CHAPTER 62E

COMPREHENSIVE HEALTH INSURANCE

62E.06 Minimum benefits of qualified plan.
62E.08 State plan premium.
62E.091 Approval of state plan premiums.
62E.12 Minimum benefits of comprehensive health insurance plan.
62E.13 Administration of plan.
62E.14 Enrollment by an eligible person.
62E.18 Health insurance for retired employees not eligible for Medicare.

62E.06 MINIMUM BENEFITS OF QUALIFIED PLAN.

Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A, 62C, and 62Q, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than $1,000,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $1,000,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarially equivalent benefit.

(b) Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) hospital services;

(2) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a physician or at the physician's direction;

(3) drugs requiring a physician's prescription;

(4) services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare;

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

(6) use of radium or other radioactive materials;

(7) oxygen;

(8) anesthetics;

(9) prostheses other than dental but including scalp hair prostheses worn for hair loss suffered as a result of alopecia areata;

(10) rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids, unless coverage is required under section 62Q.675;

(11) diagnostic x-rays and laboratory tests;

(12) oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) services of a physical therapist;

(14) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment; and

(15) services of an occupational therapist.

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, Medicare, or any other governmental program except as otherwise provided by section 62A.04, subdivision 3, clause (4);

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

(3) care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under Medicare;

(4) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semiprivate rooms, its most common semiprivate room charge shall be considered to be 90 percent of its lowest private room charge;

(5) that part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for well baby care, effective July 1, 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory, and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

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

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

[For text of subds 2 to 4, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 10*

62E.08 STATE PLAN PREMIUM.

Subdivision 1. **Establishment.** The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) the premium for the number one qualified plan shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) $1,000 annual deductible individual plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage with a $1,000 annual deductible which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(b) the premium for the number two qualified plan shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) $500 annual deductible individual plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage with a $500 annual deductible which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(c) the premiums for the plans with a $2,000, $5,000, or $10,000 annual deductible shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) $2,000, $5,000, or $10,000 annual deductible individual plans, respectively, in force in Minnesota; and

(2) individual health maintenance organization contracts of coverage with a $2,000, $5,000, or $10,000 annual deductible, respectively, which are in force in Minnesota; or

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(d) the premium for each type of Medicare supplement plan required to be offered by the association pursuant to section 62E.12 shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) Medicare supplement plans in force in Minnesota;

(2) health maintenance organization Medicare supplement contracts of coverage which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles; and

(e) the charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

The list of insurers and health maintenance organizations whose rates are used to establish the premium for coverage offered by the association pursuant to paragraphs (a) to (d) shall be established by the commissioner on the basis of information which shall be provided to the association by all insurers and health maintenance organizations annually at the commissioner's request. This information shall include the number of individuals covered by each type of plan or contract specified in paragraphs (a) to (d) that is sold, issued, and renewed by the insurers and health maintenance organizations, including those plans or contracts available only on a renewal basis. The information shall also include the rates charged for each type of plan or contract.

In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles, provided that the association shall not discriminate in charging premiums based upon sex. In order to compute a weighted average for each type of plan or contract specified under paragraphs (a) to (d), the association shall, using the information collected pursuant to this subdivision, list insurers and health maintenance organizations in rank order of the total number of individuals covered by each insurer or health maintenance organization. The association shall then compute a weighted average of the rates charged for coverage by all the insurers and health maintenance organizations by:

(1) multiplying the numbers of individuals covered by each insurer or health maintenance organization by the rates charged for coverage;

(2) separately summing both the number of individuals covered by all the insurers and health maintenance organizations and all the products computed under clause (1); and

(3) dividing the total of the products computed under clause (1) by the total number of individuals covered.

The association may elect to use a sample of information from the insurers and health maintenance organizations for purposes of computing a weighted average. In no case, however, may a sample used by the association to compute a weighted average include information from fewer than the two insurers or health maintenance organizations highest in rank order.

[For text of subds 2 to 4, see M.S.2002]

History: *2003 c 109 s 2*

62E.091 APPROVAL OF STATE PLAN PREMIUMS.

