CHAPTER 62L

SMALL EMPLOYER INSURANCE REFORM

62L.01 CITATION.

Subdivision 1. **Popular name.** Sections 62L.01 to 62L.22 may be cited as the Minnesota Small Employer Health Benefit Act.

Subd. 2. **Jurisdiction.** Sections 62L.01 to 62L.22 apply to any health carrier that offers, issues, delivers, or renews a health benefit plan to a small employer.

Subd. 3. **Legislative findings and purpose.** The legislature finds that underwriting and rating practices in the individual and small employer markets for health coverage create substantial hardship and unfairness, create unnecessary administrative costs, and adversely affect the health of residents of this state. The legislature finds that the premium restrictions provided by this chapter reduce but do not eliminate these harmful effects. Accordingly, the legislature declares its desire to phase out the remaining rating bands as quickly as possible, with the end result of eliminating all rating practices based on risk by July 1, 1997.

History: *1992 c 549 art 2 s 1; 1994 c 625 art 10 s 50*

62L.02 DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to sections 62L.01 to 62L.22.

Subd. 2. **Actuarial opinion.** "Actuarial opinion" means a written statement by a member of the American Academy of Actuaries that a health carrier is in compliance with this chapter, based on the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the health carrier in establishing premium rates for health benefit plans.

Subd. 3. **Association.** "Association" means the health coverage reinsurance association.

Subd. 4. **Base premium rate.** "Base premium rate" means as to a rating period, the lowest premium rate charged or which could have been charged under the rating system by the health carrier to small employers for health benefit plans with the same or similar coverage.

Subd. 5. **Board of directors.** "Board of directors" means the board of directors of the health coverage reinsurance association.

Subd. 6. **Case characteristics.** "Case characteristics" means the relevant characteristics of a small employer, as determined by a health carrier in accordance with this chapter, which are considered by the carrier in the determination of premium rates for the small employer.

Subd. 7. **Coinsurance.** "Coinsurance" means an established dollar amount or percentage of health care expenses that an eligible employee or dependent is required

to pay directly to a provider of medical services or supplies under the terms of a health benefit plan.

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of commerce for health carriers subject to the jurisdiction of the department of commerce or the commissioner of health for health carriers subject to the jurisdiction of the department of health, or the relevant commissioner's designated representative. For purposes of sections 62L.13 to 62L.22, "commissioner" means the commissioner of commerce or that commissioner's designated representative.

Subd. 9. **Continuous coverage.** "Continuous coverage" means the maintenance of continuous and uninterrupted qualifying coverage. An individual is considered to have maintained continuous coverage if the individual requests enrollment in qualifying coverage within 63 days of termination of qualifying coverage.

Subd. 9a. **Current employee.** "Current employee" means an employee, as defined in this section, other than a retiree or handicapped former employee.

Subd. 10. **Deductible.** "Deductible" means the amount of health care expenses an eligible employee or dependent is required to incur before benefits are payable under a health benefit plan.

Subd. 11. **Dependent.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 19 years, unmarried child under the age of 25 years who is a full-time student as defined in section 62A.301, dependent child of any age who is handicapped and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child includes a child for whom the employee or the employee's spouse has been appointed legal guardian and an adoptive child as provided in section 62A.27.

Subd. 11a. **Discounted eligible charges.** "Discounted eligible charges" means, as determined by the board of directors, eligible charges reduced by the average difference between eligible charges and the expected liability of the health carrier for services performed. The board of directors, in its discretion, may determine additional different discounts, based upon geographic area and type of delivery system.

Subd. 12. **Eligible charges.** "Eligible charges" means the actual charges submitted to a health carrier by or on behalf of a provider, eligible employee, or dependent for health services covered by the health carrier's health benefit plan. Eligible charges do not include charges for health services excluded by the health benefit plan or charges for which an alternate health carrier is liable under the coordination of benefit provisions of the health benefit plan.

Subd. 13. **Eligible employee.** "Eligible employee" means an employee who has satisfied all employer participation and eligibility requirements.

Subd. 13a. **Employee.** "Employee" means an individual employed for at least 20 hours per week and includes a sole proprietor or a partner of a partnership, if the sole proprietor or partner is included under a health benefit plan of the employer, but does not include individuals who work on a temporary, seasonal, or substitute basis. "Employee" also includes a retiree or a handicapped former employee required to be covered under sections 62A.147 and 62A.148.

Subd. 13b. **Enrollment date.** "Enrollment date" means, with respect to a covered individual, the date of enrollment of the individual in the health benefit plan or, if earlier, the first day of the waiting period for the individual's enrollment.

Subd. 14. **Financially impaired condition.** "Financially impaired condition" means a situation in which a health carrier is not insolvent, but (1) is considered by the commissioner to be potentially unable to fulfill its contractual obligations, or (2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

Subd. 14a. **Guaranteed issue.** "Guaranteed issue" means that a health carrier shall not decline an application by a small employer for any health benefit plan offered by that health carrier and shall not decline to cover under a health benefit plan any

eligible employee or eligible dependent, including persons who become eligible employees or eligible dependents after initial issuance of the health benefit plan, subject to the health carrier's right to impose preexisting condition limitations permitted under this chapter.

Subd. 15. **Health benefit plan.** "Health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a health carrier to a small employer for the coverage of medical and hospital benefits. Health benefit plan includes a small employer plan. Health benefit plan does not include coverage, including any combination of the following coverages, that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) liability insurance or supplemental to liability insurance;

(4) designed solely to provide coverage for a specified disease or illness or to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, if offered as independent, noncoordinated coverage;

(5) credit accident and health insurance as defined in section 62B.02;

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) a long-term care policy as defined in section 62A.46 or a qualified long-term care insurance policy as defined in section 62S.01;

(10) Medicare-related coverage as defined in section 62Q.01, subdivision 6;

(11) workers' compensation insurance; or

(12) limited to care provided at on-site medical clinics operated by an employer for the benefit of the employer's employees and their dependents, in connection with which the employer does not transfer risk.

For the purpose of this chapter, a health benefit plan issued to eligible employees of a small employer who meets the participation requirements of section 62L.03, subdivision 3, is considered to have been issued to a small employer. A health benefit plan issued on behalf of a health carrier is considered to be issued by the health carrier.

Subd. 16. **Health carrier.** "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan corporation licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network operating under chapter 62N; an accountable provider network regulated under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in United States Code, title 29, section 1002(40), as amended. Any use of this definition in another chapter by reference does not include a community integrated service network, unless otherwise specified. For the purpose of this chapter, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one health carrier, except that any insurance company or health service plan corporation that is an affiliate of a health maintenance organization located in Minnesota, or any health maintenance organization located in Minnesota that is an affiliate of an insurance company or health service plan corporation, or any health maintenance organization that is an affiliate of another health maintenance organization in Minnesota, may treat the health maintenance organization as a separate health carrier.

Subd. 17. **Health plan.** "Health plan" means a health plan as defined in section 62A.011 and includes individual and group coverage regardless of the size of the group, unless otherwise specified.

Subd. 18. **Index rate.** "Index rate" means as to a rating period for small employers the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

Subd. 19. **Late entrant.** "Late entrant" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period applicable to the employee or dependent under the terms of the health benefit plan, provided that the initial enrollment period must be a period of at least 30 days. However, an eligible employee or dependent must not be considered a late entrant if:

(1) the individual was covered under qualifying coverage at the time the individual was eligible to enroll in the health benefit plan, declined enrollment on that basis, and presents to the health carrier a certificate of termination of the qualifying coverage, due to loss of eligibility for that coverage, or proof of the termination of employer contributions toward that coverage, provided that the individual maintains continuous coverage and requests enrollment within 30 days of termination of qualifying coverage or termination of the employer's contribution toward that coverage. For purposes of this clause, loss of eligibility includes loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. For purposes of this clause, an individual is not a late entrant if the individual elects coverage under the health benefit plan rather than accepting continuation coverage for which the individual is eligible under state or federal law with respect to the individual's previous qualifying coverage;

(2) the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law Number 99-272, as amended, and any state continuation laws applicable to the employer or health carrier, provided that the individual maintains continuous coverage and requests enrollment within 30 days of the loss of coverage;

(3) the individual is a new spouse of an eligible employee, provided that enrollment is requested within 30 days of becoming legally married;

(4) the individual is a new dependent child of an eligible employee, provided that enrollment is requested within 30 days of becoming a dependent;

(5) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(6) a court has ordered that coverage be provided for a former spouse or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

Subd. 20. **MCHA.** "MCHA" means the Minnesota comprehensive health association established under section 62E.10.

Subd. 21. **Medical necessity.** "Medical necessity" means the appropriate and necessary medical and hospital services eligible for payment under a health benefit plan as determined by a health carrier.

Subd. 22. **Members.** "Members" means the health carriers operating in the small employer market who may participate in the association.

Subd. 23. **Preexisting condition.** "Preexisting condition" means, with respect to coverage, a condition present before the individual's enrollment date for the coverage, for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the enrollment date.

Subd. 24. **Qualifying coverage.** "Qualifying coverage" means health benefits or health coverage provided under:

(1) a health benefit plan, as defined in this section, but without regard to whether it is issued to a small employer and including blanket accident and sickness insurance, other than accident-only coverage, as defined in section 62A.11;

(2) part A or part B of Medicare;

(3) medical assistance under chapter 256B;

(4) general assistance medical care under chapter 256D;

(5) MCHA;

(6) a self-insured health plan;

(7) the MinnesotaCare program established under section 256L.02;

(8) a plan provided under section 43A.316, 43A.317, or 471.617;

(9) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or other coverage provided under United States Code, title 10, chapter 55;

(10) coverage provided by a health care network cooperative under chapter 62R;

(11) a medical care program of the Indian Health Service or of a tribal organization;

(12) the federal Employees Health Benefits Plan, or other coverage provided under United States Code, title 5, chapter 89;

(13) a health benefit plan under section 5(e) of the Peace Corps Act, codified as United States Code, title 22, section 2504(e);

(14) a health plan; or

(15) a plan similar to any of the above plans provided in this state or in another state as determined by the commissioner.

