination, the commissioner shall consider (1) loss ratios and forecasts, (2) lack of agreements between health care providers and the health maintenance organization to offer that product, (3) evidence of anticipated premium needs compared with established rates, (4) the financial impact of the replacement coverage on the overall financial solvency of the plan, and (5) the cost to the enrollee of health maintenance organization replacement coverage as compared to cost to the enrollee of the replacement coverage required under subdivision 3.

Subd. 2a. **Replacement coverage.** The terminating health maintenance organization may also offer as replacement coverage health maintenance organization coverage issued by another health maintenance organization.

Subd. 3. If health maintenance organization replacement coverage is not offered by the health maintenance organization, as explained under subdivisions 2 and 2a, the replacement coverage shall provide, for enrollees covered by title XVIII of the Social Security Act, coverage at least equivalent to a basic Medicare supplement plan as defined in section 62A.316, except that the replacement coverage shall also cover the liability for any Medicare part A and part B deductible as defined under title XVIII of the Social Security Act. After satisfac-

tion of the Medicare part B deductible, the replacement coverage shall be at least 80 percent of usual and customary eligible medical expenses and supplies not covered by Medicare part B eligible expenses. This does not include outpatient prescription drugs. The fee or premium of the replacement coverage shall not exceed the premium charged by the state comprehensive health plan as established under section 62E.08, for a qualified Medicare supplement plan. All enrollees not covered by Medicare shall be given the option of a number three qualified plan or a number two qualified plan as defined in section 62E.06, subdivisions 1 and 2, for replacement coverage. The fee or premium for a number three qualified plan shall not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number three qualified plan of insurance in force in Minnesota. The fee or premium for a number two qualified plan shall not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two qualified plan of insurance in force in Minnesota.

Subd. 3a. If the replacement coverage is health maintenance organization coverage, as explained in subdivisions 2 and 2a, the fee shall not exceed 125 percent of the cost of the average fee charged by health maintenance organizations for a similar health plan. The commissioner of health will determine the average cost of the plan on the basis of information provided annually by the health maintenance organizations concerning the rates charged by the health maintenance organizations for the plans offered. Fees or premiums charged under this section must be actuarially justified.

Subd. 4. The commissioner will approve or disapprove the replacement coverage within 30 days. A health maintenance organization shall not give enrollees a notice of cancellation of coverage until a replacement policy has been filed with the commissioner and approved or disapproved.

Subd. 5. The health maintenance organization must provide the terminated enrollees with a notice of cancellation 90 days before the date the cancellation takes effect. If the replacement coverage is approved by the commissioner under subdivision 4, the notice shall clearly and completely describe the replacement coverage that the enrollees are eligible to receive and explain the procedure for enrolling. If the replacement coverage is not approved by the commissioner, the health maintenance organization shall provide a cancellation notice with information that the enrollee is entitled to enroll in the state comprehensive health insurance plan with a waiver of the waiting period for preexisting conditions under section 62E.14, subdivisions 1, paragraph (d), and 6.

Subd. 6. The commissioner may waive the notice required in this section if the commissioner determines that the health maintenance organization has not received information regarding Medicare reimbursement rates from the Health Care Financing Administration before September 1 for contracts renewing on January 1 of the next year. In no event shall enrollees covered by title XVIII of the Social Security Act receive less than 60 days' notice of contract termination.

Subd. 7. **Geographic accessibility.** If the commissioner determines that there are not enough providers to assure that enrollees have accessible health services available in a geographic service area, the commissioner shall institute a plan of corrective action that shall be followed by the health maintenance organization. Such a plan may include but not be limited to requiring the health maintenance organization to make payments to nonparticipating providers for health services for enrollees, requiring the health maintenance organization to discontinue accepting new enrollees in that service area, and requiring the health maintenance organization to reduce its geographic service area. If a nonparticipating provider has been a participating provider with the health maintenance organization within the last year, any payments made under this section must not exceed the payment level of the previous contract unless the commissioner determines that without adjusting payments the health maintenance organization will be unable to meet the health care needs of enrollees in the area.