The association shall submit to the commissioner any premiums it proposes to become effective for coverage under the comprehensive health insurance plan, pursuant to section 62E.08, subdivision 3. No later than 45 days before the effective date for premiums specified in section 62E.08, subdivision 3, the commissioner shall approve, modify, or reject the proposed premiums on the basis of the following criteria:

(a) whether the association has complied with the provisions of section 62E.11, subdivision 11;

(b) whether the association has submitted the proposed premiums in a manner which provides sufficient time for individuals covered under the comprehensive insurance plan to receive notice of any premium increase no less than 30 days prior to the effective date of the increase;

(c) the degree to which the association's computations and conclusions are consistent with section 62E.08;

(d) the degree to which any sample used to compute a weighted average by the association pursuant to section 62E.08 reasonably reflects circumstances existing in the private marketplace for individual coverage;

(e) the degree to which a weighted average computed pursuant to section 62E.08 that uses information pertaining to individual coverage available only on a renewal basis reflects the circumstances existing in the private marketplace for individual coverage;

(f) a comparison of the proposed increases with increases in the cost of medical care and increases experienced in the private marketplace for individual coverage;

(g) the financial consequences to enrollees of the proposed increase;

(h) the actuarially projected effect of the proposed increase upon both total enrollment in, and the nature of the risks assumed by, the comprehensive health insurance plan;

(i) the relative solvency of the contributing members; and

(j) other factors deemed relevant by the commissioner.

In no case, however, may the commissioner approve premiums for those plans of coverage described in section 62E.08, subdivision 1, paragraphs (a) to (d), that are lower than 101 percent or greater than 125 percent of the weighted averages computed by the association pursuant to section 62E.08. The commissioner shall support a decision to approve, modify, or reject any premium proposed by the association with written findings and conclusions addressing each criterion specified in this section. If the commissioner does not approve, modify, or reject the premiums proposed by the association sooner than 45 days before the effective date for premiums specified in section 62E.08, subdivision 3, the premiums proposed by the association under this section become effective.

History: *2003 c 109 s 3*

62E.12 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN.

(a) The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan and a number two qualified plan, except that the maximum lifetime benefit on these plans shall be

$2,800,000; and an extended basic Medicare supplement plan and a basic Medicare supplement plan as described in sections 62A.31 to 62A.44. The association may also offer a plan that is identical to a number one and number two qualified plan except that it has a $2,000 annual deductible and a $2,800,000 maximum lifetime benefit. The association, subject to the approval of the commissioner, may also offer plans that are identical to the number one or number two qualified plan, except that they have annual deductibles of $5,000 and $10,000, respectively; have limitations on total annual out-of-pocket expenses equal to those annual deductibles and therefore cover 100 percent of the allowable cost of covered services in excess of those annual deductibles; and have a $2,800,000 maximum lifetime benefit.

(b) The requirement that a policy issued by the association must be a qualified plan is satisfied if the association contracts with a preferred provider network and the level of benefits for services provided within the network satisfies the requirements of a qualified plan. If the association uses a preferred provider network, payments to nonparticipating providers must meet the minimum requirements of section 72A.20, subdivision 15.

(c) The association shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

(d) Notwithstanding the provisions of section 62E.06 and unless those charges are billed by a provider that is part of the association's preferred provider network, the state plan shall exclude coverage of services of a private duty nurse other than on an inpatient basis and any charges for treatment in a hospital located outside of the state of Minnesota in which the covered person is receiving treatment for a mental or nervous disorder, unless similar treatment for the mental or nervous disorder is medically necessary, unavailable in Minnesota and provided upon referral by a licensed Minnesota medical practitioner.

History: *2003 c 109 s 4*

62E.13 ADMINISTRATION OF PLAN.

[For text of subd 1, see M.S.2002]

Subd. 2. **Selection of writing carrier.** The association may select policies and contracts, or parts thereof, submitted by a member or members of the association, or by the association or others, to develop specifications for bids from any entity which wishes to be selected as a writing carrier to administer the state plan. The selection of the writing carrier shall be based upon criteria established by the board of directors of the association and approved by the commissioner. The criteria shall outline specific qualifications that an entity must satisfy in order to be selected and, at a minimum, shall include the entity's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans and the $2,000, $5,000, and $10,000 deductible plans, the qualified Medicare supplement plan, and the health maintenance organization contract.

[For text of subd 3, see M.S.2002]

Subd. 3a. **Extension of writing carrier contract.** Subject to the approval of the commissioner, and subject to the consent of the writing carrier, the association may extend the effective writing carrier contract for a period not to exceed three years, if the association and the commissioner determine that it would be in the best interest of the association's enrollees and contributing members. This subdivision applies notwithstanding anything to the contrary in subdivisions 2 and 3.