Subd. 25. **Rating period.** "Rating period" means the 12-month period for which premium rates established by a health carrier are assumed to be in effect, as determined by the health carrier. During the rating period, a health carrier may adjust the rate based on the prorated change in the index rate.

Subd. 26. **Small employer.** (a) "Small employer" means, with respect to a calendar year and a plan year, a person, firm, corporation, partnership, association, or other entity actively engaged in business, including a political subdivision of the state, that employed an average of no fewer than two nor more than 50 current employees on business days during the preceding calendar year and that employs at least two current employees on the first day of the plan year. If an employer has only one eligible employee who has not waived coverage, the sale of a health plan to or for that eligible employee is not a sale to a small employer and is not subject to this chapter and may be treated as the sale of an individual health plan. A small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than two current employees. Entities that are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the federal Internal Revenue Code are considered a single employer for purposes of determining the number of current employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based upon the average number of current employees that it is reasonably expected that the employer will employ on business days in the current calendar year. For purposes of this definition, the term employer includes any predecessor of the employer. An employer that has more than 50 current employees but has 50 or fewer employees, as "employee" is defined under United States Code, title 29, section 1002(6), is a small employer under this subdivision.

(b) Where an association, as defined in section 62L.045, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association and health benefit plans it provides to small employers, are subject to section 62L.045, with respect to small employers in the association, even though the association also provides coverage to its members that do not qualify as small employers.

(c) If an employer has employees covered under a trust specified in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq., as amended, or employees whose health coverage is determined by a collective bargaining agreement and, as a result of the collective bargaining agreement, is purchased separately from the health plan

provided to other employees, those employees are excluded in determining whether the employer qualifies as a small employer. Those employees are considered to be a separate small employer if they constitute a group that would qualify as a small employer in the absence of the employees who are not subject to the collective bargaining agreement.

Subd. 27. **Small employer market.** (a) "Small employer market" means the market for health benefit plans for small employers.

(b) A health carrier is considered to be participating in the small employer market if the carrier offers, sells, issues, or renews a health benefit plan to: (1) any small employer; or (2) the eligible employees of a small employer offering a health benefit plan if, with the knowledge of the health carrier, either of the following conditions is met:

(i) any portion of the premium or benefits is paid for or reimbursed by a small employer; or

(ii) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of the Internal Revenue Code, section 106, 125, or 162.

Subd. 28. **Small employer plan.** "Small employer plan" means a health benefit plan issued by a health carrier to a small employer for coverage of the medical and hospital benefits described in section 62L.05.

Subd. 29. **Waiting period.** "Waiting period" means, with respect to an individual who is a potential enrollee under a health benefit plan, the period that must pass with respect to the individual before the individual is eligible, under the employer's eligibility requirements, for coverage under the health benefit plan.

History: *1992 c 549 art 2 s 2; 1993 c 47 s 1; 1993 c 247 art 2 s 1-5; 1993 c 345 art 7 s 1-3; 1994 c 465 art 3 s 61; 1994 c 625 art 10 s 16-28,50; 1995 c 234 art 7 s 12-15; 1995 c 258 s 44; 1997 c 71 art 2 s 7; 1997 c 175 art 2 s 1-9; 1997 c 225 art 2 s 62; 1999 c 177 s 52; 1999 c 181 s 1; 2001 c 7 s 15*

62L.03 AVAILABILITY OF COVERAGE.

Subdivision 1. **Guaranteed issue and reissue.** (a) Every health carrier shall, as a condition of authority to transact business in this state in the small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans, on a guaranteed issue basis, to any small employer, including a small employer covered by paragraph (b), that meets the participation and contribution requirements of subdivision 3, as provided in this chapter.

(b) A small employer that has its workforce reduced to one employee may continue coverage as a small employer for 12 months from the date the group is reduced to one employee.

(c) Notwithstanding paragraph (a), a health carrier may, at the time of coverage renewal, modify the health coverage for a product offered in the small employer market if the modification is consistent with state law, approved by the commissioner, and effective on a uniform basis for all small employers purchasing that product other than through a qualified association in compliance with section 62L.045, subdivision 2.

Paragraph (a) does not apply to a health benefit plan designed for a small employer to comply with a collective bargaining agreement, provided that the health benefit plan otherwise complies with this chapter and is not offered to other small employers, except for other small employers that need it for the same reason. This paragraph applies only with respect to collective bargaining agreements entered into prior to August 21, 1996, and only with respect to plan years beginning before the later of July 1, 1997, or the date upon which the last of the collective bargaining agreements relating to the plan terminates determined without regard to any extension agreed to after August 21, 1996.

(d) Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall

fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers.

(e) A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

Subd. 2. **Exceptions.** (a) No health maintenance organization is required to offer coverage or accept applications under subdivision 1 in the case of the following:

(1) with respect to a small employer, where the small employer does not have eligible employees who work or reside in the health maintenance organization's approved service areas; or

(2) with respect to an employee, when the employee does not work or reside within the health maintenance organization's approved service areas.

(b) A health carrier participating in the small employer market shall not be required to offer coverage or accept applications pursuant to subdivision 1 where the commissioner finds that the acceptance of an application or applications would place the health carrier participating in the small employer market in a financially impaired condition, provided, however, that a health carrier participating in the small employer market that has not offered coverage or accepted applications pursuant to this paragraph shall not offer coverage or accept applications for any health benefit plan until 180 days following a determination by the commissioner that the health carrier is not financially impaired and that offering coverage or accepting applications under subdivision 1 would not cause the health carrier to become financially impaired.

Subd. 3. **Minimum participation and contribution.** (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan and that contributes at least 50 percent toward the cost of coverage of each eligible employee must be guaranteed coverage on a guaranteed issue basis from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier must not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to: (1) coverage under another group health plan; (2) coverage under Medicare Parts A and B; (3) coverage under MCHA permitted under section 62E.141; or (4) coverage under medical assistance under chapter 256B or general assistance medical care under chapter 256D.

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual health plans, or a health benefit plan which must fully comply with this chapter. A health carrier that provides a health benefit plan to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer an individual health plan, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers the individual health plan, on a guaranteed issue basis, to all other employees of the same employer.

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer. This paragraph does not apply if the small employer will meet the required participation level with respect to the new coverage.

Subd. 4. **Underwriting restrictions.** (a) Health carriers may apply underwriting restrictions to coverage for health benefit plans for small employers, including any preexisting condition limitations, only as expressly permitted under this chapter. For purposes of this section, "underwriting restrictions" means any refusal of the health carrier to issue or renew coverage, any premium rate higher than the lowest rate

charged by the health carrier for the same coverage, any preexisting condition limitation, preexisting condition exclusion, or any exclusionary rider.

(b) Health carriers may collect information relating to the case characteristics and demographic composition of small employers, as well as health status and health history information about employees, and dependents of employees, of small employers.

(c) Except as otherwise authorized for late entrants, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the enrollment date of an eligible employee or dependent, but exclusionary riders must not be used. Late entrants may be subject to a preexisting condition limitation not to exceed 18 months from the enrollment date of the late entrant, but must not be subject to any exclusionary rider or preexisting condition exclusion. When calculating any length of preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying coverage, provided that the individual maintains continuous coverage. The credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. Section 60A.082, relating to replacement of group coverage, and the rules adopted under that section apply to this chapter, and this chapter's requirements are in addition to the requirements of that section and the rules adopted under it. A health carrier shall, at the time of first issuance or renewal of a health benefit plan on or after July 1, 1993, credit against any preexisting condition limitation or exclusion permitted under this section, the time period prior to July 1, 1993, during which an eligible employee or dependent was covered by qualifying coverage, if the person has maintained continuous coverage.

(d) Health carriers shall not use pregnancy as a preexisting condition under this chapter.

Subd. 5. **Cancellations and failures to renew.** (a) No health carrier shall cancel, decline to issue, or fail to renew a health benefit plan as a result of the claim experience or health status of the persons covered or to be covered by the health benefit plan. For purposes of this subdivision, a failure to renew does not include a uniform modification of coverage at time of renewal, as described in subdivision 1.

(b) A health carrier may cancel or fail to renew a health benefit plan:

(1) for nonpayment of the required premium;

(2) for fraud or misrepresentation by the small employer with respect to eligibility for coverage or any other material fact;

(3) if the employer fails to comply with the minimum contribution percentage required under subdivision 3; or

(4) for any other reasons or grounds expressly permitted by the respective licensing laws and regulations governing a health carrier, including, but not limited to, service area restrictions imposed on health maintenance organizations under section 62D.03, subdivision 4, paragraph (m), to the extent that these grounds are not expressly inconsistent with this chapter.

(c) A health carrier may fail to renew a health benefit plan:

(1) if eligible employee participation during the preceding calendar year declines to less than 75 percent, subject to the waiver of coverage provision in subdivision 3;

(2) if the health carrier ceases to do business in the small employer market under section 62L.09; or

(3) if a failure to renew is based upon the health carrier's decision to discontinue the health benefit plan form previously issued to the small employer, but only if the health carrier permits each small employer covered under the prior form to switch to its choice of any other health benefit plan offered by the health carrier, without any underwriting restrictions that would not have been permitted for renewal purposes.