History: *1988 c 434 s 13; 1989 c 258 s 10; 1990 c 538 s 25,26*

62D.122 [Repealed, 1988 c 434 s 24; 1990 c 538 s 31]

62D.123 PROVIDER CONTRACTS.

Subdivision 1. **Provider agreement.** Except for an employment agreement between a provider and health maintenance organization, an agreement to provide health care services between a provider and a health maintenance organization entered into or renewed after April 25, 1988, must contain the following provision:

PROVIDER AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST AN ENROLLEE OR PERSONS ACTING ON THEIR BEHALF FOR SERVICES PROVIDED UNDER THIS AGREEMENT. THIS PROVISION APPLIES TO BUT IS NOT LIMITED TO THE FOLLOWING EVENTS: (1) NONPAYMENT BY THE HEALTH MAINTENANCE ORGANIZATION OR (2) BREACH OF THIS AGREEMENT. THIS PROVISION DOES NOT PROHIBIT THE PROVIDER FROM COLLECTING COPAYMENTS OR FEES FOR UNCOVERED SERVICES.

THIS PROVISION SURVIVES THE TERMINATION OF THIS AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THIS AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF THE HEALTH MAINTENANCE ORGANIZATION ENROLLEES. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THIS AGREEMENT TERMINATES.

THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN THE PROVIDER AND THE ENROLLEE OR PERSONS ACTING ON THEIR BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THIS AGREEMENT.

Subd. 2. **Cooperation required.** An agreement to provide health care services between a provider and a health maintenance organization must require the provider to cooperate with and participate in the health maintenance organization's quality assurance program, dispute resolution procedure, and utilization review program.

Subd. 3. **Notice of termination.** An agreement to provide health care services between a provider and a health maintenance organization must require that if the provider terminates the agreement, without cause, the provider shall give the organization 120 days' advance notice of termination.

Subd. 4. **Late payments.** If a health maintenance organization's payments to a provider are delayed beyond the payment date in the contract, the provider may notify the commissioner who shall consider that information in assessing the financial solvency of the health maintenance organization.

History: *1988 c 612 s 21*

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

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

History: *1973 c 670 s 13*

62D.14 EXAMINATIONS.

Subdivision 1. The commissioner of health may make an examination of the affairs of any health maintenance organization and its contracts, agreements, or other arrangements

with any participating entity as often as the commissioner of health deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years. Examinations of participating entities pursuant to this subdivision shall be limited to their dealings with the health maintenance organization and its enrollees, except that examinations of major participating entities may include inspection of the entity's financial statements kept in the ordinary course of business. The commissioner may require major participating entities to submit the financial statements directly to the commissioner. Financial statements of major participating entities are subject to the provisions of section 13.37, subdivision 1, clause (b), upon request of the major participating entity or the health maintenance organization with which it contracts.

Subd. 2. The commissioner will notify the organization and any involved participating entity in writing when an examination has been initiated. The commissioner will include in this notice a full statement of the pertinent facts and of the matters being examined, and may include a statement that the organization or participating entity must submit to the commissioner within 30 days from the date of the notice a complete written report concerning those matters.

Subd. 3. In order to accomplish the duties under this section with respect to the dealings of the participating entities with the health maintenance organization, the commissioner of health shall have the right to:

(a) inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed;

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

(c) require persons or organizations under examination to be deposed and to answer interrogatories, regardless of whether an administrative hearing or other civil proceeding has been or will be initiated; and

(d) employ site visits, public hearings, or any other procedures considered appropriate to obtain the information necessary to determine the issues.