[For text of subds 4 to 11, see M.S.2002]

History: *2003 c 109 s 5,6*

62E.14 ENROLLMENT BY AN ELIGIBLE PERSON.

Subdivision 1. **Application, contents.** The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person shall enroll by submission of an application to the writing carrier. The application must provide the following:

(a) name, address, age, list of residences for the immediately preceding six months and length of time at current residence of the applicant;

(b) name, address, and age of spouse and children if any, if they are to be insured;

(c) evidence of rejection, a requirement of restrictive riders, a rate up, or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least one association member within six months of the date of the application, or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk;

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

(e) a designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan. Upon ceasing to be a resident of Minnesota a person is no longer eligible to purchase or renew coverage under the state plan, except as required by state or federal law with respect to renewal of Medicare supplement coverage.

Subd. 2. **Writing carrier's response.** Within 30 days of receipt of the application described in subdivision 1, the writing carrier shall either reject the application for failing to comply with the requirements in subdivision 1 or forward the eligible person a notice of acceptance and billing information. If the applicant otherwise complies with the requirements of sections 62E.01 to 62E.19, insurance shall be effective immediately upon receipt of the first month's state plan premium, and shall be retroactive to the date the application was received by the writing carrier, unless a different effective date is provided in this section.

Subd. 3. **Preexisting conditions.** No person who obtains coverage pursuant to this section shall be covered for any preexisting condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days immediately preceding the date the application was received by the writing carrier, except as provided under subdivisions 4, 4a, 4b, 4c, 4d, 5, 6, and 7 and section 62E.18.

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

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

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

(3) the person submitted an application that was received by the writing carrier no later than 90 days after termination of previous coverage.

Subd. 4. **Waiver of preexisting conditions for Medicare supplement plan enrollees.** Notwithstanding the above, any Minnesota resident holder of a policy or certificate of Medicare supplement coverages pursuant to sections 62A.315 and 62A.316, or Medicare supplement plans previously approved by the commissioner, may enroll in the comprehensive health insurance plan as described in section 62E.07, with a waiver of the preexisting condition as described in subdivision 3, without interruption in coverage, provided that the policy or certificate has been terminated by the insurer for reasons other than nonpayment of premium and, provided further that the option to enroll in the plan is exercised through submitting an application received by the writing carrier no later than 90 days after termination of the existing contract or certificate.

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

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

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

(2) the person:

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

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

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

(3) continuation coverage is not available; and

(4) the person's application for coverage is received by the writing carrier no later than 90 days after termination of prior coverage from a policy or plan.

Coverage in the comprehensive health plan is effective on the date of termination of prior coverage. The availability of conversion rights does not affect a person's rights under this subdivision.

Subd. 4b. **Waiver of preexisting conditions for persons covered by retiree plans.** A person who was covered by a retiree health care plan may enroll in the comprehensive health plan with a waiver of the preexisting condition limitation described in subdivision 3, provided that the following requirements are met:

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

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

(3) the person's application for coverage is received by the writing carrier no later than 90 days after termination of prior coverage.

Coverage in the comprehensive health plan is effective on the date of termination of prior coverage. The availability of conversion rights does not affect a person's rights under this section.

Subd. 4c. **Waiver of preexisting conditions for persons whose coverage is terminated or who exceed the maximum lifetime benefit.** (a) A Minnesota resident may enroll in the comprehensive health plan with a waiver of the preexisting condition limitation described in subdivision 3 if that persons's application for coverage is received by the writing carrier no later than 90 days after termination of prior coverage and if the termination is for reasons other than fraud or nonpayment of premiums.

For purposes of this paragraph, termination of prior coverage includes exceeding the maximum lifetime benefit of existing coverage.

Coverage in the comprehensive health plan is effective on the date of termination of prior coverage. The availability of conversion rights does not affect a person's rights under this paragraph.

This section does not apply to prior coverage provided under policies designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or policies providing only accident coverage.

(b) An eligible individual, as defined under United States Code, chapter 42, section 300gg-41(b) may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition limitation described in subdivision 3 and a waiver of the evidence of rejection or similar events described in subdivision 1, clause (c). The eligible individual must apply for enrollment under this paragraph by submitting a substantially complete application that is received by the writing carrier no later than 63 days after termination of prior coverage, and coverage under the comprehensive health insurance plan is effective as of the date of receipt of the complete application. The six-month durational residency requirement provided in section 62E.02, subdivision 13, does not apply with respect to eligibility for enrollment under this paragraph, but the applicant must be a Minnesota resident as of the date that the application was received by the writing carrier. A person's eligibility to enroll under this paragraph does not affect the person's eligibility to enroll under any other provision.