(d) A health carrier need not renew a health benefit plan, and shall not renew a small employer plan, if an employer ceases to qualify as a small employer as defined in

section 62L.02, except as provided in subdivision 1, paragraph (b). If a health benefit plan, other than a small employer plan, provides terms of renewal that do not exclude an employer that is no longer a small employer, the health benefit plan may be renewed according to its own terms. If a health carrier issues or renews a health plan to an employer that is no longer a small employer, without interruption of coverage, the health plan is subject to section 60A.082.

(e) A health carrier may cancel or fail to renew the coverage of an individual employee or dependent under a health benefit plan for fraud or misrepresentation by the eligible employee or dependent with respect to eligibility for coverage or any other material fact.

Subd. 6. **MCHA enrollees.** Health carriers shall offer coverage to any eligible employee or dependent enrolled in MCHA at the time of the health carrier's issuance or renewal of a health benefit plan to a small employer. The health benefit plan must require that the employer permit MCHA enrollees to enroll in the small employer's health benefit plan as of the first date of renewal of a health benefit plan occurring on or after July 1, 1993, and as of each date of renewal after that, or, in the case of a new group, as of the initial effective date of the health benefit plan and as of each date of renewal after that. Unless otherwise permitted by this chapter, health carriers must not impose any underwriting restrictions, including any preexisting condition limitations or exclusions, on any eligible employee or dependent previously enrolled in MCHA and transferred to a health benefit plan so long as continuous coverage is maintained, provided that the health carrier may impose any unexpired portion of a preexisting condition limitation under the person's MCHA coverage. An MCHA enrollee is not a late entrant, so long as the enrollee has maintained continuous coverage.

History: *1992 c 549 art 2 s 3; 1993 c 247 art 2 s 6,7; 1993 c 345 art 7 s 4,5; 1994 c 625 art 10 s 29-33; 1995 c 234 art 7 s 16-18; 1995 c 258 s 45; 1997 c 175 art 2 s 10-14; 1999 c 177 s 53; 2002 c 330 s 24,25*

62L.04 COMPLIANCE REQUIREMENTS.

Subdivision 1. **Applicability of chapter requirements.** (a) Beginning July 1, 1993, health carriers participating in the small employer market must offer and make available on a guaranteed issue basis any health benefit plan that they offer, including both of the small employer plans provided in section 62L.05, to all small employers that satisfy the small employer participation and contribution requirements specified in this chapter. Compliance with these requirements is required as of the first renewal date of any small employer group occurring after July 1, 1993. For new small employer business, compliance is required as of the first date of offering occurring after July 1, 1993.

(b) Compliance with these requirements is required as of the first renewal date occurring after July 1, 1994, with respect to employees of a small employer who had been issued individual coverage prior to July 1, 1993, administered by the health carrier on a group basis. Notwithstanding any other law to the contrary, the health carrier shall offer to terminate any individual coverage for employees of small employers who satisfy the small employer participation and contribution requirements specified in section 62L.03 and offer to replace it with a health benefit plan. If the employer elects not to purchase a health benefit plan, the health carrier must offer all covered employees and dependents the option of maintaining their current coverage, administered on an individual basis, or replacement individual coverage. Small employer and replacement individual coverage provided under this subdivision must be without application of underwriting restrictions, provided continuous coverage is maintained.

(c) With respect to small employers having no fewer than 30 nor more than 49 current employees, all dates in this subdivision become July 1, 1995, and any reference to "after" a date becomes "on or after" July 1, 1995.

Subd. 2. **New carriers.** A health carrier entering the small employer market after July 1, 1993, shall begin complying with the requirements of this chapter as of the first date of offering of a health benefit plan to a small employer. A health carrier entering

the small employer market after July 1, 1993, is considered to be a member of the health coverage reinsurance association as of the date of the health carrier's initial offer of a health benefit plan to a small employer.

History: *1992 c 549 art 2 s 4; 1993 c 345 art 7 s 6; 1994 c 625 art 10 s 34*

62L.045 ASSOCIATIONS.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given:

(a) "Association" means:

(1) an association as defined in section 60A.02;

(2) a group or organization of political subdivisions;

(3) a service cooperative created under section 123A.21; or

(4) a joint self-insurance pool authorized under section 471.617, subdivision 2.

(b) "Qualified association" means an association, as defined in this subdivision, that:

(1) is registered with the commissioner of commerce;

(2) provides health plan coverage through a health carrier that participates in the small employer market in this state, other than through associations, to the extent that the association purchases health plan coverage rather than self-insures;

(3) has and adheres to membership and participation criteria and health coverage eligibility criteria that are not designed to disproportionately include or attract small employers that are likely to have low costs of health coverage or to disproportionately exclude or repel small employers that are likely to have high costs of health coverage; and

(4) permits any small employer that meets its membership, participation, and eligibility criteria to become a member and to obtain health coverage through the association.

(c) "Health coverage" means a health benefit plan as defined in section 62L.02, subdivision 15; or similar self-insured coverage offered, sold, issued, or renewed by an association as defined in paragraph (a) to a small employer.

Subd. 2. **Qualified associations.** (a) A qualified association, as defined in this section, and health coverage offered by it, to it, or through it, to a small employer in this state must comply with the requirements of this chapter regarding guaranteed issue, guaranteed renewal, preexisting condition limitations, credit against preexisting condition limitations for continuous coverage, treatment of MCHA enrollees, and the definition of dependent, and with section 62A.65, subdivision 5, paragraph (b). They must also comply with all other requirements of this chapter not specifically exempted in paragraph (b) or (c).

(b) A qualified association and a health carrier offering, selling, issuing, or renewing health coverage to, or to cover, a small employer in this state through the qualified association, may, but are not, in connection with that health coverage, required to:

(1) offer the two small employer plans described in section 62L.05; and

(2) offer to small employers that are not members of the association, health coverage offered to, by, or through the qualified association.

(c) A qualified association, and a health carrier offering, selling, issuing, and renewing health coverage to, or to cover, a small employer in this state must comply with section 62L.08, except that:

(1) a separate index rate may be applied by a health carrier to each qualified association, provided that:

(i) the premium rate applied to participating small employer members of the qualified association is no more than 25 percent above and no more than 25 percent below the index rate applied to the qualified association, irrespective of when members applied for health coverage; and

(ii) the index rate applied by a health carrier to a qualified association is no more than 20 percent above and no more than 20 percent below the index rate applied by the health carrier to any other qualified association or to any small employer. In comparing index rates for purposes of this clause, the 20 percent shall be calculated as a percent of the larger index rate; and

(2) a qualified association described in subdivision 1, paragraph (a), clauses (2) to (4), providing health coverage through a health carrier, or on a self-insured basis in compliance with section 471.617 and the rules adopted under that section, may cover small employers and other employers within the same pool and may charge premiums to small employer members on the same basis as it charges premiums to members that are not small employers, if the premium rates charged to small employers do not have greater variation than permitted under section 62L.08. A qualified association operating under this clause shall annually prove to the commissioner of commerce that it complies with this clause through a sampling procedure acceptable to the commissioner. If the qualified association fails to prove compliance to the satisfaction of the commissioner, the association shall agree to a written plan of correction acceptable to the commissioner. The qualified association is considered to be in compliance under this clause if there is a premium rate that would, if used as an index rate, result in all premium rates in the sample being in compliance with section 62L.08. This clause does not exempt a qualified association or a health carrier providing coverage through the qualified association from the loss ratio requirement of section 62L.08, subdivision 11.

Subd. 3. **Other associations.** Associations as defined in this section that are not qualified associations; health coverage offered, sold, issued, or renewed by or through them; and the health carriers doing so, must fully comply with this chapter with respect to small employers that are members of the association.

Subd. 4. **Principles; association coverage.** (a) This subdivision applies to associations as defined in this section, whether qualified associations or not, and is intended to clarify subdivisions 1 to 3.

(b) This section applies only to associations that provide health coverage to small employers.

(c) A health carrier is not required under this chapter to comply with guaranteed issue and guaranteed renewal with respect to its relationship with the association itself. An arrangement between the health carrier and the association, once entered into, must comply with guaranteed issue and guaranteed renewal with respect to members of the association that are small employers and persons covered through them.

(d) When an arrangement between a health carrier and an association has validly terminated, the health carrier has no continuing obligation to small employers and persons covered through them, except as otherwise provided in:

(1) section 62A.65, subdivision 5, paragraph (b);

(2) any other continuation or conversion rights applicable under state or federal law; and

(3) section 60A.082, relating to group replacement coverage, and rules adopted under that section.

(e) When an association's arrangement with a health carrier has terminated and the association has entered into a new arrangement with that health carrier or a different health carrier, the new arrangement is subject to section 60A.082 and rules adopted under it, with respect to members of the association that are small employers and persons covered through them.

(f) An association that offers its members more than one plan of health coverage may have uniform rules restricting movement between the plans of health coverage, if the rules do not discriminate against small employers.

(g) This chapter does not require or prohibit separation of an association's members into one group consisting only of small employers and another group or other groups consisting of all other members. The association must comply with this section with respect to the small employer group.

(h) For purposes of this section, "member" of an association includes an employer participant in the association.

(i) For purposes of this section, health coverage issued to, or to cover, a small employer includes a certificate of coverage issued directly to the employer's employees and dependents, rather than to the small employer.

Subd. 5. **Registration.** The commissioner may require all associations that are subject to this section to register with the commissioner prior to an initial purchase of health coverage under this section.

History: *1995 c 234 art 7 s 19; 1996 c 305 art 1 s 23; 1996 c 446 art 3 s 1; 1998 c 397 art 11 s 3*

62L.05 SMALL EMPLOYER PLAN BENEFITS.

