CHAPTER 62D

HEALTH MAINTENANCE ORGANIZATIONS

62D.02 DEFINITIONS.

[For text of subds 1 to 4, see M.S.1996]

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

[For text of subds 6 to 9, see M.S.1996]

Subd. 10. "Consumer" means any person, including an enrollee, to whom a health maintenance organization directs marketing materials.

[For text of subds 11 to 16, see M.S.1996]

History: *1997 c 205 s 1; 1997 c 225 art 2 s 6*

62D.03 ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS.

[For text of subd 1, see M.S.1996]

Subd. 2. [Repealed, 1997 c 205 s 40]

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. An 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the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked. Any person directed to apply for a certificate of authority shall be subject to the provisions of this subdivision.

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;

(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, insolvency 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: *1997 c 205 s 2,3*

62D.04 ISSUANCE OF CERTIFICATE AUTHORITY.

[For text of subds 1 and 2, see M.S.1996]

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 enrollees and members elected according to section 62D.06, subdivision 1, 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.

[For text of subd 4, see M.S.1996]

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 that meet the requirements of the request for proposal provided that the requirements can be reasonably met by a health maintenance organization 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: *1997 c 203 art 4 s 1; 1997 c 205 s 4*

62D.042 NET WORTH AND WORKING CAPITAL REQUIREMENTS.

[For text of subds 1 and 2, see M.S.1996]

Subd. 3. **Existing organizations.** Each organization 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.

[For text of subds 4 to 7, see M.S.1996]

History: *1997 c 205 s 5*

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 enrollees and members elected by the enrollees and members from among the enrollees and members. For purposes of this section, "member" means a consumer who receives health care services through a self–insured contract that is administered by the health maintenance organization or its related third–party administrator. The number of members elected to the governing body shall not exceed the number of enrollees elected to the governing body. An enrollee or member elected to the governing board may not be a person:

(1) whose occupation involves, or before retirement involved, the administration of health activities or the provision of health services;

(2) who is or was employed by a health care facility as a licensed health professional; or

(3) who has or had a direct substantial financial or managerial interest in the rendering of a health service, other than the payment of a reasonable expense reimbursement or compensation as a member of the board of a health maintenance organization.

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.

[For text of subd 2, see M.S.1996]

History: *1997 c 205 s 6*

62D.07 EVIDENCE OF COVERAGE.

[For text of subds 1 and 2, see M.S.1996]

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;

(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 complaints may be registered; and

(c) On the cover page of the evidence of coverage and contract, a clear and complete statement of enrollees' rights. The statement must be in bold print and captioned "Important Enrollee 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, except that paragraph (8) does not apply to prepaid health plans providing coverage for programs administered by the commissioner of human services:

ENROLLEE 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.

(8) NEWBORN COVERAGE: If your health plan provides for dependent coverage, a newborn infant is covered from birth, but only if services are provided by participating (name of health maintenance organization) providers or authorized by (name of health maintenance organization). Certain services are covered only upon referral. (Name of health maintenance organization) will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify (name of health maintenance organization) of the infant's birth and that you would like coverage. If your contract requires an additional premium for each dependent, (name of health maintenance organization) is entitled to all premiums due from the time of the infant's birth until the time you notify (name of health maintenance organization) of the birth. (Name of health maintenance organization) may withhold payment of any health benefits for the newborn infant until any premiums you owe are paid.

(9) PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT: Enrolling in (name of health maintenance organization) does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year.

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 complaint 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.

[For text of subds 4 to 10, see M.S.1996]

History: *1997 c 205 s 7*

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 enrollee 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.

[For text of subd 2, see M.S.1996]

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 amendments thereto; and

(4) a statement of enrollee information and rights as described in section 62D.07, subdivision 3, paragraph (c).

Under clause (3), a health maintenance organization may annually alternate between providing enrollees with amendments and providing current evidence of coverage.

[For text of subds 4 to 7, see M.S.1996]

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 enrollee has a complaint;

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

(4) include one of the following:

(i) the telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. The ombudsperson shall annually provide the commissioner of health with a summary of complaints and actions taken.

History: *1997 c 205 s 8–10; 1997 c 225 art 2 s 7*

62D.102 FAMILY THERAPY.

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: *1997 c 205 s 11*

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 or on behalf of 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 alternative dispute resolution to appeal a health maintenance organization's internal appeal decision. If an enrollee chooses to use an alternative dispute resolution process, the health maintenance organization must participate.

[For text of subd 1a, see M.S.1996]

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

[For text of subd 2, see M.S.1996]

Subd. 3. **Denial of coverage.** Within a reasonable time after receiving an enrollee's written or oral communication to the health maintenance organization concerning a denial of coverage or inadequacy of services, the health maintenance organization shall provide the enrollee with a written statement of the reason for the denial of coverage, and a statement approved 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. [Repealed, 1997 c 205 s 40]

History: *1997 c 205 s 12–14*

62D.12 PROHIBITED PRACTICES.

[For text of subds 1 to 18, see M.S.1996]

Subd. 19. **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: *1997 c 205 s 15*

62D.181 INSOLVENCY; MCHA ALTERNATIVE COVERAGE.

[For text of subd 1, see M.S.1996]

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 or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization 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 or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization or community integrated service network, and the individual has not obtained alternative coverage.

Subd. 3. **Application and issuance.** If a health maintenance organization 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 or community integrated service network at the time of an order for liquidation, the association shall issue policies to eligible individuals, without the limitation on preexisting conditions described in section 62E.14, subdivision 3.

[For text of subds 4 and 5, see M.S.1996]

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 or community integrated service network, whichever is greater.

[For text of subds 7 and 8, see M.S.1996]

Subd. 9. **Coordination of policies.** If an insolvent health maintenance organization 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: *1997 c 225 art 2 s 62*

62D.20 RULES.

[For text of subd 1, see M.S.1996]

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

History: *1997 c 205 s 16*