Subd. 4. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee, or any application obtained from any person, shall be private as defined in chapter 13 and shall not be disclosed to any person except (a) to the extent necessary to carry out the purposes of sections 62D.01 to 62D.30, the commissioner and a designee shall have access to the above data or information but the data removed from the health maintenance organization or participating entity shall not identify any particular patient or client by name or contain any other unique personal identifier; (b) upon the express consent of the enrollee or applicant; (c) pursuant to statute or court order for the production of evidence or the discovery thereof; or (d) in the event of claim or litigation between such person and the provider or health maintenance organization wherein such data or information is pertinent. In any case involving a suspected violation of a law applicable to health maintenance organizations in which access to health data maintained by the health maintenance organization or participating entity is necessary, the commissioner and agents, while maintaining the privacy rights of individuals and families, shall be permitted to obtain data that identifies any particular patient or client by name. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

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

Subd. 6. Reasonable expenses of examinations under this section shall be assessed by the commissioner of health against the organization being examined, and shall be remitted to the commissioner of health for deposit in the general fund of the state treasury.

Subd. 7. Failure to provide relevant information necessary for conducting examinations pursuant to this section shall be subject to the levy of a fine up to $200 for each day the information is not provided. A fine levied under this subdivision shall be subject to the contested case and judicial review provisions of chapter 14. In the event a timely request for review is

made, accrual of a fine levied shall be stayed pending completion of the contested case and judicial review proceeding.

History: *1973 c 670 s 14; 1977 c 305 s 45; 1984 c 464 s 37; 1986 c 444; 1987 c 384 art 2 s 1; 1988 c 612 s 22*

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

Subdivision 1. The commissioner of health may suspend or revoke any certificate of authority issued to a health maintenance organization under sections 62D.01 to 62D.30 if the commissioner finds that:

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

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

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

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

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

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

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

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

(i) The health maintenance organization has otherwise failed to substantially comply with sections 62D.01 to 62D.30 or with any other statute or administrative rule applicable to health maintenance organizations, or has submitted false information in any report required hereunder.

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

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

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

History: *1973 c 670 s 15; 1977 c 305 s 45; 1984 c 464 s 38; 1986 c 444; 1987 c 384 art 2 s 1*

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

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

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

History: *1973 c 670 s 16; 1977 c 305 s 45; 1982 c 424 s 130; 1986 c 444*

62D.17 PENALTIES AND ENFORCEMENT.

Subdivision 1. The commissioner of health may, for any violation of statute or rule applicable to a health maintenance organization, or in lieu of suspension or revocation of a certificate of authority under section 62D.15, levy an administrative penalty in an amount up to $25,000 for each violation. In the case of contracts or agreements made pursuant to section 62D.05, subdivisions 2 to 4, each contract or agreement entered into or implemented in a manner which violates sections 62D.01 to 62D.30 shall be considered a separate violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of enrollees affected by the violation;

(2) the effect of the violation on enrollees' health and access to health services;

(3) if only one enrollee is affected, the effect of the violation on that enrollee's health;

(4) whether the violation is an isolated incident or part of a pattern of violations; and

(5) the economic benefits derived by the health maintenance organization or a participating provider by virtue of the violation.

Reasonable notice in writing to the health maintenance organization shall be given of the intent to levy the penalty and the reasons therefor, and the health maintenance organization may have 15 days within which to file a written request for an administrative hearing and review of the commissioner of health's determination. Such administrative hearing shall be subject to judicial review pursuant to chapter 14.

Subd. 2. Any person who violates sections 62D.01 to 62D.30 or knowingly submits false information in any report required hereunder shall be guilty of a misdemeanor.

Subd. 3. (a) If the commissioner of health shall, for any reason, have cause to believe that any violation of sections 62D.01 to 62D.30 has occurred or is threatened, the commissioner of health may, before commencing action under sections 62D.15 and 62D.16, and subdivision 1, give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

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

Subd. 4. (a) The commissioner of health may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of sections 62D.01 to 62D.30.

(1) The cease and desist order may direct a health maintenance organization to pay for or provide a service when that service is required by statute or rule to be provided.

(2) The commissioner may issue a cease and desist order directing a health maintenance organization to pay for a service that is required by statute or rule to be provided, only if there is a demonstrable and irreparable harm to the public or an enrollee.