Subdivision 1. **Two small employer plans.** Each health carrier in the small employer market must make available, on a guaranteed issue basis, to any small employer that satisfies the contribution and participation requirements of section 62L.03, subdivision 3, both of the small employer plans described in subdivisions 2 and 3. Under subdivisions 2 and 3, coinsurance and deductibles do not apply to child health supervision services and prenatal services, as defined by section 62A.047. The maximum out-of-pocket costs for covered services must be $3,000 per individual and $6,000 per family per year. The maximum lifetime benefit must be not less than $1,000,000.

Subd. 2. **Deductible-type small employer plan.** The benefits of the deductible-type small employer plan offered by a health carrier must be equal to 80 percent of the charges, as specified in subdivision 10, for health care services, supplies, or other articles covered under the small employer plan, in excess of an annual deductible which must be $2,250 per individual and $4,500 per family.

Subd. 3. **Copayment-type small employer plan.** The benefits of the copayment-type small employer plan offered by a health carrier must be equal to 80 percent of the charges, as specified in subdivision 10, for health care services, supplies, or other articles covered under the small employer plan, in excess of the following copayments:

(1) $15 per outpatient visit, including visits to an urgent care center but not including visits to a hospital outpatient department or emergency room, or similar facility;

(2) $15 per visit for the services of a home health agency or private duty registered nurse;

(3) $50 per outpatient visit to a hospital outpatient department or emergency room, or similar facility; and

(4) $300 per inpatient admission to a hospital.

Subd. 4. **Benefits.** The medical services and supplies listed in this subdivision are the benefits that must be covered by the small employer plans described in subdivisions 2 and 3. Benefits under this subdivision may be provided through the managed care procedures practiced by health carriers:

(1) inpatient and outpatient hospital services, excluding services provided for the diagnosis, care, or treatment of chemical dependency or a mental illness or condition, other than those conditions specified in clauses (10), (11), and (12). The health care services required to be covered under this clause must also be covered if rendered in a nonhospital environment, on the same basis as coverage provided for those same treatments or services if rendered in a hospital, provided, however, that this sentence must not be interpreted as expanding the types or extent of services covered;

(2) physician, chiropractor, and nurse practitioner services for the diagnosis or treatment of illnesses, injuries, or conditions;

(3) diagnostic x-rays and laboratory tests;

(4) ground transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, or as otherwise required by the health carrier;

(5) services of a home health agency if the services qualify as reimbursable services under Medicare;

(6) services of a private duty registered nurse if medically necessary, as determined by the health carrier;

(7) the rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

(8) child health supervision services up to age 18, as defined in section 62A.047;

(9) maternity and prenatal care services, as defined in sections 62A.041 and 62A.047;

(10) inpatient hospital and outpatient services for the diagnosis and treatment of certain mental illnesses or conditions, as defined by the International Classification of Diseases-Clinical Modification (ICD-9-CM), seventh edition (1990) and as classified as ICD-9 codes 295 to 299;

(11) ten hours per year of outpatient mental health diagnosis or treatment for illnesses or conditions not described in clause (10);

(12) 60 hours per year of outpatient treatment of chemical dependency; and

(13) 50 percent of eligible charges for prescription drugs, up to a separate annual maximum out-of-pocket expense of $1,000 per individual for prescription drugs, and 100 percent of eligible charges thereafter.

Subd. 4a. **Alternative benefit plan.** In addition to the small employer benefit plans described in subdivisions 1 to 4, a health carrier may offer to a small employer a benefit plan that differs from those plans in the following respects:

(1) the plan may include different copayments and deductibles; and

(2) the plan may offer coverage on a per diem, fixed indemnity, or nonexpense incurred basis.

Subd. 5. **Plan variations.** (a) No health carrier shall offer to a small employer a health benefit plan that differs from the small employer plans described in subdivisions 1 to 4a, unless the health benefit plan complies with all provisions of chapters 62A, 62C, 62D, 62E, 62H, 62N, 62Q, and 64B that otherwise apply to the health carrier, except as expressly permitted by paragraph (b).

(b) As an exception to paragraph (a), a health benefit plan is deemed to be a small employer plan and to be in compliance with paragraph (a) if it differs from one of the two small employer plans described in subdivisions 1 to 4 only by providing benefits in addition to those described in subdivision 4, provided that the health benefit plan has an actuarial value that exceeds the actuarial value of the benefits described in subdivision 4 by no more than two percent. "Benefits in addition" means additional units of a benefit listed in subdivision 4 or one or more benefits not listed in subdivision 4.

Subd. 6. **Choice products exception.** Nothing in subdivision 1 prohibits a health carrier from offering a small employer plan which provides for different benefit coverages based on whether the benefit is provided through a primary network of providers or through a secondary network of providers so long as the benefits provided in the primary network equal the benefit requirements of the small employer plan as described in this section. For purposes of products issued under this subdivision, out-of-pocket costs in the secondary network may exceed the out-of-pocket limits described in subdivision 1. A secondary network must not be used to provide "benefits in addition" as defined in subdivision 5, except in compliance with that subdivision.

Subd. 7. **Benefit exclusions.** No medical, hospital, or other health care benefits, services, supplies, or articles not expressly specified in subdivision 4 are required to be included in a small employer plan. Nothing in subdivision 4 restricts the right of a health carrier to restrict coverage to those services, supplies, or articles which are medically necessary. Health carriers may exclude a benefit, service, supply, or article not expressly specified in subdivision 4 from a small employer plan.

Subd. 8. **Continuation coverage.** Small employer plans must include the continuation of coverage provisions required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law Number 99-272, as amended, and by state law.

Subd. 9. **Dependent coverage.** Other state law and rules applicable to health plan coverage of newborn infants, dependent children who do not reside with the eligible employee, handicapped children and dependents, and adopted children apply to a small employer plan. Health benefit plans that provide dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

Subd. 10. **Medical expense reimbursement.** Health carriers may reimburse or pay for medical services, supplies, or articles provided under a small employer plan in accordance with the health carrier's provider contract requirements including, but not limited to, salaried arrangements, capitation, the payment of usual and customary charges, fee schedules, discounts from fee-for-service, per diems, diagnosis-related groups (DRGs), and other payment arrangements. Nothing in this chapter requires a health carrier to develop, implement, or change its provider contract requirements for a small employer plan. Coinsurance, deductibles, out-of-pocket maximums, and maximum lifetime benefits must be calculated and determined in accordance with each health carrier's standard business practices.

Subd. 11. **Plan design.** Notwithstanding any other law, regulation, or administrative interpretation to the contrary, health carriers may offer small employer plans through any provider arrangement, including, but not limited to, the use of open, closed, or limited provider networks. A health carrier may only use product and network designs currently allowed under existing statutory requirements. The provider networks offered by any health carrier may be specifically designed for the small employer market and may be modified at the carrier's election so long as all otherwise applicable regulatory requirements are met. Health carriers may use professionally recognized provider standards of practice when they are available, and may use utilization management practices otherwise permitted by law, including, but not limited to, second surgical opinions, prior authorization, concurrent and retrospective review, referral authorizations, case management, and discharge planning. A health carrier may contract with groups of providers with respect to health care services or benefits, and may negotiate with providers regarding the level or method of reimbursement provided for services rendered under a small employer plan.

Subd. 12. **Demonstration projects.** Nothing in this chapter prohibits a health maintenance organization from offering a demonstration project authorized under section 62D.30. The commissioner of health may approve a demonstration project which offers benefits that do not meet the requirements of a small employer plan if the commissioner finds that the requirements of section 62D.30 are otherwise met.

History: *1992 c 549 art 2 s 5; 1993 c 247 art 2 s 8; 1993 c 345 art 7 s 7-10; 1994 c 625 art 10 s 35-37; 1999 c 177 s 54; 1999 c 181 s 2,3; 2001 c 215 s 21,22*

62L.055 SMALL EMPLOYER ALTERNATIVE BENEFIT PLANS; PILOT PROJECT.

(a) Notwithstanding any provision of this chapter or other law to the contrary, the commissioner of commerce shall develop a pilot project by January 1, 2000, to authorize health carriers to offer alternative health benefit plans to small employers if the following requirements are satisfied:

(1) the health carrier is assessed less than three percent of the total amount assessed by the Minnesota comprehensive health association;

(2) the health plans must be offered in compliance with this chapter, except as otherwise permitted in this section;

(3) the health plans to be offered must be designed to enable employers and covered persons to better manage costs and coverage options through the use of copays, deductibles, and other cost-sharing arrangements;

(4) the health plans must be issued and administered in compliance with sections 62E.141; 62L.03, subdivision 6; and 62L.12, subdivisions 3 and 4, relating to prohibitions against enrolling in the Minnesota comprehensive health association persons eligible for employer group coverage;

(5) the health plans must meet a 71 percent loss ratio for small employers with fewer than ten employees, and a 75 percent loss ratio for all other plans;

(6) the health plans may alter or eliminate coverages that would otherwise be required by law, other than the requirement that care provided for covered services by osteopaths, optometrists, and chiropractors, or registered nurses meeting the requirements of section 62A.15, subdivision 3a, be reimbursed on a nondiscriminatory basis; and

(7) each health plan must be approved by the commissioner of commerce.

(b) The definitions in section 62L.02 apply to this section as modified by this section.

(c) This section expires August 1, 2003.

History: *1999 c 181 s 4*

62L.06 DISCLOSURE OF UNDERWRITING RATING PRACTICES.