(c) A qualifying individual, as defined in the Internal Revenue Code of 1986, section 35(e)(2)(B), who is eligible under the Federal Trade Act of 2002 for the credit for health insurance costs under the Internal Revenue Code of 1986, section 35, may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition limitation described in subdivision 3, and without presenting evidence of rejection or similar requirements described in subdivision 1, paragraph (c). The six-month durational residency requirement provided in section 62E.02, subdivision 13, does not apply with respect to eligibility for enrollment under this paragraph, but the applicant must be a Minnesota resident as of the date of application. A person's eligibility to enroll under this paragraph does not affect the person's eligibility to enroll under any other provision. This paragraph is intended solely to meet the minimum requirements necessary to qualify the comprehensive health insurance plan as qualified health coverage under the Internal Revenue Code of 1986, section 35(e)(2).

Subd. 4d. **Insurer insolvency; waiver of preexisting conditions.** A Minnesota resident who is otherwise eligible may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition limitation described in subdivision 3, if that person submits an application for coverage that is received by the writing carrier no later than 90 days after termination of prior coverage due to the insolvency of the insurer.

Coverage in the comprehensive insurance plan is effective on the date of termination of prior coverage. The availability of conversion rights does not affect a person's rights under this subdivision.

Subd. 4e. **Waiver of preexisting conditions; persons covered by publicly funded health programs.** A person may enroll in the comprehensive plan with a waiver of the preexisting condition limitation in subdivision 3, provided that:

(1) the person was formerly enrolled in the medical assistance, general assistance medical care, or MinnesotaCare program;

(2) the person is a Minnesota resident; and

(3) the person submits an application for coverage that is received by the writing carrier no later than 90 days after termination from medical assistance, general assistance medical care, or MinnesotaCare program.

Subd. 5. **Terminated employees.** An employee who is voluntarily or involuntarily terminated or laid off from employment and unable to exercise the option to continue coverage under section 62A.17 may enroll, by submitting an application that is received by the writing carrier no later than 90 days after termination or layoff, with a waiver of the preexisting condition limitation set forth in subdivision 3 and a waiver of the evidence of rejection set forth in subdivision 1, paragraph (c).

Subd. 6. **Termination of individual policy or contract.** A Minnesota resident who holds an individual health maintenance contract, individual nonprofit health service corporation contract, or an individual insurance policy previously approved by the commissioners of health or commerce, may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition as described in subdivision 3, without interruption in coverage, provided (1) no replacement coverage that meets the requirements of section 62D.121 was offered by the contributing member, and (2) the policy or contract has been terminated for reasons other than (a) nonpayment of premium; (b) failure to make co-payments required by the health care plan; (c) moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for the terminated policy or contract; and, provided further, that the option to enroll in the plan is exercised by submitting an application that is received by the writing carrier no later than 90 days after termination of the existing policy or contract.

Coverage allowed under this section is effective when the contract or policy is terminated and the enrollee has submitted the proper application that is received within the time period stated in this subdivision and paid the required premium or fee.

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

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

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

(b) A Minnesota resident who was covered by a conversion policy or contract of health coverage may enroll in the comprehensive health plan with a waiver of the preexisting condition limitation in subdivision 3 and a waiver of the evidence of rejection in subdivision 1, paragraph (c), if that person applies for coverage by submitting an application that is received by the writing carrier no later than 90 days after termination of the conversion policy or contract coverage regardless of: (1) the reasons for the termination; or (2) the party terminating coverage.

(c) Coverage under this subdivision is effective upon termination of prior coverage if the enrollee has submitted a completed application that is received within the time period stated in paragraph (a) or (b), whichever applies, and paid the required premium or fee.

History: *2003 c 109 s 7*

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

A Minnesota resident who is age 65 or over and is not eligible for the health insurance benefits of the federal Medicare program is entitled to purchase the benefits of a qualified plan, one or two, or the $2,000, $5,000, or $10,000 annual deductible plan if available, offered by the Minnesota Comprehensive Health Association without any of the limitations set forth in section 62E.14, subdivision 1, paragraph (c), and subdivision 3.

History: *2003 c 109 s 8*