(3) If the cease and desist order involves a dispute over the medical necessity of a procedure based on its experimental nature, the commissioner may issue a cease and desist order only if the following conditions are met:

(i) the commissioner has consulted with appropriate and identified experts;

(ii) the commissioner has reviewed relevant scientific and medical literature; and

(iii) the commissioner has considered all other relevant factors including whether final approval of the technology or procedure has been granted by the appropriate government agency; the availability of scientific evidence concerning the effect of the technology or procedure on health outcomes; the availability of scientific evidence that the technology or procedure is as beneficial as established alternatives; and the availability of evidence of benefit or improvement without the technology or procedure.

(b) Within 20 days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of sections 62D.01 to 62D.30 have occurred. Such hearings shall be subject to judicial review as provided by chapter 14.

If the acts or practices involve violation of the reporting requirements of section 62D.08, or if the commissioner has ordered the rehabilitation, liquidation, or conservation of the health maintenance organization in accordance with section 62D.18, the health maintenance organization may request an expedited hearing on the matter. The hearing shall be held within 15 days of the request. Within ten days thereafter, an administrative law judge shall issue a recommendation on the matter. The commissioner shall make a final determination on the matter within ten days of receipt of the administrative law judge's recommendation.

When a request for a stay accompanies the hearing request, the matter shall be referred to the office of administrative hearings within three working days of receipt of the request. Within ten days thereafter, an administrative law judge shall issue a recommendation to grant or deny the stay. The commissioner shall grant or deny the stay within five days of receipt of the administrative law judge's recommendation.

To the extent the acts or practices alleged do not involve (1) violations of section 62D.08; (2) violations which may result in the financial insolvency of the health maintenance organization; (3) violations which threaten the life and health of enrollees; (4) violations which affect whole classes of enrollees; or (5) violations of benefits or service requirements mandated by law; if a timely request for a hearing is made, the cease and desist order shall be stayed for a period of 90 days from the date the hearing is requested or until a final determination is made on the order, whichever is earlier. During this stay, the respondent may show cause why the order should not become effective upon the expiration of the stay. Arguments on this issue shall be made through briefs filed with the administrative law judge no later than ten days prior to the expiration of the stay.

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

History: *1973 c 670 s 17; 1977 c 305 s 45; 1982 c 424 s 130; 1984 c 464 s 39; 1984 c 640 s 32; 1984 c 641 s 6; 1987 c 384 art 2 s 1; 1988 c 434 s 15; 1990 c 538 s 27,28*

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

Subdivision 1. **Commissioner of health; order.** The commissioner of health may apply by verified petition to the district court of Ramsey county or the county in which the principal office of the health maintenance organization is located for an order directing the commissioner of health to rehabilitate or liquidate a health maintenance organization. The rehabilitation or liquidation of a health maintenance organization shall be conducted under the supervision of the commissioner of health under the procedures, and with the powers granted to a rehabilitator or liquidator, in chapter 60B, except to the extent that the nature of health

maintenance organizations renders the procedures or powers clearly inappropriate and as provided in this subdivision or in chapter 60B. A health maintenance organization shall be considered an insurance company for the purposes of rehabilitation or liquidation as provided in subdivisions 4, 6, and 7.

Subd. 2. [Repealed, 1990 c 538 s 32]

Subd. 3. [Repealed, 1990 c 538 s 32]

Subd. 4. **Powers of rehabilitator.** The powers of the rehabilitator include, subject to the approval of the court the power to change premium rates, without the notice requirements of section 62D.07, and the power to amend the terms of provider contracts, and of contracts with participating entities for the provision of administrative, financial, or management services, relating to reimbursement and termination, considering the interests of providers and other contracting participating entities and the continued viability of the health plan.

If the court approves a contract amendment that diminishes the compensation of a provider or of a participating entity providing administrative, financial, or management services to the health maintenance organization, the amendment may not be effective for more than 60 days and shall not be renewed or extended.

Subd. 5. [Repealed, 1990 c 538 s 32]

Subd. 6. **Special examiner.** The commissioner as rehabilitator shall make every reasonable effort to employ a senior executive from a successful health maintenance organization to serve as special examiner to rehabilitate the health maintenance organization, provided that the individual does not have a conflict of interest. The special examiner shall have all the powers of the rehabilitator granted under this section and section 60B.17.