When offering or renewing a health benefit plan, health carriers shall disclose in all solicitation and sales materials:

(1) the case characteristics and other rating factors used to determine initial and renewal rates;

(2) the extent to which premium rates for a small employer are established or adjusted based upon actual or expected variation in claim experience;

(3) provisions concerning the health carrier's right to change premium rates and the factors other than claim experience that affect changes in premium rates;

(4) provisions relating to renewability of coverage;

(5) the use and effect of any preexisting condition provisions, if permitted;

(6) the application of any provider network limitations and their effect on eligibility for benefits; and

(7) the ability of small employers to insure eligible employees and dependents currently receiving coverage from the comprehensive health association through health benefit plans.

History: *1992 c 549 art 2 s 6; 1994 c 625 art 10 s 38*

62L.07 SMALL EMPLOYER REQUIREMENTS.

Subdivision 1. **Verification of eligibility.** Health benefit plans must require that small employers offering a health benefit plan maintain information verifying the continuing eligibility of the employer, its employees, and their dependents, and provide the information to health carriers on a quarterly basis or as reasonably requested by the health carrier.

Subd. 2. **Waivers.** Health benefit plans must require that small employers offering a health benefit plan maintain written documentation indicating that each eligible employee was informed of the availability of coverage through the employer and of a waiver of coverage by the eligible employee. This documentation must be provided to the health carrier upon reasonable request.

History: *1992 c 549 art 2 s 7; 1994 c 625 art 10 s 39*

62L.08 RESTRICTIONS RELATING TO PREMIUM RATES.

Subdivision 1. **Rate restrictions.** Premium rates for all health benefit plans sold or issued to small employers are subject to the restrictions specified in this section.

Subd. 2. **General premium variations.** Beginning July 1, 1993, each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, industry of the employer, and duration of coverage from the date of issue. For purposes of this subdivision, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been

determined to be actuarially valid and approved by the commissioner. Variations permitted under this subdivision must not be based upon age or applied differently at different ages. This subdivision does not prohibit use of a constant percentage adjustment for factors permitted to be used under this subdivision.

Subd. 2a. **Renewal premium increases limited.** (a) Beginning January 1, 2003, the percentage increase in the premium rate charged to a small employer for a new rating period must not exceed the sum of the following:

(1) the percentage change in the index rate measured from the first day of the prior rating period to the first day of the new rating period;

(2) an adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of the employer; and

(3) any adjustment due to change in coverage or in the case characteristics of the employer.

(b) This subdivision does not apply if the employer, employee, or any applicant provides the health carrier with false, incomplete, or misleading information.

Subd. 3. **Age-based premium variations.** Beginning July 1, 1993, each health carrier may offer premium rates to small employers that vary based upon the ages of the eligible employees and dependents of the small employer only as provided in this subdivision. In addition to the variation permitted by subdivision 2, each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

Subd. 4. **Geographic premium variations.** A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. A health carrier may also request approval to establish one or more additional geographic regions and one or more separate index rates for premiums for employees working and residing outside of Minnesota. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) if one geographic region is rural, the index rate for the rural region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area;

(4) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

Subd. 5. **Gender-based rates prohibited.** Beginning July 1, 1993, no health carrier may determine premium rates through a method that is in any way based upon the gender of eligible employees or dependents. Rates must not in any way reflect marital status or generalized differences in expected costs between employees and spouses.

Subd. 6. **Rate cells permitted.** Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based on the number of adults and children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect marital status or differences in expected costs between employees and spouses.

Subd. 7. **Index and premium rate development.** (a) In developing its index rates and premiums, a health carrier may take into account only the following factors:

(1) actuarially valid differences in benefit designs of health benefit plans;

(2) actuarially valid differences in the rating factors permitted in subdivisions 2 and 3;

(3) actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4.

(b) All premium variations permitted under this section must be based upon actuarially valid differences in expected cost to the health carrier of providing coverage. The variation must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All premium variations are subject to approval by the commissioner.

Subd. 7a. [Repealed, 1995 c 234 art 7 s 28]

Subd. 8. **Filing requirement.** No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates. The rates shall not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. For premium rates proposed to go into effect between July 1, 1993 and December 31, 1993, the pertinent growth rate is the growth rate applied under section 62J.04, subdivision 1, paragraph (b), to calendar year 1994.

Subd. 9. **Effect of assessments.** Premium rates must comply with the rating requirements of this section, notwithstanding the imposition of any assessments or premiums paid by health carriers as provided under sections 62L.13 to 62L.22.

Subd. 10. **Rating report.** Beginning January 1, 1995, and annually thereafter, the commissioners of health and commerce shall provide a joint report to the legislature on the effect of the rating restrictions required by this section and the appropriateness of proceeding with additional rate reform. Each report must include an analysis of the availability of health care coverage due to the rating reform, the equitable and appropriate distribution of risk and associated costs, the effect on the self-insurance market, and any resulting or anticipated change in health plan design and market share and availability of health carriers.

Subd. 11. **Loss ratio standards.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, each policy or contract form used with respect to a health benefit plan offered, or issued in the small employer market, is subject, beginning July 1, 1993, to section 62A.021. The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.

History: *1992 c 549 art 2 s 8,23; 1993 c 345 art 7 s 11,12; 1994 c 625 art 10 s 40-46,50; 1Sp1995 c 3 art 13 s 2; 1997 c 7 art 1 s 18; 1997 c 225 art 2 s 63; 2002 c 330 s 26*

62L.081 PHASE-IN.

Subdivision 1. **Compliance.** No health carrier, as defined in section 62L.02, shall renew any health benefit plan, as defined in section 62L.02, except in compliance with this section.

Subd. 2. **Premium adjustments.** (a) Any increase or decrease in premiums by a health carrier that is caused by section 62L.08, and that is greater than 30 percent, is subject to this subdivision. A health carrier shall determine renewal premiums only as follows:

(1) one-half of that premium increase or decrease may be charged upon the first renewal of the coverage on or after July 1, 1993; and

(2) the remaining one-half of that premium increase or decrease may be charged upon the renewal of the coverage one year after the date of the renewal under clause (1).

(b) For purposes of this subdivision, the premium increase or decrease is the total premium increase or decrease caused by section 62L.08 and not just the portion that exceeds 30 percent. This subdivision does not apply to any portion of a premium increase or decrease that is not caused by section 62L.08.

History: *1993 c 345 art 7 s 15*

62L.09 CESSATION OF SMALL EMPLOYER BUSINESS.

Subdivision 1. **Notice to commissioner.** A health carrier electing to cease doing business in the small employer market shall notify the commissioner 180 days prior to the effective date of the cessation. The health carrier shall simultaneously provide a copy of the notice to each small employer covered by a health benefit plan issued by the health carrier. For purposes of this section, "cease doing business" means to discontinue issuing new health benefit plans to small employers and to refuse to renew all of the health carrier's existing health benefit plans issued to small employers, the terms of which permit refusal to renew under the circumstances specified in this subdivision. This section does not permit cancellation of a health benefit plan, unless permitted under its terms.

Upon making the notification, the health carrier shall not offer or issue new business in the small employer market. The health carrier shall renew its current small employer business due for renewal within 120 days after the date of the notification but shall not renew any small employer business more than 120 days after the date of the notification. The renewal period for business renewed during that 120-day period shall end on the effective date of the cessation.

A health carrier that elects to cease doing business in the small employer market shall continue to be governed by this chapter with respect to any continuing small employer business conducted by the health carrier.

Subd. 2. [Repealed, 1993 c 345 art 7 s 16]

Subd. 3. **Reentry prohibition.** (a) Except as otherwise provided in paragraph (b), a health carrier that ceases to do business in the small employer market after July 1, 1993, is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the small employer market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the small employer market in that same service area.

(b) The commissioner of commerce or the commissioner of health may permit a health carrier that ceases to do business in the small employer market in this state after July 1, 1993, to begin writing new business in the small employer market if:

(1) since the carrier ceased doing business in the small employer market, legislative action has occurred that has significantly changed the effect on the carrier of its decision to cease doing business in the small employer market; and

(2) the commissioner deems it appropriate.

Subd. 4. **Continuing assessment liability.** A health carrier that ceases to do business in the small employer market remains liable for assessments levied by the association as provided in section 62L.22.

History: *1992 c 549 art 2 s 9; 1993 c 247 art 2 s 9; 1993 c 345 art 7 s 13; 1994 c 465 art 3 s 61; 1995 c 234 art 7 s 20; 1996 c 446 art 1 s 49*

62L.10 SUPERVISION BY COMMISSIONER.

Subdivision 1. **Reports.** A health carrier doing business in the small employer market shall file by April 1 of each year an annual actuarial opinion with the commissioner certifying that the health carrier complied with the underwriting and

rating requirements of this chapter during the preceding year and that the rating methods used by the health carrier were actuarially sound. A health carrier shall retain a copy of the opinion at its principal place of business.

Subd. 2. **Records.** A health carrier doing business in the small employer market shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

Subd. 3. **Submissions to commissioner.** Subsequent to the annual filing, the commissioner may request information and documentation from a health carrier describing its rating practices and renewal underwriting practices, including information and documentation that demonstrates that a health carrier's rating methods and practices are in accordance with sound actuarial principles and the requirements of this chapter. Except in cases of violations of this chapter or of another chapter, information received by the commissioner as provided under this subdivision is nonpublic.

Subd. 4. **Review of premium rates.** The commissioner shall regulate premium rates charged or proposed to be charged by all health carriers in the small employer market under section 62A.02. The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.

Subd. 5. **Transitional practices.** The commissioner shall disapprove index rates, premium variations, or other practices of a health carrier if they violate the spirit of this chapter and are the result of practices engaged in by the health carrier between April 23, 1992, and July 1, 1993, where the practices engaged in were carried out for the purpose of evading the spirit of this chapter. Each health carrier shall report to the commissioner, within 30 days and on a form prescribed by the commissioner, each cancellation, nonrenewal, or other termination of coverage of a small employer between April 23, 1992, and June 30, 1993. The health carrier shall provide any related information requested by the commissioner within the time specified in the request. Any health carrier that engages in a practice of terminating or inducing termination of coverage of small employers in order to evade the effects of Laws 1992, chapter 549, is guilty of an unfair method of competition and an unfair or deceptive act or practice in the business of insurance and is subject to the remedies provided in sections 72A.17 to 72A.32.

History: *1992 c 549 art 2 s 10*

62L.11 PENALTIES AND ENFORCEMENT.

Subdivision 1. **Disciplinary proceedings.** The commissioner may, by order, suspend or revoke a health carrier's license or certificate of authority and impose a monetary penalty not to exceed $25,000 for each violation of this chapter. Violations include the failure to pay an assessment required by section 62L.22, and knowingly and willfully encouraging a small employer to not meet the contribution or participation requirements of section 62L.03, subdivision 3, in order to avoid the requirements of this chapter. The notice, hearing, and appeal procedures specified in section 60A.052 or 62D.16, as appropriate, apply to the order. The order is subject to judicial review as provided under chapter 14.

Subd. 2. **Enforcement powers.** The commissioners of health and commerce each has for purposes of this chapter all of each commissioner's respective powers under other chapters that are applicable to their respective duties under this chapter.

History: *1992 c 549 art 2 s 11; 1993 c 13 art 2 s 1; 1993 c 345 art 7 s 14*

62L.12 PROHIBITED PRACTICES.

Subdivision 1. **Prohibition on issuance of individual policies.** A health carrier operating in the small employer market shall not knowingly offer, issue, or renew an individual health plan to an eligible employee of a small employer that meets the

minimum participation and contribution requirements under section 62L.03, subdivision 3, except as authorized under subdivision 2.

Subd. 2. **Exceptions.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees as required.

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to substitute individual health plans for a group health plan nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

(h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.31 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., as amended.

(i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

Subd. 3. **Agent's licensure.** An agent licensed under chapter 60K or section 62C.17 who knowingly and willfully breaks apart a small group for the purpose of selling individual health plans to eligible employees and dependents of a small employer that meets the participation and contribution requirements of section 62L.03, subdivision 3, is guilty of an unfair trade practice and subject to disciplinary action, including the revocation or suspension of license, under section 60K.43 or 62C.17. The action must be by order and subject to the notice, hearing, and appeal procedures specified in section 60K.43. The action of the commissioner is subject to judicial review as provided under chapter 14.

Subd. 4. **Employer prohibition.** A small employer shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another health carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.

Subd. 5. **Sale of other products.** A health carrier shall not condition the offer, sale, issuance, or renewal of a health benefit plan on the purchase by a small employer of

other insurance products offered by the health carrier or a subsidiary or affiliate of the health carrier, including, but not limited to, life, disability, property, and general liability insurance. This prohibition does not apply to insurance products offered as a supplement to a health maintenance organization plan, including, but not limited to, supplemental benefit plans under section 62D.05, subdivision 6.

History: *1992 c 549 art 2 s 12; 1993 c 13 art 2 s 1; 1994 c 625 art 10 s 47; 1995 c 234 art 7 s 21; 2001 c 117 art 2 s 11*

62L.13 REINSURANCE ASSOCIATION.

Subdivision 1. **Creation.** The health coverage reinsurance association may operate as a nonprofit unincorporated association, but is authorized to incorporate under chapter 317A. All health carriers in the small employer market shall be and remain members of the association as a condition of their authority to transact business.

Subd. 2. **Purpose.** The association is established to provide for the fair and equitable transfer of risk associated with participation by a health carrier in the small employer market to a private reinsurance pool established and maintained by the association.

Subd. 3. **Exemptions.** The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, premiums taxes imposed under chapter 297I, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 13, 13D, 60A, and 62A to 62H. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. The board of directors and health carriers who are members of the association are exempt from sections 325D.49 to 325D.66 in the performance of their duties as directors and members of the association.

Subd. 4. **Powers of association.** The association may exercise all of the powers of a corporation formed under chapter 317A, including, but not limited to, the authority to:

(1) establish operating rules, conditions, and procedures relating to the reinsurance of members' risks;

(2) assess members in accordance with the provisions of this section and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses;

(3) sue and be sued, including taking any legal action necessary to recover any assessments;

(4) enter into contracts necessary to carry out the provisions of this chapter;

(5) establish operating, administrative, and accounting procedures for the operation of the association; and

(6) borrow money against the future receipt of premiums and assessments up to the amount of the previous year's assessment, with the prior approval of the commissioner.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association may operate under the plan of operation approved by the board and shall be governed in accordance with this chapter and may operate in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation meets the requirements of filing articles.

Subd. 5. **Supervision by commissioner.** The commissioner of commerce shall supervise the association in accordance with this chapter. The commissioner of commerce may examine the association. The association's reinsurance policy forms, its contracts, its premium rates, and its assessments are subject to the approval of the commissioner of commerce. The association's policy forms, contracts, and premium rates are deemed approved if not disapproved by the commissioner of commerce within 60 days after the date of filing them with the commissioner of commerce. The

association's assessments are deemed approved if not disapproved by the commissioner of commerce within 15 business days after filing them with the commissioner of commerce. The association shall notify the commissioner of all association or board meetings, and the commissioner or the commissioner's designee may attend all association or board meetings. The association shall file an annual report with the commissioner on or before July 1 of each year, beginning July 1, 1994, describing its activities during the preceding calendar year. The report must include a financial report and a summary of claims paid by the association. The annual report must be available for public inspection.

History: *1992 c 549 art 2 s 13; 1993 c 47 s 2-4; 1993 c 247 art 2 s 10-12; 1994 c 465 art 3 s 61; 1997 c 187 art 3 s 17; 2000 c 394 art 2 s 16*

62L.14 BOARD OF DIRECTORS.

Subdivision 1. **Composition of board.** The association shall exercise its powers through a board of 13 directors. Four directors must be public members appointed by the commissioner. The public directors must not be employees of or otherwise affiliated with any member of the association. The nonpublic directors must be representative of the membership of the association and must be officers, employees, or directors of the members during their term of office. No member of the association may have more than three directors. Directors are automatically removed if they fail to satisfy this qualification.

Subd. 2. **Election of board.** On or before July 1, 1992, the commissioner shall appoint an interim board of directors of the association who shall serve until the annual meeting in 1994. Except for the public directors, the commissioner's initial appointments must be equally apportioned among the following three categories: accident and health insurance companies, nonprofit health service plan corporations, and health maintenance organizations. Thereafter, members of the association shall elect the board of directors in accordance with this chapter and the plan of operation, subject to approval by the commissioner. Members of the association may vote in person or by proxy. The public directors shall continue to be appointed by the commissioner to terms meeting the requirements of subdivision 3.

Subd 3. **Term of office.** After the annual meeting in 1994, each director shall serve a three-year term, except that the board shall make appropriate arrangements to stagger the terms of the directors so that approximately one-third of the terms expire each year. Each director shall hold office until expiration of the director's term or until the director's successor is duly elected or appointed and qualified, or until the director's death, resignation, or removal.

Subd. 4. **Resignation and removal.** A director may resign at any time by giving written notice to the commissioner. The resignation takes effect at the time the resignation is received unless the resignation specifies a later date. A nonpublic director may be removed at any time, with cause, by the members. If a vacancy occurs for a public director, the commissioner shall appoint a new public director for the duration of the unexpired term.

Subd. 5. **Quorum.** A majority of the directors constitutes a quorum for the transaction of business. If a vacancy exists by reason of death, resignation, or otherwise, a majority of the remaining directors constitutes a quorum.

Subd. 6. **Duties of directors.** On or before January 1, 1993, the board or the interim board shall develop a plan of operation and reasonable operating rules to assure the fair, reasonable, and equitable administration of the association. The plan of operation must include the development of procedures for selecting an administering carrier, establishment of the powers and duties of the administering carrier, and establishment of procedures for collecting assessments from members, including the imposition of interest penalties for late payments of assessments. The plan of operation must be submitted to the commissioner for review and approval and must be submitted to the members for approval at the first meeting of the members. The board of

directors may subsequently amend, change, or revise the plan of operation without approval by the members.

Subd. 7. **Compensation.** Public directors may be reimbursed by the association for reasonable and necessary expenses incurred by them in performing their duties as directors and may be compensated by the association at a rate of up to $55 per day spent on authorized association activities.

Subd. 8. **Officers.** The board may elect officers and establish committees as provided in the bylaws of the association. Officers have the authority and duties in the management of the association as prescribed by the bylaws and determined by the board of directors.

Subd. 9. **Majority vote.** Approval by a majority of the directors present is required for any action of the board. The majority vote must include one vote from a director representing an accident and health insurance company, one vote from a director representing a health service plan corporation, one vote from a director representing a health maintenance organization, and one vote from a public director.

History: *1992 c 549 art 2 s 14; 1993 c 47 s 5-8; 1993 c 247 art 2 s 13-20; 1994 c 465 art 3 s 61; 1999 c 177 s 55*

62L.15 MEMBERS.

Subdivision 1. **Annual meeting.** The association shall conduct an annual meeting of the members of the association for the purpose of electing directors and transacting any other appropriate business of the membership of the association. The board shall determine the date, time, and place of the annual meeting. The association shall conduct its first annual member meeting on or before December 1, 1992.

Subd. 2. **Special meetings.** Special meetings of the members must be held whenever called by any three of the directors. At least two categories must be represented among the directors calling a special meeting of the members. The categories are public directors, accident and health insurance companies, nonprofit health service plan corporations, and health maintenance organizations. Special meetings of the members must be held at a time and place designated in the notice of the meeting.