Subd. 7. **Examination account.** The commissioner of health shall assess against a health maintenance organization not yet in rehabilitation or liquidation a fee sufficient to cover the costs of a special examination. The fee must be deposited in an examination account. Money in the account is appropriated to the commissioner of health to pay for the examinations. If the money in the account is insufficient to pay the initial costs of examinations, the commissioner may use other money appropriated to the commissioner, provided the other appropriation is reimbursed from the examination account when it contains sufficient money. Money from the examination account must be used to pay per diem salaries and expenses of special examiners, including meals, lodging, laundry, transportation, and mileage. The salary of regular employees of the health department must not be paid out of the account.

History: *1973 c 670 s 18; 1977 c 305 s 45; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1988 c 612 s 23; 1990 c 538 s 29*

62D.181 INSOLVENCY; MCHA ALTERNATIVE COVERAGE.

Subdivision 1. **Definition.** "Association" means the Minnesota comprehensive health association created in section 62E.10.

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 in-

tegrated 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.

Subd. 4. **Coverage.** Alternative coverage issued under this section must be at least a number two qualified plan, as described in section 62E.06, subdivision 2, or for individuals over age 65, a basic Medicare supplement plan, as described in section 62A.316.

Subd. 5. **Premium.** The premium for alternative coverage issued under this section must not exceed 80 percent of the premium for the comparable coverage offered by the association.

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.

Subd. 7. **Replacement coverage; limitations.** The association is not obligated to offer replacement coverage under this chapter or conversion coverage under section 62E.16 at the end of the periods specified in subdivision 6. Any continuation obligation arising under this chapter or chapter 62A will cease at the end of the periods specified in subdivision 6.

Subd. 8. **Claims expenses exceeding premiums.** Claims expenses resulting from the operation of this section which exceed premiums received shall be borne by contributing members of the association in accordance with section 62E.11, subdivision 5.

Subd. 9. **Coordination of policies.** If an insolvent health maintenance organization, integrated service network, or community integrated service network has insolvency insurance 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: *1988 c 612 s 24; 1989 c 258 s 11; 1995 c 234 art 1 s 6–9*

62D.182 LIABILITIES.

Every health maintenance organization shall maintain liabilities estimated in the aggregate to be sufficient to pay all reported or unreported claims incurred that are unpaid and for which the organization is liable. Liabilities are computed under rules adopted by the commissioner.

History: *1988 c 612 s 25*

62D.19 UNREASONABLE EXPENSES.

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner of health shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62D.01 to 62D.30; in order to safeguard the underlying nonprofit status of health maintenance organizations; and to ensure that the payment of health maintenance organization money to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense. The commissioner has standing to sue, on behalf of a health maintenance organization, officers or trustees of the health maintenance organization who have breached their fiduciary duty in entering into and performing such contracts.

History: *1973 c 670 s 19; 1983 c 289 s 114 subd 1; 1984 c 464 s 41; 1984 c 655 art 1 s 92; 1Sp1985 c 10 s 62; 1987 c 384 art 2 s 1; 1988 c 612 s 26*

62D.20 RULES.

Subdivision 1. **Rulemaking.** The commissioner of health may, pursuant to chapter 14, promulgate such reasonable rules as are necessary or proper to carry out the provisions of sections 62D.01 to 62D.30. Included among such rules shall be those which provide minimum requirements for the provision of comprehensive health maintenance services, as defined in section 62D.02, subdivision 7, and reasonable exclusions therefrom. Nothing in such rules shall force or require a health maintenance organization to provide elective, induced abortions, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility, or the office of a physician; the rules shall provide every health maintenance organization the option of excluding or including elective, induced abortions, except as medically necessary to prevent the death of the mother, as part of its comprehensive health maintenance services.