Subd. 3. **Member voting.** Each member's vote is a weighted vote and is based on each member's total insurance premiums, subscriber contract charges, health maintenance contract payments, or other health benefit plan revenue derived from, or on behalf of, small employers during the preceding calendar year, as determined by the board and approved by the commissioner, based on annual statements and other reports considered necessary by the board of directors.

Subd. 4. **Initial member meeting.** At least 60 days before the first annual meeting of the members, the commissioner shall give written notice to all members of the time and place of the member meeting. The members shall elect directors representing the members, approve the initial plan of operation of the association, and transact any other appropriate business of the membership of the association.

Subd. 5. **Member compliance.** All members shall comply with the provisions of this chapter, the association's bylaws, the plan of operation developed by the board of directors, and any other operating, administrative, or other procedures established by the board of directors for the operation of the association. The board may request the commissioner to secure compliance with this chapter through the use of any enforcement action otherwise available to the commissioner.

History: *1992 c 549 art 2 s 15; 1993 c 47 s 9; 1993 c 247 art 2 s 21; 1994 c 465 art 3 s 61*

62L.16 ADMINISTRATION OF ASSOCIATION.

Subdivision 1. **Administrator.** The association shall contract with a qualified entity to operate and administer the association. If there is no available qualified entity, or in the event of a termination under subdivision 2, the association may directly operate and

administer the reinsurance program. The administrator shall perform all administrative functions required by this chapter. The board of directors shall develop administrative functions required by this chapter and written criteria for the selection of an administrator. The administrator must be selected by the board of directors, subject to approval by the commissioner.

Subd. 2. **Term.** The administrator shall serve for a period of three years, unless the administrator requests the termination of its contract and the termination is approved by the board of directors. The board of directors shall approve or deny a request to terminate within 90 days of its receipt after consultation with the commissioner. A failure to make a final decision on a request to terminate within 90 days is considered an approval.

Subd. 3. **Duties of administrator.** The association shall enter into a written contract with the administrator to carry out its duties and responsibilities. The administrator shall perform all administrative functions required by this chapter including the:

(1) preparation and submission of an annual report to the commissioner;

(2) preparation and submission of monthly reports to the board of directors;

(3) calculation of all assessments and the notification thereof of members;

(4) payment of claims to health carriers following the submission by health carriers of acceptable claim documentation; and

(5) provision of claim reports to health carriers as determined by the board of directors.

Subd. 4. **Bid process.** The association shall issue a request for proposal for administration of the reinsurance association and shall solicit responses from health carriers participating in the small employer market and from other qualified entities. Methods of compensation of the administrator must be a part of the bid process. The administrator shall substantiate its cost reports consistent with generally accepted accounting principles.

Subd. 5. **Audits.** The board of directors may conduct periodic audits to verify the accuracy of financial data and reports submitted by the administrator. The board may establish in the plan of operation a uniform audit program. All costs of the uniform audit program and any additional audits conducted by the board to verify the accuracy of claims submissions are the responsibility of the health carrier. Failure of a health carrier to comply with the requirements of the audit program, including the failure to pay the costs of an audit, may subject the health carrier to the penalties described in section 62L.11.

Subd. 6. **Records of association.** The association shall maintain appropriate records and documentation relating to the activities of the association. All individual patient-identifying claims data and information are confidential and not subject to disclosure of any kind, except that a health carrier shall have access upon request to individual claims data relating to eligible employees and dependents covered by a health benefit plan issued by the health carrier. All records, documents, and work product prepared by the association or by the administrator for the association are the property of the association. The commissioner shall have access to the data for the purposes of carrying out the supervisory functions provided for in this chapter.

Subd. 7. **Indemnification.** The association shall indemnify members, directors, officers, employees, and agents to the same extent that persons may be indemnified by corporations under section 317A.521.

History: *1992 c 549 art 2 s 16; 1993 c 47 s 10,11; 1993 c 247 art 2 s 22,23*

62L.17 PARTICIPATION IN THE REINSURANCE ASSOCIATION.

Subdivision 1. **Minimum standards.** The board of directors or the interim board shall establish minimum claim processing and managed care standards which must be met by a health carrier in order to have its business reinsured by the association.

Subd. 2. **Participation.** A health carrier may elect to not participate in the reinsurance association through transferring risk only after filing an application with the commissioner of commerce. The commissioner may approve the application after consultation with the board of directors. In determining whether to approve an application, the commissioner shall consider whether the health carrier meets the following standards:

(1) demonstration by the health carrier of a substantial and established market presence;

(2) demonstrated experience in the small group market and history of rating and underwriting small employer groups;

(3) commitment to comply with the requirements of this chapter for small employers in the state or its service area; and

(4) financial ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance.

Initial application for nonparticipation must be filed with the commissioner no later than February 1993. The commissioner shall make the determination and notify the carrier no later than April 15, 1993.

Subd. 2a. **Participation of new small employer health carriers.** A health carrier that enters the small employer market subsequent to February 1993, may elect to not participate in the reinsurance association by filing an application within 60 days of entry into the small employer market or May 26, 1995, whichever is later. The commissioner shall make a determination and notify the health carrier no later than 60 days after receipt of the application. In determining whether to approve the application, the commissioner shall consider the standards defined in subdivision 2, except that the commissioner may also consider whether the health carrier has a guaranteeing organization as defined in section 62D.043, subdivision 1, or as permitted under chapter 62N.

Subd. 3. **Length of participation.** A health carrier's initial election is for a period of two years. Subsequent elections of participation are for five-year periods.

Subd. 4. **Appeal.** A health carrier whose application for nonparticipation has been rejected by the commissioner may appeal the decision. The association may also appeal a decision of the commissioner, if approved by a two-thirds majority of the board. Chapter 14 applies to all appeals under this subdivision.

Subd. 5. **Annual certification.** A health carrier that has received approval to not participate in the reinsurance association shall annually certify to the commissioner on or before December 1 that it continues to meet the standards described in subdivision 2.

Subd. 6. **Subsequent election.** Election to participate in the reinsurance association must occur on or before December 31 of each year. If after a period of nonparticipation, the nonparticipating health carrier subsequently elects to participate in the reinsurance association, the health carrier retains the risk it assumed when not participating in the association.

If a participating health carrier subsequently elects to not participate in the reinsurance association, the health carrier shall cease reinsuring through the association all of its small employer business and is liable for any assessment described in section 62L.22 which has been prorated based on the business covered by the reinsurance mechanism during the year of the assessment.

Subd. 7. **Election modification.** The commissioner, after consultation with the board, may authorize a health carrier to modify its election to not participate in the association at any time, if the risk from the carrier's existing small employer business jeopardizes the financial condition of the health carrier. If the commissioner authorizes a health carrier to participate in the association, the health carrier shall retain the risk it assumed while not participating in the association. This election option may not be exercised if the health carrier is in rehabilitation.

History: *1992 c 549 art 2 s 17; 1993 c 247 art 2 s 24,25; 1995 c 234 art 7 s 22*

62L.18 CEDING OF RISK.

Subdivision 1. **Prospective ceding.** For health benefit plans issued on or after July 1, 1993, all health carriers participating in the association may prospectively reinsure an employee or dependent within a small employer group and entire employer groups of seven or fewer eligible employees. A health carrier must determine whether to reinsure an employee or dependent or entire group within 60 days of the commencement of the coverage of the small employer and must notify the association during that time period.

Subd. 2. **Eligibility for reinsurance.** (a) A health carrier may not reinsure existing small employer business through the association. A health carrier may reinsure an employee or dependent who previously had coverage from MCHA who is now eligible for coverage through the small employer group at the time of enrollment as defined in section 62L.03, subdivision 6. A health carrier may not reinsure individuals who have existing individual health care coverage with that health carrier upon replacement of the individual coverage with group coverage as provided in section 62L.04, subdivision 1.

(b) A health carrier may cede to the association the risk of any newly eligible employees or continue to reinsure small employer business for employers who, at the time of renewal of coverage by the same health carrier prior to July 1, 1995, have more than 29 current employees but fewer than 49 current employees. This paragraph is effective retroactively for coverage renewed on or after July 1, 1994.

Subd. 3. **Reinsurance termination.** A health carrier may terminate reinsurance through the association for an employee or dependent or entire group on the anniversary date of coverage for the small employer. If the health carrier terminates the reinsurance, the health carrier may not subsequently reinsure the individual or entire group.

Subd. 4. **Continuing carrier responsibility.** A health carrier transferring risk to the association is completely responsible for administering its health benefit plans. A health carrier shall apply its case management and claim processing techniques consistently between reinsured and nonreinsured business. Small employers, eligible employees, and dependents shall not be notified that the health carrier has reinsured their coverage through the association.

History: *1992 c 549 art 2 s 18; 1995 c 234 art 7 s 23*

62L.19 ALLOWED REINSURANCE BENEFITS.

A health carrier may reinsure through the association only those benefits described in section 62L.05. The board may establish guidelines to clarify what coverage is included within the benefits described in this chapter. If a health plan conforms to those benefits as clarified by the board, the benefits are considered to be in accordance with this chapter for purposes of the association's obligations.

History: *1992 c 549 art 2 s 19; 1993 c 47 s 12; 1993 c 247 art 2 s 26*

62L.20 TRANSFER OF RISK.

Subdivision 1. **Reinsurance threshold.** A health carrier participating in the association may transfer up to 90 percent of the risk above a reinsurance threshold of $5,000 of eligible charges resulting from issuance of a health benefit plan to an eligible employee or dependent of a small employer group whose risk has been prospectively ceded to the association. If the eligible charges exceed $55,000, a health carrier participating in the association may transfer 100 percent of the risk each policy year not to exceed 12 months.

Satisfaction of the reinsurance threshold must be determined by the board of directors based on discounted eligible charges. The board may establish an audit process to assure consistency in the submission of charge calculations by health carriers to the association. The association shall determine the amount to be paid to the health carrier for claims submitted based on discounted eligible charges. The board may also establish upper limits on the amount paid by the association based on a usual and

customary determination. The board shall establish in the plan of operation a procedure for determining the discounted eligible charge.

Subd. 2. **Conversion factors.** The board shall establish a standardized conversion table for determining equivalent charges for health carriers that use alternative provider reimbursement methods. If a health carrier establishes to the board that the health carrier's conversion factor is equivalent to the association's standardized conversion table, the association shall accept the health carrier's conversion factor.

Subd. 3. **Board authority.** The board shall establish criteria for changing the threshold amount or retention percentage. The board shall review the criteria on an annual basis. The board shall provide the members with an opportunity to comment on the criteria at the time of the annual review.

Subd. 4. **Notification of transfer of risk.** A participating health carrier must notify the association, within 90 days of receipt of proof of loss, of satisfaction of a reinsurance threshold. After satisfaction of the reinsurance threshold, a health carrier continues to be liable to its providers, eligible employees, and dependents for payment of claims in accordance with the health carrier's health benefit plan. Health carriers shall not pend or delay payment of otherwise valid claims due to the transfer of risk to the association.

Subd. 5. **Periodic studies.** The board shall, on a biennial basis, prepare and submit a report to the commissioner of commerce on the effect of the reinsurance association on the small employer market. The first study must be presented to the commissioner no later than January 1, 1995, and must specifically address whether there has been disruption in the small employer market due to unnecessary churning of groups for the purpose of obtaining reinsurance and whether it is appropriate for health carriers to transfer the risk of their existing small group business to the reinsurance association. After two years of operation, the board shall study both the effect of ceding both individuals and entire small groups of seven or fewer eligible employees to the reinsurance association and the composition of the board and determine whether the initial appointments reflect the types of health carriers participating in the reinsurance association and whether the voting power of members of the association should be weighted and recommend any necessary changes.

History: *1992 c 549 art 2 s 20; 1993 c 47 s 13; 1993 c 247 art 2 s 27,28*

62L.21 REINSURANCE PREMIUMS.

Subdivision 1. **Monthly premium.** A health carrier ceding an individual to the reinsurance association shall be assessed a monthly reinsurance coverage premium that is 5.0 times the adjusted average market price. A health carrier ceding an entire group to the reinsurance association shall be assessed a monthly reinsurance coverage premium that is 1.5 times the adjusted average market price. The adjusted average market premium price must be established by the board of directors in accordance with its plan of operation. The board may consider benefit levels in establishing the reinsurance coverage premium.

Subd. 2. **Adjustment of premium rates.** The board of directors shall establish operating rules to allocate adjustments to the reinsurance premium charge of no more than minus 25 percent of the monthly reinsurance premium for health carriers that can demonstrate administrative efficiencies and cost-effective handling of equivalent risks. The adjustment must be made monthly, unless the board provides for a different interval in its operating rules. The operating rules must establish objective and measurable criteria which must be met by a health carrier in order to be eligible for an adjustment. These criteria must include consideration of efficiency attributable to case management, but not consideration of such factors as provider discounts.

Subd. 3. **Liability for premium.** A health carrier is liable for the cost of the reinsurance premium and may not directly charge the small employer for the costs. The reinsurance premium may be reflected only in the rating factors permitted in section 62L.08, as provided in section 62L.08, subdivision 10.

History: *1992 c 549 art 2 s 21; 1994 c 625 art 10 s 48*

62L.22 ASSESSMENTS.

Subdivision 1. **Assessment by board.** For the purpose of providing the funds necessary to carry out the purposes of the association, the board of directors shall assess members as provided in subdivisions 2, 3, and 4 at the times and for the amounts the board of directors finds necessary. Assessments are due and payable on the date specified by the board of directors, but not less than 30 days after written notice to the member. Assessments accrue interest at the rate of six percent per year on or after the due date.

Subd. 2. **Initial capitalization.** The interim board of directors shall determine the initial capital operating requirements for the association. The board shall assess each licensed health carrier $100 for the initial capital requirements of the association. The assessment is due and payable no later than January 1, 1993.

Subd. 3. **Retrospective assessment.** On or before July 1 of each year, the administering carrier shall determine the association's net loss, if any, for the previous calendar year, the program expenses of administration, and other appropriate gains and losses. If reinsurance premium charges are not sufficient to satisfy the operating and administrative expenses incurred or estimated to be incurred by the association, the board of directors shall assess each member participating in the association in proportion to each member's respective share of the total insurance premiums, subscriber contract payments, health maintenance organization payments, and other health benefit plan revenue derived from or on behalf of small employers during the preceding calendar year. The assessments must be calculated by the board of directors based on annual statements and other reports considered necessary by the board of directors and filed by members with the association. The amount of the assessment shall not exceed four percent of the member's small group market premium. In establishing this assessment, the board shall consider a formula based on total small employer premiums earned and premiums earned from newly issued small employer plans. A member's assessment may not be reduced or increased by more than 50 percent as a result of using that formula, which includes a reasonable cap on assessments on any premium category or premium classification. The board of directors may provide for interim assessments as it considers necessary to appropriately carry out the association's responsibilities. The board of directors may establish operating rules to provide for changes in the assessment calculation.

Subd. 4. **Additional assessments.** If the board of directors determines that the retrospective assessment formula described in subdivision 3 is insufficient to meet the obligations of the association, the board of directors shall assess each member not participating in the reinsurance association, but which is providing health plan coverage in the small employer market, in proportion to each member's respective share of the total insurance premiums, subscriber contract payments, health maintenance organization payments, and other health benefit plan revenue derived from or on behalf of small employers during the preceding calendar year. The assessment must be calculated by the board of directors based on annual statements and other reports considered necessary by the board of directors and filed by members with the association. The amount of the assessment may not exceed one percent of the member's small group market premium. Members who paid the retrospective assessment described in subdivision 3 are not subject to the additional assessment.

If the additional assessment is insufficient to meet the obligations of the association, the board of directors may assess members participating in the association who paid the retrospective assessment described in subdivision 3 up to an additional one percent of the member's small group market premium.

Subd. 5. **Abatement or deferment.** The association may abate or defer, in whole or in part, the retrospective assessment of a member if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations or the member is placed under an order of rehabilitation, liquidation, receivership, or conservation by a court of competent jurisdiction. In the event that a retrospective assessment against a member is abated or deferred, in whole

or in part, the amount by which the assessment is abated or deferred may be assessed against other members in accordance with the methodology specified in subdivisions 3 and 4.

Subd. 6. **Refund.** The board of directors may refund to members, in proportion to their contributions, the amount by which the assets of the association exceed the amount the board of directors finds necessary to carry out its responsibilities during the next calendar year. A reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses.

Subd. 7. **Appeals.** A health carrier may appeal to the commissioner of commerce within 30 days of notice of an assessment by the board of directors. A final action or order of the commissioner is subject to judicial review in the manner provided in chapter 14.

Subd. 8. **Liability for assessment.** Employer liability for other costs of a health carrier resulting from assessments made by the association under this section are limited by the rate spread restrictions specified in section 62L.08.

History: *1992 c 549 art 2 s 22*

62L.23 [Renumbered 62L.08, subd 11]

62L.23 SUSPENSION OF REINSURANCE OPERATIONS; REACTIVATION.

Subdivision 1. **Suspension.** The commissioner may, by order, suspend the operation of sections 62L.13 to 62L.22, upon receipt of a recommendation for suspension from the association board of directors. The order is effective 30 days after publication in the State Register.

Subd. 2. **Suspension of reinsurance operations.** Upon the issuance of an order issued pursuant to subdivision 1, the association shall suspend its operations in an orderly manner supervised by the commissioner and shall provide for the proper storage of the association's records. Notwithstanding the provisions of subdivision 1, the association may continue to levy assessments under section 62L.22 for the purpose of satisfying the association's presuspension expenses and the expenses associated with the association's suspension activities pursuant to this subdivision. The assessments must be approved by the commissioner.

Subd. 3. **No cancellation permitted.** Effective upon the effective date of an order issued pursuant to subdivision 1, reinsurance must be terminated for any person reinsured by the association pursuant to section 62L.18. No health carrier may cancel or fail to renew a health benefit plan for any person whose reinsurance with the association has been terminated subsequently to the issuance of an order pursuant to subdivision 1 solely because of the termination of reinsurance.

Subd. 4. **Reactivation of reinsurance operations.** The commissioner may, by order, reactivate the operation of sections 62L.13 to 62L.22, on a finding that the private market for reinsurance of health benefit plans has failed and that commercial reinsurance is unavailable to health carriers operating in the small employer market in Minnesota. The commissioner may not make findings or issue an order pursuant to this subdivision until a hearing is held pursuant to chapter 14.

Subd. 5. **Transition.** After issuance of any order pursuant to subdivision 4, the commissioner shall immediately appoint an interim board of directors of the association. The terms of members of this interim board must be for a period not to exceed 18 months. The board shall cause the reinsurance operations of the association to be resumed within 180 days of an order issued pursuant to subdivision 4.

Subd. 6. **Modification of five-year rule.** If the commissioner issues an order pursuant to subdivision 4, any health carrier may elect to participate in the reinsurance association, notwithstanding any departicipation by the health carrier within the preceding five years that, pursuant to section 62L.17, would have otherwise prohibited the health carrier's participation.

History: *2001 c 215 s 23*