Subd. 2. **Prior authorization.** The commissioner shall adopt rules that address the issue of appropriate prior authorization requirements, considering consumer needs, administrative concerns, and the nature of the benefit.

History: *1973 c 670 s 20; 1977 c 305 s 45; 1981 c 122 s 2; 1982 c 424 s 130; 1985 c 248 s 70; 1987 c 384 art 2 s 1; 1988 c 434 s 16; 1988 c 592 s 10*

62D.21 FEES.

Every health maintenance organization subject to sections 62D.01 to 62D.30 shall pay to the commissioner of health fees as prescribed by the commissioner of health pursuant to section 144.122 for the following:

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

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

(c) Filing each annual report, and

(d) Other filings, as specified by rule.

History: *1973 c 670 s 21; 1975 c 310 s 1; 1977 c 305 s 45; 1985 c 248 s 70; 1987 c 384 art 2 s 1*

62D.211 RENEWAL FEE.

Each health maintenance organization subject to sections 62D.01 to 62D.30 shall submit to the commissioner of health each year before June 15 a certificate of authority renewal fee in the amount of $10,000 each plus 20 cents per person enrolled in the health maintenance organization on December 31 of the preceding year. The commissioner may adjust the renewal fee in rule under the provisions of chapter 14.

History: *1987 c 384 art 2 s 1; 1987 c 403 art 2 s 2; 1990 c 538 s 30*

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

Subdivision 1. Except as otherwise provided herein, sections 62D.01 to 62D.30 do not apply to an insurer or nonprofit health service plan corporation licensed and regulated pursuant to the laws governing such corporations in this state.

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

Subd. 3. Any health maintenance organization authorized under sections 62D.01 to 62D.30 shall not be deemed to be practicing a healing art.

Subd. 4. To the extent that it furthers the purposes of sections 62D.01 to 62D.30, the commissioner of health shall attempt to coordinate the operations of sections 62D.01 to 62D.30 relating to the quality of health care services with the operations of United States Code, title 42, sections 1320c to 1320c–20.

Subd. 5. Except as otherwise provided in sections 62A.01 to 62A.42 and 62D.01 to 62D.30, and except as they eliminate elective, induced abortions, wherever performed, from health or maternity benefits, provisions of the insurance laws and provisions of nonprofit

health service plan corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under sections 62D.01 to 62D.30.

Subd. 6. [Repealed, 1982 c 614 s 12]

Subd. 7. A licensed health maintenance organization shall be deemed to be a prepaid group practice plan for the purposes of chapter 43A and may be allowed to participate as a carrier for state employees subject to any collective bargaining agreement entered into pursuant to chapter 179A and reasonable restrictions applied pursuant to section 43A.23.

Subd. 8. All agents, solicitors, and brokers engaged in soliciting or dealing with enrollees or prospective enrollees of a health maintenance organization, whether employees or under contract to the health maintenance organization, shall be subject to the provisions of sections 60K.01 to 60K.18, concerning the licensure of health insurance agents, solicitors, and brokers, and lawful rules thereunder. Medical doctors and others who merely explain the operation of health maintenance organizations shall be exempt from the provisions of sections 60K.01 to 60K.18. Section 60K.03, subdivision 2, shall not apply except as to provide for an examination of an applicant in the applicant's knowledge concerning the operations and benefits of health maintenance organizations and related insurance matters.

Subd. 9. [Repealed, 1984 c 464 s 46]

Subd. 10. Any person or committee conducting a review of a health maintenance organization or a participating entity, pursuant to sections 62D.01 to 62D.30, shall have access to any data or information necessary to conduct the review. All data or information is subject to admission into evidence in any civil action initiated by the commissioner of health against the health maintenance organization. The data and information are subject to chapter 13.

History: *1973 c 670 s 22; 1974 c 284 s 6; 1977 c 305 s 45; 1979 c 332 art 1 s 57; 1980 c 617 s 18; 1981 c 122 s 3; 1981 c 210 s 54; 1Sp1981 c 4 art 1 s 50; 1984 c 464 s 42,43; 1985 c 248 s 70; 1Sp1985 c 17 s 10; 1986 c 444; 1Sp1986 c 3 art 1 s 8; 1987 c 384 art 2 s 1; 1992 c 564 art 3 s 23*

62D.23 FILINGS AND REPORTS AS PUBLIC DOCUMENTS.

All applications, filings and reports required under sections 62D.01 to 62D.30 shall be treated as public documents.

History: *1973 c 670 s 23; 1987 c 384 art 2 s 1*

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

The commissioner of health, in carrying out the obligations under sections 62D.01 to 62D.30, may contract with the commissioner of commerce or other qualified persons to make recommendations concerning the determinations required to be made. Such recommendations may be accepted in full or in part by the commissioner of health.

History: *1973 c 670 s 24; 1977 c 305 s 45; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444; 1987 c 384 art 2 s 1*

62D.25 [Repealed, 1Sp1985 c 9 art 2 s 104]

62D.26 [Repealed, 1Sp1985 c 9 art 2 s 104]

62D.27 [Repealed, 1984 c 464 s 46]

62D.28 [Repealed, 1Sp1985 c 9 art 2 s 104]

62D.29 [Repealed, 1Sp1985 c 9 art 2 s 104]

62D.30 DEMONSTRATION PROJECTS.

Subdivision 1. The commissioner of health may establish demonstration projects to allow health maintenance organizations to extend coverage to:

(a) Individuals enrolled in Part A or Part B, or both, of the Medicare program, Title XVIII of the Social Security Act, United States Code, title 42, section 1395 et seq.;

(b) Groups of fewer than 50 employees where each group is covered by a single group health policy;

(c) Individuals who are not eligible for enrollment in any group health maintenance contracts; and

(d) Low income population groups.

For purposes of this section, the commissioner of health may waive compliance with minimum benefits pursuant to sections 62A.151 and 62D.02, subdivision 7, full financial risk pursuant to section 62D.04, subdivision 1, clause (f), open enrollment pursuant to section 62D.10, and to applicable rules if there is reasonable evidence that the rules prohibit the operation of the demonstration project. The commissioner shall provide for public comment before any statute or rule is waived.

Subd. 2. A demonstration project must provide health benefits equal to or exceeding the level of benefits provided in Title XVIII of the Social Security Act and an out of hospital prescription drug benefit. The out of hospital prescription drug benefit may be waived by the commissioner if the health maintenance organization presents evidence satisfactory to the commissioner that the inclusion of the benefit would restrict the operation of the demonstration project.

Subd. 3. A health maintenance organization electing to participate in a demonstration project shall apply to the commissioner for approval on a form developed by the commissioner. The application shall include at least the following:

(a) A statement identifying the population that the project is designed to serve;

(b) A description of the proposed project including a statement projecting a schedule of costs and benefits for the enrollee;

(c) Reference to the sections of Minnesota Statutes and department of health rules for which waiver is requested;

(d) Evidence that application of the requirements of applicable Minnesota Statutes and department of health rules would, unless waived, prohibit the operation of the demonstration project;

(e) Evidence that another arrangement is available for assumption of full financial risk if full financial risk is waived under subdivision 1;

(f) An estimate of the number of years needed to adequately demonstrate the project's effects; and

(g) Other information the commissioner may reasonably require.

Subd. 4. The commissioner shall approve, deny, or refer back to the health maintenance organization for modification, the application for a demonstration project within 60 days of receipt from the health maintenance organization.

Subd. 5. The commissioner may approve an application for a demonstration project for a maximum of six years, with an option to renew.

Subd. 6. Each health maintenance organization for which a demonstration project is approved shall annually file a report with the commissioner summarizing the project's experience at the same time it files its annual report required by section 62D.08. The report shall be on a form developed by the commissioner and shall be separate from the annual report required by section 62D.08.

Subd. 7. The commissioner may rescind approval of a demonstration project if the commissioner makes any of the findings listed in section 62D.15, subdivision 1, with respect to the project for which it has not been granted a specific exemption, or if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

History: *1979 c 268 s 1*